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# The Canadian Practitioner and Review.

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## Original Communications.

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### RUBBER SPLINTS IN THE TREATMENT OF SEPTAL CURVATURE.\*

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By J. PRICE-BROWN, M.D., TORONTO.  
Fellow of the American Laryngological Association, etc.

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Three years ago I had the honor of reading a paper before another American Society on the use of rubber splints in the treatment following intra-nasal operations. Since that time I have had occasion to use them in many instances in which operative treatment was required; and now desire to lay before the Fellows of this Association, in a brief paper, the result of that experience; confining my remarks, however, to their use in cases in which septal curvature was the principal evil to be dealt with.

While vomeric ridges and exostoses may extend all the way back to the posterior nares, curvatures are usually confined to the anterior two thirds of the septum; and a majority of these principally to the triangular cartilage. It is in the treatment of the latter class of cases that the rubber splint is particularly suitable.

In the formation of septal curvature there are several points which are of great practical interest. In a large majority of instances, particularly when occurring in adult life, the curvature of the cartilage is accompanied by thickening, which develops chiefly on the convex side and in the neighborhood of the so-called septal tubercle. While this thickening is simply physiological on the straight septum, it becomes pathological on the curved septum, owing to the hypertrophic enlargement of the glandular tissue, occasioned by the rounding or stretching which the curvature gives to the mucus membrane. In

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\* Read at the annual meeting of the American Laryngological Association in Boston, May, 1902.

these cases, while the tubercle on the concave side will shrink away into less than normal development, the tubercle on the convex side, lying in the region of the union of the vomer with the perpendicular plate of the ethmoid, will enlarge sufficiently to interfere with normal breathing; and together with the general curvature of the whole triangular cartilage almost occlude the passage. Projecting backwards from the tubercle along the union of the supra-vomerine cartilage with the vomer, the hypertrophy may continue forming, in old cases, the long osseous ridge so often met with. On the other hand, anterior to and below the tubercle, along the line of union of Jackson's cartilage with the anterior end of the vomer a similar hypertrophic ridge may form, complicating and making larger the general curve.

Upon the etiology of septal deviations I will not enter, except to offer a mild protest against the idea that the method of handling the olfactory organ has nothing to do with either the cause or increase of the deformity. It cannot be the chief cause; but I believe from my own professional experience, that in many cases of septal curvature, the habit of wiping the nose toward the concave from the convex side—which is habitual in all these cases—has a serious effect in aggravating the deformity.

If a dentist in a young adult can attach a chain to a tooth, which is blocked behind the adjoining ones for want of space, and by constant traction, in the course of a few weeks, draw the two apart, and pull the laggard one into line, it is reasonable to believe that the oft-repeated twiggling of the nose in the one direction will have a serious effect upon the softer cartilage. These curved noses are always weeping; and pulling them many thousands of times each year to the one side, acts upon the principle of bending a green stick. The more frequently you apply the pressure, the more curved will the bow become.

My own experience differs also from some clinicians, who claim that when the bony septum is curved to one side the triangular cartilage is usually curved to the other side. The rule I have found to be the opposite. It is possible when the chief deflection is that of the vomer that the septal cartilage may curve the other way; but when the main deformity is of the cartilage, and septal ridge extending backwards has been almost invariably on the same side, as though the whole septum had formed a bow-like protrusion into one or other nasal cavity.

Sometimes these deformities are confined entirely to the cartilaginous region, the concavity on the one side being book-notched in form and ending abruptly at the commencement of the bony septum—the convex side being rounded and hypertrophied in the region of the tubercle. In the treatment of

such cases as these are the rubber splints especially useful; and it is to Mr. Lake that we owe the suggestion. He does not, however, mention the nature of the cases in which its use is advisable, nor the operation to which it serves as an adjunct. Still the shape of the splint and its advantages are spoken of by him in these words:

"Rubber sheeting should be kept in three thicknesses, one-eighth, two-eighths and three-eighths. The exact shape and size varies with each case. It may be either straight or boomerang, the latter enabling one to get pressure higher up the septum. If the thickest sheeting be used, the edges should have a long bevel given them by cutting with a sharp wet knife. These splints cannot become septic any more than can vulcanite; while they exert an elastic pressure which is less apt to cause sloughing and is surprisingly effective."

The class of cases in which I have personally found them most useful is the one that is the title of this paper; but the splint is rarely inserted without previously incising the cartilage. The usual method of procedure is the following:

The nasal passages are first sprayed with a one per cent. solution of cocaine. This shrinks the tissues and renders the passages more open, enabling the operator to more thoroughly cleanse them. To accomplish the latter, I prefer using an albolene or glycolene spray under pressure as less likely to produce abrasion of the mucus membrane than are the alkaline solutions when similarly used.

A five per cent. solution of cocaine is then applied on a cotton holder to the septal cartilage on both sides, chiefly to the convex one. Also a solution of adrenalin 1 to 5,000. Local anesthesia being induced, the hypertrophied tubercle is removed if present, by knife or saw. Then a tetotomy knife is passed from behind forward in one or two straight lines over the convex surface and through the cartilage—the lines being a short distance apart and parallel to each other. These incisions are usually made on the bevel, enabling the cut edges to glide over each other. The finger is next passed into the nostril and the cut septum pressed with little difficulty toward the median line. A splint is now chosen that after insertion will produce a slight pressure upon both inferior turbinated and septum when straightened. I like to have a fairly tight fit, with a splint not too wide, so that the elastic pressure will keep it in position. There should be room enough above the splint to pass a light cotton holder armed with a small pledget as far as its posterior end; and the inferior meatus sufficiently free to allow a similar cleansing right through to the pharynx. After insertion, as a rule, the splint should not be removed at all until healing and solidity have been accomplished, whether

this takes two weeks or four, or even longer. Still for some time the patient should be under the daily observation of the surgeon, and the nasal passage regularly cleansed by the use of the cotton holder dipped in a weak solution of cocaine or mentholated albolene or other medicament, as the exigencies of the case might require.

For a day or two there might be a slight rise of temperature and some pain; but these would soon pass away; and after a week or so I have always been able to allow the patient to go to his home, usually at a distance, with instructions to keep me informed of the progress of the case, and to return for examination, etc., at a certain time.

The advisability of moderate tightness on the part of the splint is instanced in several ways: First, by its elasticity it maintains its position, giving immovable support to the septal cartilage during the process of healing. Second, it promotes absorption of the overlapping edges of the cut cartilage; for on removal, if allowed to remain until healing takes place, the septum on the side operated upon will present a uniformly smooth surface.

I know that I run the risk of opposition to this method of treatment, on the ground that such prolonged retention of the splint might favor the occurrence of sepsis. This has not proved to be the case. As I said before, when fever occurs at all, it is due to irritation, arising almost immediately after operation and quickly subsiding. During the long process of wearing the splint there is no fever whatever, and no symptoms save those that arise from the occlusion caused by the presence of the instrument; and which is usually less than that previously experienced from the simple existence of curvature.

The operation in regard to hands and instruments is done antiseptically. Within the nasal passage is placed a smooth compressible aseptic body, which, as stated by Lake, cannot become septic; and the nasal passage above and below this harmless body, being kept clearer of secretions than it was before the operation, it is difficult to believe that the retention of the instrument during the process of healing can be productive of evil.

As illustrative of these facts I will briefly quote the history of the following cases:

Case I.—A boy, aged 6 years, was brought to the outdoor clinic of the Western Hospital for treatment on account of entire inability to breathe through the right nostril. The occlusion had been increasing for several years and was occasioned, the mother thought, by a fall on the face which flattened the nose somewhat when he was two years old. There was a

marked curvature of the cartilaginous septum to the right with a longitudinal ridge at its base. Under chloroform the ridge was excised. Then an incision made over the centre of the convex curvature from behind forward, the course of the knife being guarded by the little finger in the left nostril. Notwithstanding this, the knife accidentally penetrated the mucus membrane into the left nasal cavity. Hemorrhage was free; but a one-eighth splint long enough to extend beyond the triangular cartilage was at once pressed into the nostril. Bleeding ceased as soon as the splint was in place; and after the first hour or two there was no suffering. Nothing whatever was done afterwards except to wipe away any discharge that might exude. The splint was removed two weeks later, revealing a perfectly healed, smooth, straight septum. After cleaning the splint it was replaced and worn another week; when it was taken out and the little patient discharged cured.

Case II.—A carpenter, aged 28, had his nose broken when a child, by a fall, partially depressing the bridge. For years he had suffered from almost complete stenosis on left side. Examination: Right nasal cavity enlarged, presenting concave book-notched septum on that side. On left, large curvature with thickened tubercle and ridge along Jacobson's cartilage, filling the passage. After cocainization an osseous ridge was discovered on same side, extending to near the posterior choana; while in the centre a bony synechia connected inferior turbinated with septum.

The first operation was to excise a portion of the enlarged tubercle and Jacobson's ridge and put in a rubber splint. Four days later the synechia and osseous ridge were sawn out; and after hemorrhage had subsided a long rubber splint, extending to the posterior nares, was inserted. This was left in for a week; then taken out daily, and, after being cleansed, returned. The excisions in this case were extensive, although there was no linear cut into the septal cartilage. In six weeks the healing was very satisfactory, resulting in a clear chink from end to end of the passage with re-formation of mucus membrane.

Case III.—A boy, aged 7 years, was brought to the hospital as a mouth breather for treatment. He had been stunned by a blow on the forehead when four years old, since which time, his mother reported, nasal breathing gradually became more difficult and finally ceased. There was curvature of cartilage to left with ridge at base. Columnar cartilage curved to right. Adenoids in nasopharynx. Under chloroform this ridge was excised; then two bevelled incisions from behind forward were made through the cartilage on the curved side, the finger being placed in the right nostril to act as guide and protect mucus

membrane from perforation. A two-eighth splint was at once inserted, pressing the cartilage into the medial line. While still under the anesthetic a slip was taken from the columnar cartilage on the right side and the adenoids removed. Two weeks later the rubber splint was taken out, the result being free nasal respiration and a good left nasal passage.

Case IV.—Boy aged 17. Nose externally twisted to right. Said that he was struck by a ball on the nose, two years ago, since which time nasal stenosis and deformity had occurred. Examination revealed extensive ridge formation on left side, with curve filling up the fossa, the tubercle part of the cartilage being adherent to the middle turbinated. Under cocaine I excised front part of ridge and the tubercle synechia, and after compressing septum to right with a chisel, I inserted a one-eighth inch rubber splint. Four days later, under chloroform, I made two incisions from behind forward through the septal cartilage, guiding as in the other cases by the finger in the opposite nasal passage. The cut septum was forced by finger to the medial line and a two-eighth rubber splint inserted. This was left in two weeks. The front part of the passage being now freely open, a bony ridge extending along the lower part of the vomer backwards was removed by saws; and to favor the formation of a smooth and even surface a long and wide one-eighth splint was placed in position. This created no discomfort. As the patient was returning home to a distant village he was instructed to leave it in without removal for a month. He wrote later that he had followed the directions, taking it out at the time stated, with the result of a better-shaped nose and better breathing on both sides.

Case V.—Divinity student, aged 26, October, 1900. Has had increasing nasal stenosis on left side for years, amounting to complete occlusion at time of examination and destroying the tone and quality of the voice. There was a deep book-notch with wide passage on right side. On left, curvature and general hypertrophy sufficient to completely fill the passage. One part of the cartilage from exposure to the dry air of respiration had become denuded of epithelium. The cartilage seemed to be very hard and resistant to pressure.

Under local anesthesia from cocaine the case was operated on as in the others mentioned; but I could not press the septum to the medial line successfully, and only inserted a one-eighth splint. Ten days later chloroform was administered at the hospital and a central cut made through the cartilage on the concave side along the floor of the notch. Relying on the previous cuts as well, the septum was then more successfully pressed toward the medial line and a two-eighths splint put in.

The patient was kept in bed for several days. There was

during this period some pain, and a rise of temperature of one or two degrees. But these symptoms gradually abated. The splint was worn continuously for two weeks and becoming loose was removed. As I was going south for the winter, a splint was not inserted again—simpler treatment for the time being resorted to.

In May, 1901, he returned to the hospital for treatment, a good deal of stenosis on the same side having recurred. Under chloroform I sawed out a ridge bone behind the curvature; and then made two horizontal cuts from behind forward on the concave side. Then with a spatula slipped over the curvature I forced the septum partially over, following this by the use of Delstanche's instrument. This time I put in a long and wide two-eighths splint. The pain following the operation was very slight and the fever practically nil. Several weeks later the splint was removed, and as the patient felt well and was going on a summer missionary tour to the north, I made and inserted a splint that would give adequate support and not be likely to become displaced. He went away on the 26th of June and returned on the 19th of September, a period of twelve weeks, without ever having it removed. It had occasioned no discomfort. He had breathed somewhat through that side and had found no difficulty in using his voice. On removing the splint the passage was free and the mucus membrane healed.

Case VI.—Boy, age 13. Mouth breather, snores and restless while sleeping. This, too, was an extensive curvature to the left with spur-ridge along Jacobson's cartilage. Deep saucer-like concavity on the right side. After chloroform anesthesia, a solution of adrenalin was applied, and the ridge removed with a knife. Then three incisions from back to front were made over the convexity and a good sized one-eighth splint was used. There was neither pain nor rise of temperature. Three days later under cocaine the splint was removed and a two-eighths one put in its place. The boy felt very well, and two days later, contrary to orders, took a long ride on his bicycle in the bent-over position. This caused a severe epistaxis from the other nostril, one of the incisions having perforated the septum. There was no bleeding from the plugged side. Tampons had to be inserted; but the splint was not removed. In another week I allowed the boy to return to his home, forty miles away, still carrying it. I heard from his father from time to time, but as the lad was attending school and free from all symptoms he did not come back to the city to have it removed until four months afterwards. The result is that he has a free open passage, and has lost all his old naso-pharyngeal symptoms.



Case VII.—Lady, age 60, with curvature of septum; no anterior spur, but bony ridge along the base of vomer. In this case, under cocaine and adrenalin I treated the curvature first. The septum was hard. So instead of knife incisions over the rounded surface I made two saw incisions about half an inch apart; and then two knife incisions on the concave or left side. With Delstanche's instrument the septum was then pressed over to the medial line, and a two-eighths splint put in. Two days later this was removed, the parts cocainized, and a three-eighths inserted in its place. This was worn for three weeks. The septum seemed consolidated, the ridge was sawn out and another splint worn for a few weeks longer. I then showed the case to the hospital staff, the contracted nasal passage having been restored to a normal condition and appearing the same size as the other.

In closing, I would remark that these splints can readily be made by the surgeon, the only tools required being a sharp knife, a pair of scissors, a file and a piece of sandpaper. They are, as already remarked, smooth and pliable, and thoroughly aseptic; while their compressibility renders them superior to any other material of which nasal splints can be made. I may say, also, that the edges should always be rounded, and while it would not be wise to put them in too tightly, care should be taken to have the instrument thick enough to keep its position, without resting for support on the floor of the inferior meatus.

While I advocate the wearing of the splint uninterruptedly as long as its services are required, I insist again on the necessity for oversight of the patient by the surgeon for the first few days; and subsequently keeping in touch with him until the splint is finally removed.

## THE DOCTOR AND THE MEDICAL SOCIETY.

By JOHN HUNTER, M.B., TORONTO.

This is a perennial problem, for after each meeting the medical editor is found bewailing the paucity of attendance, lack of interest, etc. Before dealing with some special phases of this question, I crave permission to make the following somewhat lengthy quotation, as I think it admirably expresses the views of those who make a practice of attending medical meetings: "Now, one of the good things about conventions is that a man who has attended one can never be as if he had not attended one. This is not to say that he will want to go again, or that he will certainly enjoy it, but only that he will never be able to treat the matter as if it had never happened. If it does not refresh him (and it is quite conceivable that it may bore him) it will at least make it impossible for him to think of the world exactly as he did before he went. He has seen something else than the narrow scenery of his own task. There are other tasks than his own, and there are other ways of approaching his own task, unsettling it may be, but henceforth one realizes that he is not the whole world, and, try as he will, he will never be able to shrink things back to their old village proportions."

Whether the above picture be a true one or not, the fact remains that there must be something radically wrong with the man who persistently absents himself from attendance at these meetings, or with the character of such meetings or the methods in which they are conducted.

Let us first enquire into the morbid elements in the character of those doctors who never attend, or are indifferent about their attendance at medical meetings. We pass over the excuses—seldom valid enough to merit attention—such as "want of time," "expense," etc., and endeavor to ascertain as accurately as possible the real causes for this most unfortunate condition, and I use the word unfortunate advisedly, for I certainly think it is such to the physician, his patients and his profession:

1. *Morbid Self-Esteem.*—Swelled head is the unscientific, inelegant, but well understood term. Such an one is fully impressed with the conviction that he is far above all need of assistance from the "rank and file." Medical associations may be all right for the "little fellows" but not for such as he, and he alone, deems himself to be.

2. *Morbid Modesty.*—There is no more beautiful virtue than innate modesty, but does not the term "morbid modesty" explain fairly well the attitude of that large class of physicians who conscientiously believe that they cannot contribute anything of sufficient merit to be of interest to the meeting, and

therefore conclude that their absence will not be felt. These men seem to overlook the fact that the presence of a large appreciative audience is one of the most important factors that go to make up a successful gathering.

3. Morbid Indifference.—The adage is no less true than trite, that "no man liveth unto himself." The physician who is solely "in" his profession for all he can get out of "it," utterly regardless as to whether his profession is keeping abreast of "the times" or not, is either a monstrosity incapable of appreciating his obligations to his profession, or else a parasite willing to live upon the labor of others, but unwilling to contribute anything himself.

4. Morbid Fears.—How many physicians believe that they must spend their whole life within easy call of their patients. These timid souls seem to imagine that if they were to take a few hours, or a day or two, to attend a medical association, their whole practice would immediately go to the "bow-wows." This is a delusion, for the separation is invariably mutually advantageous. The patients realize, probably for the first time, what a great privilege it is to have the prompt attendance of a physician in whom they have full confidence, and the physician is getting the change and the wider views that will add very materially to the character of his work.

Many more morbid elements suggest themselves; but I must hurry on to briefly discuss the second phase of this question, viz.: What is radically wrong with the character of such meetings or the methods in which they are conducted.

1. Morbid Character of Papers.—A medical audience is a keenly critical one. It quickly discovers the motive of the reader, as to whether his paper is intended to be an honest contribution to scientific medicine, a personal advertisement, or an act of mere courtesy to the president. Any paper worthy of the attention of a medical association must be on a subject suitable to the audience, and be an accurate, intelligible presentation of the subject in keeping with the scientific attainments of the day.

2. Morbid Length of Papers.—Is there anything that has a more demoralizing influence on the minds of an audience than to see the reader of a paper unfold a role of twenty or thirty pages? All inspiration is at once dispelled, pleasure vanishes, and a sullen determination to endure the agony as best they can, creeps over the listeners.

3. Morbid Character of the Discussions.—It is said that the distance a cannon can throw a projectile can be roughly estimated by the weight of the former over the latter. The proportion is about as 100 to 1 for great propelling power. The influence a man can wield over his fellows is governed by his character, tact and intelligence. How often does it happen

during the discussion of a paper that there is a want of proportion between the speaker and his subject. A light man's efforts at discussing a weighty subject is, to say the least, not a very inspiring spectacle, nor is it any wonder such speakers drift far afield. However, an audience will always be interested in any man whom it believes to be truthfully and honestly endeavoring to make the best contribution he possibly can to advance the interests of his profession.

Fourth, and Last, Morbid Defects in Elocution.—How few medical men can read or speak attractively. Elocution seems to be a lost art with us, and yet by tone of voice and gesture impressions can be made too subtle perhaps to be caught by stenographer's pen, or set up in cold type, but none the less potent for good. The classic language, the rich cadences of voice, the expressive features, the bewitching eyes, the graceful gesture, the poise of body; these often remain as charming memories long after the subject discussed has been forgotten, perchance long after he who was the embodiment of them has passed away.

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## THE PRODUCTION OF THE SEX AT WILL.

BY JAS. S. FREEBORN, MAGNETAWAN.

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From observations extending over a period of ten years, I have come to the conclusion that the sex can be produced at will. My attention was at first directed to the statement of mothers in confinement, when it was stated, "I am two or three weeks over my count," I invariably delivered a male child; and when it was stated, "I did not expect to be sick so soon," a female. I began to think that the time of conception between the periods or dates of menstruation determined the sex, mothers reckoning from date of last menses. From notes of over 500 cases my prediction as to sex has been verified in 98 per cent. of all confinements, when correct date of last change was noted. My rule has been, when called to a patient in labor at full term, to ascertain date of last normal menstruation, take the average time for gestation, count back, and should the date fall in the first half of interval between menses, I predict a female; should it drop in latter half, *i.e.* in the two weeks previous to next expected change, my prediction is a male.

My anxious patients, who desired boys, and limited sexual congress to a period of ten days previous to next expected change, have never been disappointed in results. So far, I have had no appeals for girls.

Possibly some of your many readers may. If so, advise your anxious parent to limit congress to ten days after cessation of menstruation and note the result.

## THE FILLING OF A LONG-FELT WANT.

BY H. S. HUTCHISON, M.D.

The magic name, Muskoka, brings to many minds remembrances of delightful holiday times in a truly delightful region. Not least amongst the charms of the place is an atmosphere, pure and free, with which the fragrance of the pine is blended.

This element caused thoughts to turn towards putting to practical healthful use this country of enjoyment, and five years ago by the generosity of two men a fine sanatorium was erected for patients just commencing the tedious battle with lung trouble. This institution has flourished, and cottages have been erected by different people to provide extra bedroom accommodation for the numerous applicants for admission.

While time enough has been going by for satisfactory conclusions, as to benefits of climate, to be drawn amongst patients in possession of sufficient means to pay fairly for their maintenance, cities and towns throughout the land have been striving to cope with the problem of helping cases in which the individual is not able to pay fairly for his living and medical treatment, or possibly cannot afford even the expenses of the journey. Many suggestions have been made. The addition of a wing to the Home for Incurables was talked of, and though the need for this has in no way been lessened, the original idea of housing hopeful and even incipient cases with those in which the disease has made terrible ravages, seems a cruel one. Again, a hospital near Toronto has been spoken of, but it is questionable whether, in the belt of land which borders on the great lakes, suitable climatic and atmospheric conditions could be obtained.

The difficulty has now been solved through the liberality of the two men who erected the first building. On Saturday, July 5th, a free hospital for consumptives was handed over to the trustees of the National Sanatorium Association by Mr. W. J. Gage, of Toronto, the gift of himself and of the late Hart A. Massey.

A special excursion was arranged from Toronto, and a large number of people came up for the function. Addresses were given by Sir William Meredith, Mayor Howland, Rev. J. Pitt Lewis, Ald. Hubbard and others all of whom, from the prominence of the positions held by them in public life seemed to have been seriously impressed with the needs for such a place, and to be sincerely glad that everything was now so completely satisfactory.

The situation of the new place is on the shores of Lake Muskoka, about two miles from Gravenhurst, and three

quarters of a mile from the Muskoka Cottage Sanatorium. The building is placed upon a rocky elevation about one hundred yards from the water, down to which there is a gentle slope of lawn. Immediately behind is the bush, which is high enough to afford shelter from the north wind. The view is magnificent. The lake is here composed of a series of bays, the points of land aiding the rocky isles with which all Muskoka waters are beautifully studded, in presenting a view thoroughly typical of this beautiful district at its best. An almost continuous stream of gaily bedecked steamers and handsome launches is an element added by man to the beauties provided by Providence, and is one that serves the purpose of preventing any feelings of isolation. Moreover, not much less beautiful than the approach from the front is that from the rear, the property of the Association being beautifully wooded, the road being a winding avenue through stately pine trees.

The building itself is a very fine structure, handsomely finished, lit throughout by electricity, and is adapted as much as possible to meet the requirements of the work. The front faces south, as do all bedrooms, in each of which there is a large window opening into the balconies. In this way the sunlight is secured for the greatest possible number of hours daily. Ventilation is effected by means of the large windows in the rooms, the very large fanlights over the doors, and the windows at the ends of the long corridors. Incidentally, this system, though the simplest is by no means the cheapest, for the amount of heat required to warm such a large amount of incoming cold air is very great. The lavatories are large and airy. A new departure is the placing within the stone foundations of the verandahs, so that, the boilers being placed close to the front wall in the basement, the floors of these verandahs are warmed, thus adding immeasurably to the comfort of a very important part of the treatment, sitting out-of-doors in winter.

Recreation, a factor by no means small in the successful treatment now in vogue, is here made possible by means of several features. Indoors there is a fine large sitting room with a piano, a library, and a well-equipped billiard room. Outside rowboats, and hammocks in the cool grove near by in summer, and tobogganing and snow-shoe trips in winter form pleasures in which many may participate.

The respects in which the new hospital differs from the sanatorium are, less elaborate fittings of the building, less elaborate minor details of various kinds, and the presence of public wards and of more than one bed in all rooms.

A number of the prominent phthisiologists of Canada and the United States have already visited the new place, and all

have pronounced everything to be eminently satisfactory for the needs of the work.

Philanthropy has stood the brunt of commencing this noble work, and the public, for whose good it has been started, is asked to provide the means for the carrying of it on. Already the feeling in regard to this charity has been shown by the raising of a substantial sum for the fitting up of the interior of the building, and there is no doubt that the wide interest now being taken in tuberculosis will manifest itself in a practical way in the future.

## Selected Article.

### FRACTURES OF THE UPPER THIRD OF THE FEMUR.

BY W. BURT, M.D., PARIS, ONT.

As it does not yet seem to be generally established that all, or nearly all, fractures of the femur may be treated by the straight position with Buck's extension apparatus, I will add to the record one of my latest experiences, with the permission of Dr. Sinclair, who asked me on the day following the accident to see the case with him and others. The doctor has handed me a short history of the accident, which is as follows:

Y. L., age 16 years, always enjoyed good health. He met with the present accident in the Y. M. C. A. gymnasium on November 16th, 1901, while trying to jump over a horizontal bar three feet from the floor. He caught the left foot, which tripped him, and he fell with great violence to the floor.

He was seen shortly afterward by Dr. Dunton and myself. Under an anesthetic, we found the femur dislocated upward on the ilium, which was reduced, the head of the bone going in with a thud. After the reduction of the dislocation we discovered that we had a fracture of the upper third of the femur to deal with and shortening to the extent of two inches and a half, the proximal fragment projecting markedly forward and outward. On an assistant making extreme flexion and extension upward, I could push the upper fragment into place, but the moment I let go it would tilt forward. The greatest flexion on the part of the assistant would not reduce the fracture. We put him up with a flexion apparatus, but the displacement remained.

I have been induced to publish this case on account of the articles by Dr. Hibbs and Dr. Shaffer in your issues of February 1st and 8th, and for the reason that there are to-day teachers of surgery who would think it a criminal procedure to treat a fracture of the upper or lower third of the femur in the straight position. I feel that if ever I had a bad case and was proceeded against for malpractice, there are many surgeons who would testify that a better result might have been obtained by the flexed position.

In my early days, when I was an interne in the Brooklyn City Hospital, and fractures of the thigh were somewhat numerous for a time, I gleaned from Hamilton's classical work and discarded double-inclined planes and flexed positions alto-



gether, and I have never had reason to repent, fractured thighs coming under my care now and again ever since.

In the present case Dr. Sinclair, with the assistance of Dr. Dunton and Dr. Scott, put up the fracture in the flexed position, and with all that they could do the upper fragment was plainly visible, projecting forward and outward. Their faith was in the flexed position. I felt that the straight position could not make matters worse and possibly a good deal better. The flexed apparatus was removed and Buck's extension applied. The projection forward of the upper fragment disappeared in a great measure almost immediately, and I felt that the condition of affairs would still improve and that in a few days at least the fragments would be in the best possible condition, which took place.

I examined our patient about three weeks ago at the request of Dr. Sinclair. I found him in the garden using a wheelbarrow and scarcely favoring the injured limb at all. The contour of the limb was normal. A better result could not be desired. Any unevenness on the outer side could not be detected, nor was there shortening to the extent of five millimetres.

I may state here, what is self-evident to every one, that the tendency of the upper fragment to tilt outward is completely overcome by Buck's extension apparatus, which brings both fragments into a straight line, and the pelvis does the tilting, which often makes the fractured limb to appear the longer. This is why I take exception to the necessity of abducting the limb when applying the apparatus. There are other points which the advocates of the extension splint allege for their method, which those in favor of Buck's apparatus will not concede to them, *e.g.*, immobility of the pelvis, continuous extension, and mobility of the lumbar spine.

Not long after the above-mentioned case occurred, Dr. Sinclair had a compound fracture of the lower third of the femur in a boy aged twelve. Although the lower part of the thigh was much swollen, the same procedure was adopted, and the result is most promising. The doctor tells me that there is not a quarter of an inch shortening, and the patient is walking without a cane, favoring the limb very little. Coaptation and the long side splints were used in both cases.

While I should not say that there are not many surgeons who can obtain good results with inclined planes and extension splints, neither should I like to say that a better result might have been obtained in some cases by the straight position with Buck's appliance. In the present status of affairs I do not think that those who pin their faith to the flexed position should malign those who have greater confidence in the straight

position or give testimony against them in case of suit for malpractice. It is next to impossible for the surgeon to visit a case several miles in the country and make daily changes of the dressings, as is required with the extension splint, whereas almost any onlooker can attend to the treatment by Buck's plan, and then, again, it is so simple, no special apparatus being required. The use of an anesthetic is seldom required unless it is thought desirable to use plaster of Paris, both as a coaptation splint and to prevent shortening after reducing the fracture, a plan to which, if I remember right, the late Dr. Henry B. Sands was very partial.—*New York Medical Journal*.

# Progress of Medical Science.

## MEDICINE.

IN CHARGE OF W. H. B. AIKINS, T. M. McMAHON, H. J. HAMILTON,  
AND INGERSOLL OLMISTED.

### Cholelithiasis.

For regular, dependable treatment of gall-stones (aside from those cases that have progressed to a surgical condition), and the states of the stomach, liver and bowels preceding, coincidentally-occurring or dependent thereon, the method long held by Thomson commands respect.

The regular use, and for a long time, of saline cathartics, alternating between sodium phosphate and sodium sulphate, is important. The saline should be taken in doses of about two drams dissolved in a glass of hot water slowly sipped before arising each morning. Distinct advantage is obtained by adding ten grains of the salicylate of sodium to the saline draught; and it is wise in some instances to interrupt the saline cathartic once each week or two with a light mercurial at night.

The beneficial action of this much of treatment alone lies in the overcoming of the state of habitual constipation that seems to belong to cholelithiasis, as well as the lessened liability, because of increased elimination and increased peristaltic action, to infection of the gall tracts and bladder. To facilitate the discharge of biliary calculi no better means is known than the employment of olive oil. This has been so long in use, and so universal, that its value admits of scarcely any question.

Instead of using large quantities of the oil a smaller amount, that will be well held up by the stomach day after day, is probably better. One or two ounces, in milk, taken each night for a week or ten days, when a rest of the same period is allowed then resuming the oil again, is a plan that may be followed for some time, in this manner clearing away the paroxysmal attacks of biliary colic and the more or less constant hepatic distress attendant upon cholelithiasis.—*The Clinical Review.*

### Heterochylia.

Korn, Berlin (*Archiv fuer Verdauungs-Krankheiten*).—This term was introduced by Hemmeter for the classification of those cases of nervous dyspepsia in which there are sudden and frequent changes in the gastric secretions. In such cases there have been observed within one week after test meals normal

acidity, hyperacidity and anacidity. The author reports a series of eleven cases in which such a condition prevailed.

In seven of these cases the possibility of any anatomical changes in the gastric mucosa could be absolutely excluded. The variation in the acidity must be explained by a nervous influence acting upon the secretions in both an augmentatory and an inhibitory way. In three cases in which there were pathologic changes there existed also this variation. Here there was no doubt a combination of organic and nervous involvement of the stomach.

In order to avoid false conclusions, frequent examinations of the gastric contents should be made in all doubtful cases.—*Inter-State Medical Journal.*

### **Rheumatism of Single Joints.**

Rheumatism, as we know, is often a refuge for the destitute in the matter of diagnosis, and this fact may serve to explain the frequency with which inflammation of a single joint is ascribed to rheumatism. There are very good reasons in favour of the view that there is no such thing as single rheumatic joint disease. If joint disease be due to rheumatism, more than one joint will be involved, but multiple joint affections are not on that account necessarily rheumatic, witness the polyarthritides met with in gonorrhœa, syphilis, and sepsis. Disease of a single joint is either purulent, tuberculous, gonorrhœal, or is due to some central nerve lesion. If the disease commences in one joint and subsequently spreads to others it is presumptive evidence that the affection of the other joints is due to secondary infection. The distinction is not merely of interest from the point of view of scientific accuracy, for it may have, and often has, a very important bearing on treatment and prognosis.—*Medical Press and Circular.*

### **The Treatment of Pericarditis.**

In the *Journal des Praticiens*, Deguy makes the following statements in regard to interference in cases of pericardial effusion. He first begins by stating that paracentesis of the pericardium is only indicated when the accumulation of fluid is so great as to be a menace to life, and to cause unduly feeble contractions of the heart, with a filiform pulse, precordial distress, and evidences of suffocation. When pus is present, these symptoms may be associated with great variations in temperature, profuse sweats, and chills, and under these circumstances pericardiotomy should be performed to permit the escape of the purulent fluid. Puncture of the pericardium is therefore to be considered as an operation of urgency, and the gravity of the prognosis depends not so much upon the operation

itself as upon the nature of the disease, the state of the heart, and the general condition of the patient. Deguy asserts that the puncture is without danger in cases of serous pericardial effusion, such as is met with in rheumatism. Different authors advise different points for operation. The third intercostal space on the left of the sternum has been recommended by Stevenson, Mader, Loebel, and Schuh, and puncture of the fourth interspace is recommended by Lrousseau, Pirogoff, and Guerin; in the fifth interspace by Baizeau, Aran, Bouchut, and Raynaud; operation in the sixth interspace is recommended by Delorme and Mignon, Hare, Woinitch, and Sianijentzky. Still other investigators believe in puncturing at the right side of the sternum in the fifth interspace. Undoubtedly the exact point of puncture depends somewhat upon the physical signs of the disease which are present. The method of relieving the serous effusion varies, but probably the safest is to make an incision through the skin and subcutaneous tissues until the pericardium is approached on the left of the sixth interspace. Through this the trocar is gently pushed and the fluid removed.

Pericardiotomy is not justified except in the presence of pyopericardium, which arises either as the result of injury, or follows infection of the pneumococcus or other microörganism. Ollier recommends that an incision be made at the left of the sternum, and that the fifth cartilage be disarticulated. At this point it will be found that the pleura is intimately adherent. After the pleura is pushed aside, puncture of the pericardium may be readily accomplished. Still another method consists in resection of the xiphoid cartilage with subsequent incision of the distended pericardial sac. Trephining of the sternum for the purpose of entering the pericardial sac has now been abandoned.—*The Therapeutic Gazette*.

#### **Peptonuria**—Ito. (*Deutsches Archiv. für klin. Med.*).

The writer has investigated a number of specimens of urine in order to determine the presence of peptone. The method employed was as follows:—The usual methods were used for albumin and nucleo—albumin and also the biuret reaction. About 300 cc. of urine were saturated with ammonium sulphate at a temperature of from 60° to 70°, allowed to cool, filtered, made alkaline with ammonium carbonate, again saturated with ammonium sulphate and then filtered again. The filtrate was then neutralized with acetic acid, again saturated with ammonium sulphate, and again filtered after boiling. The filtrate was then diluted with an equal quantity of water, and the peptone precipitated by tannin. The precipitate was filtered the following day, dried, dissolved in baryta solution, boiled, filtered, and the filtrate tested by the biuret reaction. In addition to the urine

of patients suffering from various diseases, rabbits were fed upon peptone and their urine tested, and all the reactions were positive. The results on human beings were positive in six and negative in two cases of croupous pneumonia; negative in two cases of suppurative pleuritis; positive in one and negative in four cases of suppurative phthisis; negative in eight cases of ulcer of the stomach; positive in one and negative in ten cases of confinement, and negative in two cases of pregnancy. All these cases were also tested by the precipitation of peptone with alcohol, and the results were 17 positive and 21 negative, as compared with eight positive and thirty negative by the method described. As, however, deutero-albumoses are also precipitated by this method, it cannot be depended upon for the recognition of peptone.—F. CRAVEN MOORE, in *Medical Chronicle*.

**Researches on Tuberculosis**—FERRAN (*Revue de Médecine*).

Up to the present time all attempts at procuring a specific therapeutic and prophylactic agent in the treatment of tuberculosis have practically failed; and yet the problem is by no means insoluble, since the vast majority of cases of tuberculosis undergo spontaneous cure. Failure has been due to a faulty conception of the bacillus of Koch and the pathology of tuberculosis. It is necessary to entirely remodel our ideas on the subject.

In the sputum from pulmonary foci there appears at a more or less advanced stage a new phthical bacillus which agrees in its characters partly with the bacillus coli and partly with the bacillus of Koch. When present it is found in far greater numbers than the bacillus of Koch. It may be called the bacille phthisiogène or spermigène, because it is capable of producing profound cachexia and intense pneumonia, with or without tubercles, and because some varieties cultivated in suitable media involve spermine in quantities large enough to be recognizable by its odor.

In sputum it is a thin rod-like organism, but after cultivation for several generations in bouillon it attains the thickness and length of the colon bacillus. It stains readily, and is decolorized by mineral acids. It does not stain by Gram, possesses flagella and forms spores. It grows readily on ordinary media at room temperatures. It does not liquefy gelatine, it acidulates lactose media and cultures in peptone bouillon give an indol reaction. Certain races grown in liquid serum produce a large quantity of spermine, but none is formed in vacuo. The bacillus is an active reducing agent, especially in anerobic conditions. It retains its vitality in media for from ten days to five weeks. It is killed at 80° C. in five minutes, but is

unaffected by low temperatures. The serum of tuberculous patients or of immunized animals causes rapid agglutination.

Virulence and spermine production vary in different races, and are not always concurrent. Inoculated animals may be rapidly killed, extensive hemorrhagic edema occurring at the point of inoculation, or they may die after two to eight months, with emaciation, pneumonic patches, hepatitis and splenitis, the inoculated point first ulcerating and afterwards healing. The most important lesions are found in the spleen, liver, lungs, and kidneys, and are the result of an intense interstitial inflammation. In the lungs there are large and small foci of an intense dark carmine color, strongly contrasting with the normal lung tissue. These appearances are due to the active reducing properties of the bacillus. With less virulent cultures there are found more or less discrete tubercles in the spleen, liver and lungs, placed invariably in reduction areas. The number of tubercles is never sufficient to account for death, the severity of the disease is always dependent on the pre-tubercular pneumonia.

The bacillus of Koch or, in rare cases, the inoculated bacillus, may be demonstrated in the pneumonic patches, though generally no bacilli can be found. Histologically the tubercles are identical with those produced by inoculation of the bacillus of Koch, and reinoculation is followed by typical tubercular lesions containing the typical tubercle bacillus.

Sputa, in which the bacillus of Koch cannot be found, are capable of producing tuberculosis. In such cases the tuberculosis is caused by the bacille phthisiogene. The bacillus of Koch is not the sole agent of spontaneous tuberculosis. It is always accompanied by another bacillus, markedly saprophytic, very abundant, growing readily at ordinary temperatures and eminently capable of producing tuberculosis. It is far more probable that this bacillus, and not the bacillus of Koch, is the cause of the enormous diffusion of tuberculosis in man and animals.

The bacillus of Koch is merely a modified colon bacillus. In 1897 the author succeeded in modifying the bacillus of Koch so that it became motile and was decolorized by mineral acids after staining by the Ziehl-Neelsen method. In this condition it closely resembled the bacillus coli, gave an indol reaction, acidulated lactose media, and was agglutinated by the sera of tubercular animals. These observations were confirmed by Arloing in 1898 and 1900. The modification was effected by repeated cultures in broth, containing a gradually lessened quantity of glucose or glycerine, along with daily shaking of the tubes. All races were not modified with the same ease. Their powers of producing tuberculosis became rapidly diminished.

Modified races could be reconverted into the bacillus of Koch by the method of passage.

Ordinary colon bacilli can be converted into the bacillus of Koch. The colon bacillus of the dog is well suited for this experiment, and the author was struck with the strong resemblance between it and the bacille phthisiogene. Both are "phthisigenous," are convertible into the bacillus of Koch, cause cachexia, pretubercular pneumonia, and tubercles histologically identical with classical tubercles. Thus tuberculosis is merely a variety of colon bacteriosis. Similar results were obtained with colon bacilli from man and from the cat.

Anti-tubercular vaccination and immunization therefore require revision. Animals can be immunized against the bacille phthisiogene by repeated doses of dead cultures. The immunity is rather in the direction of preventing secondary and tertiary lesions. Local lesions occur in immunized animals, but their extent is less.

Spontaneous tuberculosis in man is produced by the bacille phthisiogene, the formation of tubercles is always preceded by pretubercular pneumonia. It is logical to assume that by immunization against the phlegmasia there would be obtained immunity against the subsequent tuberculosis.

The toxins of the bacillus of Koch obtained in vitro are not identical with those formed in an infected animal. The true tuberculo-toxin does not exist in a free state, and a true anti-tubercular serum cannot be got by the injection of toxins isolated from the bacillus of Koch or its cultures. The coagulation ferment is produced by the stimulus or contact of cells with bacilli, and at once combines with protoplasm. Hence it is difficult to bring about the formation of antibodies except by the injection of tubercular pus. Serum, so prepared, is anti-tubercular, but it necessarily contains a leuco-toxin, and it is to the presence of this leuco-toxin that the failure of anti-tubercular sera hitherto employed must be attributed.—ARTHUR SELLERS, in *Medical Chronicle*.

#### **The Heart in Diphtheria.**—CHAS. BOLTON (*Edinburgh Med. Jour*).

There can be no doubt about the statement that "cardiac failure is one of the most important as well as the commonest of the toxic effects of diphtheria." A large percentage of patients have signs of cardiac failure at some period or other of the disease, and death during the acute toxic stage unless due to an accidental cause, as asphyxia, is invariably the result of primary cardiac failure. The fatal termination, as Dr. Bolton says, usually takes place during the first fortnight of the disease, the onset of the signs being first noticed generally about the sixth day.



During convalescence its supervention is usually associated with the presence of some form of post-diphtheritic paralysis, and it may be secondary to or accelerated by some strain or shock. In this stage it is not so uniformly fatal as during the acute toxic period. It must, however, be remembered that sudden death from syncope may occur at any stage, though its supervention, when convalescence is established, is always referable to some strain.

In the non-fatal cases of heart failure the evidence consists of irregularity or intermittence of the pulse, with or without the physical signs of dilatation of the heart; at the same time there is usually increased rapidity or slowing of the pulse. With regard to the pulse, Dr. Bolton comes to the following conclusion:—

(1) It alters considerably both in degree of irregularity and in frequency during the 24 hours.

(2) These changes occur frequently, and often at very short intervals.

(3) On the whole the irregularity is most marked at night.

(4) As a rule, when the pulse becomes irregular, there is a diminution in its frequency, but this rule is by no means absolute.

(5) The irregularity coming on in the acute stage is a primary affection, but is, nevertheless, greatly affected by strain.

(6) The irregularity does not conform to any type.

(7) As a rule the patient appears quite well and suffers no inconvenience or distress on account of the heart failure.—*Medical Chronicle*.

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## SURGERY.

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IN CHARGE OF EDMUND E. KING AND HERBERT A. BRUCE.

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### Seminal Vesiculitis.

In genito-urinary diseases, as in all others, the most important thing is to make a correct diagnosis, and in no other field is diagnosis more neglected. A good example of this is that the average doctor ignores the fact that there are such things as the seminal vesicles, or that they are ever diseased. Inflammation of these organs frequently give rise to a urethral discharge, which is usually labelled "gleet," and the patient treated for stricture. It is needless to say that the gleet persists in spite of the stretching, and will only yield when treatment is directed against the vesicles. Again, no patient should be convicted of "sexual neurasthenia" until an examination of the vesicles is made, for we often see a man's "neurasthenia" disappear as his vesiculitis is cured and sexual function restored.—*Col. Med. Jour*

The following deductions and conclusions arrived at by Dr. Irvin Abell in his very concise paper on the "Treatment of Tuberculosis of Testicle and Epididymis," in the *Journal of Dermatology*, July, 1902, are worthy of reproduction, and we here present them :

1. That the epididymis is the most frequent starting point of uro-genital tuberculosis.

2. That it is usually secondary to some other focus, but it may be a primary deposition.

3. That the testicle is rarely primarily affected, but as a rule secondarily so from the epididymis.

4. That when the epididymis is primarily infected through the blood-supply the process is probably an intertubular one.

5. That when secondary to other foci of uro-genital tract, constituting a descending infection, the process is probably intratubular.

6. That foci in other portions of the genital tract, or even distant lesions, do not necessarily contraindicate operation, since abundant clinical evidence proves that, when operated early, foci in genital tract recover as a rule, and healing of distant lesions following operation has been noted in a sufficient number of instances to invite further investigation.

7. That castration should be limited to those cases in which the process has invaded the testicle proper.

8. That epididymectomy with high resection of cord, after the method of Villeneuve, is to be practiced in all other cases.

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## OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES W. F. ROSS, ALBERT A. MACDONALD  
AND K. McILWRAITH.

### Abandonment of Vaginal Examination in Labor.—W. A. BRIGGS, M.D. (*American Medicine*, Feb. 1).

The information necessary to conduct labor can be obtained by other means than vaginal examination, and more fully, more exactly, at an earlier period of labor, and without the possibility of infecting the genital tract. These means are the usual ones of abdominal palpation and auscultation, pelvimetry, and those the writer now advocates—digital examination per rectum, simple and bimanual, and palpation of the perineum.

The technique of digital examination per rectum is similar to that of digital examination per vaginam:—Cleanse and disinfect the vulva and adjacent parts; place the patient on her back with the knees well flexed, and close to the edge of the bed; sit beside the bed on a low chair facing the patient; introduce

the disinfected and gloved right hand under the patient's right knee and the index finger into the rectum, carrying, if possible its tip to the sacral promontory, and the tip of the thumb to the pubes, and by their divergence estimate the conjugate diameter; place the left hand on the lower abdomen just above the pubes, and by gentle bimanual palpation map out the presenting part and determine its size, position, descent, mobility, and stage of evolution; should the head present, dip the fingers of the left hand down about the chin or the occiput, and the position may be determined even if the fontanelles and sagittal suture cannot be felt. With the tip of the finger carefully search for the os and cervix, and if they cannot be recognized continue the search during and after a pain, when, if dilation has begun, the alternate tension and relaxation of the cervical ring and of the bag of waters will direct attention aright; the sagittal suture and fontanelles should be sought and identified. Should the head recede before the examining finger it may be fixed by the left hand from above and even made more accessible by being pushed down into the pelvis. The simplicity and the clearness of this method of examination, and its results are surprising. The presentation, position, size, mobility, progress, os, cervix, bag of membranes—all may be made out clearly. Diagnosis of the position may be made at an earlier stage by the rectum than by the vagina.

Palpation of the vulva and perineum is not so important as rectal examination, but when the head descends well into the pelvis the mobility and the progress of the presenting part may be determined and the necessity of internal examination obviated. It is best performed by separating the index and second fingers of the pronated or supinated hand and pressing their tips (one on either side of the commissure) against the vulva or perineum during and after a pain. By these means, in all but operative cases, vaginal examination will be avoided.—*Medical Review.*

### Early Diagnosis of Pregnancy.

During the greater part of the first three months of pregnancy almost the only reliable objective evidences of pregnancy are the structural changes in the uterus itself, which are stated by Jewett as follows: (1) Softening of the cervix; (2) size of the body and progressive growth at the rate of pregnancy; (3) extreme compressibility of the isthmus. Hegar's sign; (4) relative density of the median and lateral sections of the isthmus; (5) asymmetry and differential density of the body; (6) consistence and shape of the body as a whole. The first sign is not of much value before the end of the second month. Hegar's sign he considers of less value than that of the shape

and consistence of the corpus because it is not so readily appreciable. The change in the differential density of the isthmus is well marked by the fifth week, the middle portion which usually presents a dense longitudinal ridge by that time being less dense than the parts on each side.—*Medical News Amer. Med.*

#### **Treatment of Puerperal Eclampsia.**

Herman disagrees with those who contend that emptying the uterus is an almost certain means of arresting eclamptic convulsions. Schauta quotes from the records of the lying-in clinic of Vienna 342 cases of eclampsia, in 185 of which the fits began during labor. In only 62 of these did they cease on delivery, while they continued in 123, in 50 with increased violence. Brummerstadt gives a record of 63 cases, in 18 of which the fits ceased on delivery, in 17 became less severe, and continued unaltered in 28. Herman cites the figures of Dührssen, Olshausen and others showing similar results, and then reports from his own experience two cases of eclamptic fits with a temperature of about 105°. In the treatment the use of tepid baths reduced the temperature and resulted in the abatement and early cessation of the convulsions and final recovery of the patients.—*Amer. Med.*

#### **Venesection and Transfusion in Puerperal Eclampsia.—By DR. R. ABRAHAMS.**

The author asserts that the abstraction of blood in eclampsia produces (1) an immediately favorable change; cyanosis, muscle rigidity, spasms and twitchings, all stop at once. (2) The pulse loses its tenseness. (3) The coma yields, either abruptly or slowly, but surely. Transfusion (1) improves the pulse; (2) induces free sweating and free micturition; and (3) produces intense thirst, which causes the patient to drink copiously.

#### **Benign Tumors Complicating Pregnancy.—By DR. BACHE M. F. ENNET.**

The author would operate on all young women non-pregnant, to remove any fibroid of the uterus which is accessible. Should the young woman be recently pregnant, such a growth should be removed, if it is large, wherever situated. If it is in the body, small, and of slow growth, it should be left, but should be removed if in the lower segment or neck. If midway in pregnancy, such growths in the body should be left alone; if in the lower segment or neck, we should temporize, seeking to crowd them out of the pelvis, and try to tide over until the uterus has become thoroughly accustomed to the pregnancy

If such growths are discovered in the later months, operation should be resorted to only if they grow in the neck of such a size as to threaten to impede delivery. Operation should be from below. Tumors, however, may be so general and threatening that one is obliged to remove the whole uterus, even early in pregnancy.—*N. Y. Medical Record.*

#### **Acute Gonorrhœal Peritonitis.**

Kolamenkin (*Vestnik Khirurgii*, August, 1901) publishes a genuine case, where an exploratory operation proved speedily fatal, and a bacteriological exploration proved what was the origin of the serous inflammation. A woman aged 34 was admitted into a hospital suffering from all the symptoms of acute general peritonitis. She refused all operative interference at first, but consented three days later. When the abdomen was opened, much serous exudation was detected, and there were false membranes on the intestinal coils and parietal peritoneum. The coils adhered to each other, but not firmly. The cecum and vermiform appendix were intact. In Douglas's pouch lay the ovaries, inflamed and much enlarged. It was thought good to remove them. But at the necropsy, ten hours later, purulent acute inflammation of the peritoneum, bladder, and genital tract were detected. The gonococcus, and no other germ, was detected in pus taken from the cervical canal, the appendages, the bladder, abscesses around the uterus, and the peritoneal cavity itself.—*Epit. B. M. J.*

#### **Surgical Treatment of Puerperal Pyemia.**

Trendelenburg (*Münchener Medicinische Wochenschrift*) discusses the different forms of pyemia, the difficulty of diagnosing puerperal pyemia, of differentiating it from other forms of puerperal infection, and its comparative frequency. Among 43 sections of women who died of puerperal infection, 21 had pyemic thrombosis. This is more difficult to treat surgically than otitis, or thrombosis of the transverse sinus, because it cannot be so readily and definitely located, since it may be in the hypogastric vein, or the ovarian vein or both, and on one or both sides. Trendelenburg, in conclusion, gives the history of a patient who suffered abortion in the second month, on August 31. September 16 there was a diagnosis of septic pyosalpinx. On the 19th the abscess was punctured and drained through the vagina, streptococci being found in the pus. As the symptoms continued, on October 12 there was a resection and ligation of the right hypogastric vein. Ten days later the chills returned, increasing in frequency and duration until November 12 when, through an incision from the angle of the eleventh rib backward, a piece 5 cm. in

length was resected from the ovarian vein, a greyish yellow thrombosis removed and the vein ligated. The chills grew milder, but did not entirely cease until, 16 days later, a subcutaneous, metastatic abscess was opened in the region of the shoulder blade. Three weeks later the patient left the hospital still weak, but entirely well. Trendelenburg says this is the first case of puerperal pyemia cured by resection and ligation of the veins, but he thinks more will follow, and hopes that eventually not only the chronic, but also acute forms of puerperal pyemia will be successfully treated by surgical means.—*Amer. Med.*

#### Treatment of Placenta Previa—Caesarean Section Not Justifiable.

Dr. Robert A. Murray, New York, in a contribution on this subject, referred to a paper read last year before the American Association of Obstetricians and Gynecologists, by Dr. Zinke, Cincinnati, on this subject, also to a discussion which it elicited. In Zinke's paper a strong plea was made for the treatment of placenta previa by Caesarean section. Dr. Murray protested against such a radical measure, and believes that by proper treatment one can avoid the performance of this operation in many instances. In fact, only a very small minority of cases of placenta previa should, in his opinion, be treated by Caesarean section.

Dr. J. Whitridge Williams, Baltimore, questioned the propriety of Caesarean section for placenta previa, and said the operation was done too frequently. Recent statistics as to the great safety attending this operation were liable to do almost as much harm as good. If the society did not take a decided position in regard to Caesarean section in cases of placenta previa, he feared that this operation might be practiced as frequently and indiscriminately as was oophorectomy. In his opinion there was a small field for Caesarean section in placenta previa.

Dr. Edwin B. Cragin, New York, said the conditions were so numerous which would justify Caesarean section in placenta previa that they were seldom found present, and among them were a good condition of the child, good surroundings for the patient, and a cervix so rigid that there would be great difficulty in dilating it and resorting to version. These three conditions were rarely met with in cases of placenta previa. A fourth condition was central implantation of the placenta.—*N.Y. Med. Jour.*

#### Two Conditions Simulating Ectopic Gestation.

Dr. Edward P. Davis, Philadelphia, read a paper reporting a case of hematocele and one of retroverted gravid, simulating ectopic gestation. Segond, Routier and Varnier have recently

reported to the Obstetrical Society of Paris similar cases. In obscure cases of hemorrhage in which a diagnosis is not evident, he thinks abdominal section is safer than continued uncertainty. Conditions simulating ectopic gestation usually require prompt interference and surgical treatment.—*Amer. Gyn. Soc. Jour. A. M. A.*

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## OPHTHALMOLOGY AND OTOTOLOGY.

IN CHARGE OF J. T. DUNCAN AND J. O. ORR.

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### Tuberculosis of the Iris.

H. Friedenwald (*American Medicine*, July 5th), says that there are three varieties of this:—

1. The first variety is unilateral and not accompanied by inflammation of the iris. In one or other iris appears a considerable prominence, which often has the appearance of a new growth.

2. Miliary tuberculosis of the iris:—This is more likely to be seen in both irides. Miliary tuberculosis is likely to cause inflammation in the iris; in other words, we have a case of iritis. Small yellow, yellowish-grey or grey elevations are observed on the surface of the iris, generally on the lower part.

3. In this form the tubercles are so small and so deep in the tissue of the iris as not to be visible to the naked eye. They are, however, apt to produce chronic iritis. Friedenwald details two interesting cases of miliary tuberculosis. In this connection Chalderero (*La Clinica Oculistica, in Journal of Eye, Ear and Throat*) may be mentioned. He reports four cases. The first patient was a girl, seven years old, with good family history. At the first examination, six days from the beginning of the disease, there was a slight periconal injection, the cornea was transparent and a wine colored exudate could be seen in the anterior chamber. The iris seemed a little darker than in the good eye, pupil contracted, immobile and oval. On the external margin a greyish brown nodule was seen. The pupil was covered with a greyish exudate. T=n. V=light perception. There was no pain. O.D. normal. Insipient tuberculosis was suspected. Treatment—hypodermic injections of sublimate atropine, warm applications and bandage. The eye gradually grew worse and became painful. Enucleation was advised and accepted. Recovery was rapid, but six months later the child died of probable tubercular peritonitis. The exudate from the eye was inoculated into the anterior chamber of the eyes of two rabbits. One rabbit died six days later without special symptoms. In the other animal on the 63rd day

the iris began to show small grey nodules. Two days later the aqueous was turbid. On the 72nd day the iris was infiltrated with a greyish yellow exudate. The eye became soft and atrophic. The animal was killed four months after the inoculation. The eye was filled with a white, caseous mass which, under the microscope showed pus cells, amorphous granules and small pieces of necrotic choroid. No bacilli found. The nodules from the iris showed giant cells. The second case had the same general symptoms as the first. The eye was enucleated and the patient died three months later of acute meningitis. The iris of an inoculated rabbit showed tubercular nodules on the 49th day. The iris from the patient's eye showed giant cells, but no bacilli. In case three, with same eye symptoms enucleation was practiced. Streptococci, staphylococci and tubercular bacilli were found in the exudates. The author calls attention to the three forms of tuberculosis of the iris, viz.: (1) Tuberculosis disseminata, occurring in about one-half of all cases. All ages are liable to be attacked. The pathognomonic symptom is the presence on the iris of greyish yellow or yellowish white nodules about the size of millet seeds. (2) Tuberculosis solitary or conglomerate in one-third of all cases. The tubercle is single and sometimes occupies the greater part of the anterior chamber. (3) Infiltrated tubercle of the iris, a true tubercular inflammation without the formation of nodules. Histological examination shows giant and epithelial cells. The prognosis is always bad. Medical treatment avails nothing. The most rational treatment is enucleation.

The "Absorption" treatment of Cataract, J. W. Wright (*The Ophthalmic Record*, June) raises strong objection to the use of this method, especially where an operation has to be performed. The treatment produces a flabby condition of the cornea. At least seven patients who were operated upon for cataract had the flabby condition of the cornea, and in these cases it was not unusual to lose vitreous. Strange to say, some physicians advise their patients to use this "infallible" nostrum, but Wright is satisfied that the "treatment," whatever it may be, is very injurious, and physicians should advise against its use.

J. T. D.



## LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF J. PRICE-BROWN.

### Subcutaneous Injection of Paraffin in the Correction of Nasal Deformities.—MARMION SMITH (*New York Medical Journal*, May, 1902).

This is the presentation by photographs, taken before and after, of a number of cases of the condition known as saddle-back nose, in which the deformity had been partially removed and the personal appearance of the subjects greatly improved by the subcutaneous injections of paraffin at the site of disfigurement.

The deformity is caused by the destruction from one cause or other of the cartilages and bones supporting the external nose. For these cases but little can be done in the way of general surgery, and any other effectual method of treatment available should receive careful consideration. It is claimed that paraffin, having a melting point of about 110 deg. Fah., is both aseptic and non-irritant, and at the same time non-absorbable, and if injected at a temperature of about 115 deg. Fah. subcutaneously in the neighborhood of the nasal depression it can be moulded by the fingers into the shape of the nose, and by permanently supporting the integument will minimize the unsightly deformity, which would otherwise exist.

The depressed bridge is first anesthetised by hypodermic injection of solution of cocaine. A hypodermic syringe is next filled with paraffin melted at a temperature of 115 deg. Fah., and placed in a jar filled with water at a temperature of 120 deg. Fah. At the right moment the tissues are uplifted with the fingers of the left hand and the point of the needle inserted well beneath the skin, carrying its point beyond the site of greatest deformity. The injection is made slowly, at the same time gently withdrawing the needle and moulding the distended tissues to the required shape. The paraffin remains plastic for about half a minute, and can be moulded as desired during that time, after which it retains the acquired form.

There is usually some swelling and soreness with slight fever lasting two or three days or a week, but this subsides, and a good result follows. In some cases the patient remained in hospital for several days, and ice was applied, off and on, as required. In no case was there sloughing of the cuticle, though the eyelids sometimes swelled.

**Saddle-Nose in a Woman Treated by Subcutaneous Injection of Paraffin.**—SCANES SPICER (*Journal of Laryngology, Rhinology and Otology*, March, 1902).

The patient, aged 25, had suffered since childhood from nasal suppuration and fetor. The nose was tip-tilted and the nasal framework stunted. The bridge was depressed and covered with crescentric wrinkles.

In treating the case the skin of the nose was cleansed with alcohol and bichloride of mercury. Then a mixture of hard and soft paraffin was sterilized and injected at a temperature of 105 deg. F. with a glass hypodermic syringe, a hot water bath being used to keep the paraffin and instrument at the right temperature.

Ten or twelve syringefuls were injected to the amount of about six drachms. He was very careful to insure asepsis during the operation. The injections were made slowly into the parts where the bolster was most required, and were moulded during the act into form by an assistant. There was not the slightest reaction of any kind after injection in this case. He tried to make the shape of the bolster like an omelette beneath the skin. Although there was no pain, the skin of the nose looked tense and brawny for days after the operation, and the upper eyelids became edematous, which was somewhat persistent. In the left upper eyelid a nodule formed of the size of a large shot. To avoid accidents of this kind it was proposed to apply a strip of lead sheeting over the root of the nose, adapted to the skin, during injection to prevent the paraffin from invading the ocular tissues.

Gersung, of Vienna, the originator of this method of treatment, used injections of cocaine preparatory to inserting the paraffin. Scanes Spicer did not think this necessary, but intended in his next case to try small injections at intervals, and not to perform the whole operation at once.

**Fibroma of the Nose.**

W. Lincoln (*American Journal of Medical Sciences*, November, 1901) gives an instance of this rare affection, with details of the history, operative treatment and the result. It occurred in a male aged 18 years. There was a history of complete blockage of left nasal passage, frequent copious epistaxis from same side, and constant purulent discharge.

Patient was weak and emaciated, had broadened bridge, with frog-face, and pain over left side of face and head. On examination, a grayish tumor filled left nasal cavity from vestibule to posterior naris, pressing down the soft palate on that side, and interfering with speech and deglutition. No lymphatic swelling discoverable.

Attempts to remove the tumor by snare were unsuccessful, owing to the pressure of adhesions, while they occasioned severe hemorrhages. Microscopical examination of detached pieces showed the tumor to be pure fibroma; and external operation was decided upon.

An incision was made from near inner canthus of left eye, across bridge of nose to same point on right side; and thence directly down to right ala nasi. Next, pressing periosteum aside, the bones were cut through with Hey's saw, in the line of skin incision. The nose was also cut free from the upper lip, avoiding the gingivolabial fold of mucous membrane; and the septum divided in a line parallel to its anterior border, and connecting with the incision at the bridge. The whole nose was then turned over by strong forceps on to the left cheek, the hemorrhage being easily controlled by hemostatic forceps. By the use of a powerful electric headlight, an excellent view of the tumor was obtained.

After one or two ineffectual attempts at removal, a powerful wire snare was adjusted through the naris, and pressed into position by finger in the naso-pharynx. The latter was then packed with a sponge, the wire gradually tightened, and the growth removed. The operation was completed by curetting the pedicle, and burning with the Paquelin cautery. The nostril was packed with iodoform gauze, and the nose sutured in position with silk sutures. Although the patient required frequent stimulation with hypodermic injections of strychnine, he made a good recovery. The first packing was removed after 24 hours, and the second after a like interval; after which the nose was left open, and simple sprays used.

Subsequent examinations after recovery were made every few months, but there had been no recurrence  $5\frac{1}{2}$  years after operation. The writer concludes: "The interest in this case lies in the comparative rarity of the tumor in the nose, unaccompanied by similar growth in the naso-pharynx; and also in the satisfactory result secured by full exposure of the mass, and its thorough removal."

(As coincident with the above, possibly endo-nasal operative treatment, by the combined use of the electrical current and the glavano-cautery, is not without interest, as witnessed in a similar case reported by the abstractor at the Laryngological Section of the American Medical Association at Baltimore in May, 1895, and published in *THE PRACTITIONER* for that year. In this case neither external nor oral incisions were made. The recovery was complete, and in eight years there has been no recurrence.)

**Two Cases of Radical Cure of Ozena Under Influence of an Intercurrent Erysipelas of the Face.**—MONTORS DE FRANCESCO, (*Revue Hebde laryng., D'Otol. et de Rhin.*, March, 1902.)

This is the history of two cases, one occurring in a young girl, the other in a young lad, ages not given, in which severe ozena with atrophy of turbinals, partial destruction of bones and cartilages of the nose, presence of mal-odor and crusts, etc., were relieved; and the symptoms cured by the accidental occurrence of erysipelas of the face. As the latter disease was in each case recovered from, the former likewise disappeared.

**Eye Disease in Tubercular Disease of the Nasal Mucous Membrane, and Treatment of the Latter with Lactic Acid.**—KINSBERG (*Leitschr. für Ohrenheilk.*, Bd. 39, Neft 3.)

There were five out of nine nasal tubercular cases in which the lachrymal duct and eye were affected. What was more, they were all secondary to the primary disease in the nose. In treating these cases the writer obtained the best results with lactic acid, using solutions on tampons. They were inserted daily, and allowed to remain for three hours. They were found to act upon the diseased mucous membrane only, the normal tissue remaining almost unchanged.

**Keratosis as Distinguished from Mycosis.**

George Wood (*University of Philadelphia Medical Bulletin*, Vol. XIV., No. 11, January, 1902) quotes Kelly, of Glasgow, as saying:—

1. Keratosis appears in the prime of life; mycosis may affect any age.
2. The cause of keratosis is unknown; mycosis is generally caused by some local abnormality of buccal secretion or of the digestive tract; possibly by some diathesis, as rheumatism.
3. In keratosis the symptoms are slight or absent; in mycosis they are pronounced.
4. In keratosis the surrounding mucosa is normal, while in mycosis it is inflamed.
5. In keratosis the excrescences are tough, firmly adherent, and assume characteristic shapes; in mycosis they are soft and easily moved.
6. Keratosis is confined to some part of Waldeyer's ring, while mycosis may appear at any point between the mouth and stomach.
7. Mycosis shows a resemblance to other mycoses, as thrush and sarcinia, while keratosis does not (if we leave the leptothris out of account).
8. Local application will cure mycosis, while it has no effect on keratosis.

### Secondary Hemorrhage on the Fifth Day after Tonsillotomy.

Lee Weber (*Laryngoscope*, April, 1902) reports the above-mentioned case recurring in a female child aged 6 years. Recovery took place. The writer considers the case as one of special interest owing to the length of time that elapsed between the operation and the attack of secondary hemorrhage, the usual time being two or three days.

Two cases were reported in *THE PRACTITIONER* of November, 1894, by the abstractor, in which secondary hemorrhage occurred on the fifth day. Both were males, and the ages respectively 6 and 22 years.

### Acquired Deaf Mutism Probably Due to Impacted Cerumen in the Ears.—Rapid Recovery of Hearing and Speech on Removing the Wax.—MAYO COLLIER (*Journal of Laryngology and Rhinology*, April, 1902).

The title of the paper almost describes the case. The child, female, as a baby was bright and intelligent and could speak. At the age of two years she had typhoid fever. A year later had a virulent attack of measles, and was unconscious for fourteen days. She never had discharge from ears, but after this was deaf, and gradually lost the memory of words. At age of nine she was bright and intelligent in all other ways. An examination, which was difficult to obtain on account of unusually long and curved auditory canals, hard inspissated cerumen was found impacted in each. This was removed and the drum membranes found to be retracted and opaque, but otherwise healthy. Politz's bag was used and the nose attended to. After this improvement hearing and speech were both remarkably rapid. In this case there were no adenoids, and the deafness must have originated entirely from the presence of the impacted cerumen.

### Laryngeal Paralysis and Their Importance in General Medicines.—GLEITSMANN (*New York Medical Journal*, December, 1901).

In an interesting and scientific paper, the writer devotes much attention to the anatomical and physiological aspect of the subject. He deals with the experiments of Krause, Lemon, Storsley, etc., and shows, as taught by Krause, that the planatory cortical centre in dogs is located at the descending surface of the prefrontal convolution. Irritation of one of these areas by electricity is always followed by symmetrical bilateral adduction of the vocal cords, which always takes place when one phonatory centre has been experimentally removed or destroyed.

Adduction of the cords can also be produced by stimulating a small area in the bulbus. The fact, too, that acephalous monsters are able to cry indicates that phonation has a limit centre in the bulbus.

"The superior laryngeal nerve is the sensory nerve of the larynx, and only sends motor fibres to the cricothyroid muscles, while the recurrent is the motor nerve for all the intrinsic muscles of the larynx, and supplies the adductors as well as the abductors."

During life the normal state of the abductors is one of partial contraction, rendering the chink of the glottis during quiet respiration a little wider than when in the cadaveric position. Consequently, when abductor paralysis occurs, search for lesion of the nerve trunk should be made.

### An Artificial Larynx.

Hankins (*Australas Med. Gaz.*), has devised an apparatus for use in those cases of total extirpation of the larynx where all sinuses between the oral cavity and the external air and all direct communication between the lungs and upper air passages are cut off. It consists of a bottle containing a stopper that has three apertures, one of which is opened for breathing and may be closed by the finger at will. The second communicates by rubber tube 4 inches long with vulcanite nipple for plugging the tracheal tube. The third tube begins in the bottle with a reed on the principle of that of a clarinet, and terminates outside the bottle in a No. 14 (English) soft rubber catheter cut off obliquely at the end, that is introduced through the nose for 6 inches, at which point it is arrested by vulcanite olive that plugs the orifice of the nostril. In ordinary breathing the first tube is left open, but when one desires to speak it is closed by the finger so that the air passes into the bottle from the trachea by means of the second tube, is caused to vibrate by the reed, and in this condition carried by the third tube through the nose into the pharynx, where the sound is formed into words and issues from the mouth. With an instrument using shorter column of air, as advised by Glück, the tone is very unnatural. —*International Med. Magazine.*

# Editorials.

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## THE ONTARIO MEDICAL COUNCIL.

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We publish by request in this issue an article, which appeared in the *Oshawa Vindicator*, written in the interests of the Medical Defence Association. The author uses the "personal rancor and the virulent and intemperate language of a portion" of the Council as an argument in favor of legislative reform. In advocating reform why is it deemed necessary or advisable to call the Council, as at present constituted, a "legislative outrage;" why speak of "improper amendments clandestinely sought and fraudulently secured by interested parties?" why refer to "legislative injustice created by stealth, in defence of which the teaching bodies and their allies have been arrayed for years?"

We beg leave to remind the members of the Defence Association that these accusations and insinuations are serious. If certain members of our profession have been guilty of perpetrating injustice fraudulently and by stealth they should be exposed and punished if possible. These charges are not made in the heat of council wars, but deliberately, we presume, with some definite object in view.

Certain parties think that college representation should be abolished. Men who hold such opinions have a perfect right to do so. The writer, a teacher in a college, is perfectly willing to acknowledge that, but dislikes to be accused of fraud. Others think (and among these are included many Defence men) that college representation should not be abolished, but that it should be reduced. Now we happen to agree with this view, but we have no desire to discuss the matter in an angry way. We happen to believe also that the territorial representation is too large. The increase in such representation was due to the influence of men from territorial divisions. Fortunately no one has ever charged that the legislation necessary for such changes was fraudulently secured by interested parties.

We would like to assure the members of the Council that the profession of Ontario have a great respect for them individ-

ually and collectively. We feel that the record of the Council in a general way has been highly creditable to all parties in that body. We all feel, however, that there is an unnecessary blot on each year's record. The defence men have an excellent opportunity. For some inexplicable reason certain shrewd level-headed men got *rattled* at the last meeting of the Council, and inadvertently supplied their opponents with a lot of ammunition which may be used in the coming elections. Let the opposition carefully avoid the mistakes of the government party as to the use of intemperate language, etc. Let its members and sympathizers repudiate the intemperate language used by the anonymous writer in the *Vindicator*! Let the Defence Association show that it can rise equal to the occasion, and conduct its discussions without indulging in personalities, but rather in a way becoming to a body of educated and cultured gentlemen!

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#### PUBLICATION OF THE TRANSACTIONS OF THE ONTARIO MEDICAL ASSOCIATION.

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Many members of the Ontario Medical Association would like to see the transactions published in book form. We believe the majority of those in attendance at the last meeting favored such publication. The Publication Committee was asked to investigate the matter with a view of publishing the transactions of the last meeting. Two meetings of the committee were held under the chairmanship of Dr. J. J. Cassidy; and for certain reasons, which will be forthcoming at the proper time, it was decided not to publish the proceedings this year.

We have no authority to speak definitely as to particulars. We may say, however, that the views of the majority of the Association should be carried out. The matter will be brought before the Association at its next meeting.

Two difficulties present themselves in connection with such an undertaking. In the first place it requires an enormous amount of work to get a volume of transactions through the press before the subject matter gets to a certain extent stale. In the second place the expense is, in the writer's opinion, so great as to be out of all proportion to the intrinsic value of the publication.



The Canadian Medical Association, after careful consideration, published the transactions of one of its meetings something like twenty years ago. The result was not an unqualified success. Indeed it would be more nearly correct to say it was a dismal failure. Many of the state Associations in the United States have had such poor success in the same direction that they have ceased to publish their proceedings.

It has been suggested that the members should be required to pay the annual fee every year whether present at the meeting or not. We sincerely hope that such a requirement will never become law, because it would seriously curtail the membership, especially in districts distant from Toronto. For instance, a member after an absence of two years might hesitate to come from Windsor to Toronto, if he found that in addition to other items he were required to pay six dollars when he put in an appearance at the meeting. But some say he should pay his fee each year. Perhaps he should, but a good many won't. Many years ago such a rule was adopted by the Canadian Association; but it worked so badly that it was rescinded. We in Toronto should always aim at bringing as many from the outside as possible to the meetings, and avoid throwing the slightest impediments in the way.

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#### **Victoria Hospital, London.**

The following staff was appointed, July 15th, at a special meeting of the Board called for that purpose. It comprises the present "outside" summer staff, and the staff named by the medical school: Surgeons: Drs. Williams, Wishart, Jento and Niven. Physicians: Drs. Hodge, McCallum, Drake and Geo. Wilson. Gynecologists: Drs. Meek, W. J. Stevenson, Moore and John D. Wilson. Obstetricians: Drs. Balfour and Hogg. Anesthetists: Drs. H. A. Stevenson and Pardee Bucke. Pathologists and Bacteriologists: Dr. Neu. Eye, ear, nose and throat: Drs. Norman Henderson and Butler. Consulting surgeons: Drs. Waugh and J. M. Piper. Consulting physicians: Drs. Moorhouse and McLaren.

## THE ONTARIO MEDICAL COUNCIL.

### LEGISLATIVE REFORM BADLY NEEDED.

Whatever the opinion heretofore may have been, on the part of the public, regarding the composition, authority, general character and functions of the Ontario Medical Council, we must say the display of personal rancor, and the virulent and intemperate language of a portion of that body, indulged in at the late meeting of the council, is calculated to bring disgrace upon the whole body, and to reflect upon the profession generally.

So far as the press reports go—and we have reason for knowing they fell much short of what actually occurred—it would appear that the principal transgressors in debate were representatives of some of the universities whose conduct was simply scandalous.

The necessity of a purely representative council, an elective council, as advocated by members of the Medical Defence Association and many others in the profession, is becoming more and more evident every year. A step in this direction is greatly needed, as it would afford protection against entrance to the council of ill-behaved members.

As a matter of fact, the whole constitution of the council is at fault. In our opinion, *no public corporate body should be permitted to exercise authority, having in effect the force of law, in which appointed, or non-elected members have a voice.* The principle is bad wherever allowed to exist, for, as a rule, appointed members, feeling safe in their positions and responsible to no one, act as autocrats, and become so carried away by the force of their irresponsibility, that tyranny, injustice and oppression invariably follow.

The Ontario Medical Council, besides being largely unrepresentative, is also hybrid, professionally, and is clothed with powers possessed by no other public corporate body in existence, and so long as this legislative "outrage"—admitted by the government to "be such—is allowed to continue, the "infernal lie," "damn rascal," and every other unseemly expression and epithet will find vent from the mouths of irresponsible and ill-tempered members who, through appointment gain admittance to the council.

Many of the representatives in the Ontario Medical Council, we feel sure, know how to govern their language in debate. It would be deplorable indeed, and a reflection upon the profession if such were not the case. But when a concerted onslaught of violent and intemperate language, from the seats of a few appointed representatives of any corporate body, is directed

against one, two, or more of a minority of that body, and the attack, whether abetted or not, is allowed to proceed without protest or restraint, the onus and disgrace of such conduct fall equally, in the eyes of the public, upon the presiding officer and other members not engaged in the attack.

The Ontario Medical Act, as it at present stands, seems to have caused, from the outset, no end of trouble and division, and is responsible for a large supply of acrimony between the contending sections of the profession. The Act, as at first passed, though an outgrowth of school jealousies and sect rivalry, we believe, was generally regarded as a move along the line of useful legislation; but improper amendments since, clandestinely sought and fraudulently secured by interested parties, have given rise to no end of dissatisfaction, and must prove harmful so long as they are allowed to exist. Indeed, they have already seriously disturbed harmony in the profession.

That serious wrongs exist as a result of these improper amendments, and that redress is needed, is strongly evidenced by the violent and offensive spirit in which in the council and before the legislature all attempts at reform have been resisted. The more logical and more strongly legislative reform is advocated by Dr. Sangster and other members of the Medical Defence Association, the more vicious and abusive the appointed and irresponsible element in the council becomes. This fact in itself indicates the possession of unjust and arbitrary power which the ruling faction in the council fear it will lose.

If the legislature does not, at its next session, provide a remedy for existing grievances under the Act, the influence of public opinion will surely, sooner or later, step in and make itself felt in correcting a legislative injustice, created by stealth, in defence of which the teaching bodies and their allies have been arrayed for years, and concerning which both the government and members of the legislature have apparently manifested a notable and shameful degree of indifference.—*Oshawa Vindicator*.

## Personals.

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Dr. John Wishart, of London, Ont., has recently returned from England.

Dr. George E. Millichamp, of Toronto, has removed from Church Street to 49 Carlton Street.

Dr. Gordon C. Draeseke has been appointed house surgeon to the Western Hospital of Toronto.

Dr. Martin, of last year's staff in the Toronto General Hospital, will practise at Port Arthur.

Dr. D. J. Gibb Wishart, will spend the month of August on his island at the Madawaska Club, Go-Home Bay.

Dr. Hugh McCormick of Auburn, Wis., was married June 25th, to Miss Alice Evelyn Sutherland, of Milwaukee.

Dr. H. S. Hutchison, after spending a few months at Gravenhurst in the Sanatorium, will probably settle in Toronto.

In a letter received by Dr. Crawford Scadding, July 12th, Dr. Bertram Spencer said his condition was considerably improved.

Dr. Thomas McCrae, of John Hopkins Hospital, Baltimore, passed through Toronto, June 22nd, on his way to his old home at Guelph.

Dr. Frederick Cleland, one of last year's staff Toronto General Hospital, left Toronto, July 25th, for New York, where he has commenced practice.

Dr. J. A. Roberts, Captain of the Field Ambulance Corps, returned from South Africa July 24th. Dr. J. T. Clarke gave a pleasant at home on the same evening, when a large number of Toronto physicians met to extend a cordial welcome to Captain Roberts and some of his brave comrades who so signally distinguished themselves in South Africa, especially after the battle of Hart's River.

## Book Reviews.

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**Surgical Technic.** A Text-Book on Operative Surgery. By Fr. von ESMARCH, M.D., Professor of Surgery at the University of Kiel, and Surgeon-General of the German Army, and E. KOWALZIG, M.D., late First Assistant at the Surgical Clinic of the University of Kiel; Translated by Professor Ludwig H. GRAU, Ph.D., formerly of Leland Stanford Junior University, and William N. SULLIVAN, M.D., formerly Surgeon of U.S.S. "Corwin" Assistant of the Surgical Clinic at Cooper Medical College, San Francisco. Edited by Nicholas Senn, M.D., Professor of Surgery at Rush Medical College, Chicago, with fourteen hundred and ninety-seven illustrations and fifteen colored plates. New York and London: The Macmillan Co., Limited. Toronto: G. N. Morang & Co.

The work we have before us is the volume which won the German Empress's prize, on the occasion of the Vienna World's Exhibition, for the best hand-book of Surgical Technic. It is superfluous to praise so distinguished a gentleman as von Esmarch, and it is with the greatest of pleasure that we welcome a translation of this book to the English language. The work is one that is most thorough and complete, and begins from the earliest treatment of simple wounds through technique of dressing, appliances and operations, giving a description of the thoroughness with which the German surgeon handles his work. In the chapter on the treatment of wounds we are exceedingly pleased to note the warnings that are given in reference to many antiseptic solutions in common use. The toxic effects that may be produced by their long continued use—the recognition of the symptoms produced and the safeguards to prevent their occurrence is very clearly brought out. The subject of the many antiseptics that can be used is very elaborately treated, and their weak and strong points beautifully brought out. While we do not believe that the surgeon whose armamentarium is largest is better than the one who confines himself to the few well tried helps, yet all surgeons should be acquainted with the many drugs and appliances in use.

The dressing of the wound is described with great minuteness. This point we greatly appreciate. We fear that this subject is often overlooked by students; the striking point about operations and wounds, from a student's standpoint, is the brilliancy of the operative technic; in many instances they leave the operating theatre before the dressings are applied, and rarely see the patient after; only those few who have clinical advantages as hospital internes really become acquainted with the technic of surgical dressings. If it was only for these first chapters the work is one that would thoroughly repay its purchase.

The work differs largely from most German works in its freedom from verbosity. What is to be said is said in the fewest words commensurate with accuracy. The descriptions here are precise, yet thoroughness is by no means overlooked. The portion dealing with anesthesia is treated of from two stand-points—chloroform and ether. The author does not allow us to know which he favors most, but the pros and cons on the subject are thoroughly put forward. The local anesthetics are referred to, and the strong advantage that Schleich anesthesia has over the other forms, for many minor, and some major, operations, is pointed out. The details of the minor operations are as thoroughly entered into as those of the major ones. It is really from points like these that the greatest advantage of such an admirable treatise can be attained. We cannot speak too highly of the work; there are few surgical operations that are not thoroughly described or referred to. It is a volume on surgery—surgical technique—that is a great addition to the already large number existing in the English language, and is one that should be in the hands of every practitioner who wishes to be thoroughly informed on surgery, or requires a work for immediate reference. We can almost class it as an encyclopedia on surgical subjects. The publishers were exceedingly fortunate in securing so distinguished an editor as Dr. Nicholas Senn. They have presented their work with their usual elegance of typography and illustrations, and we bespeak a large sale for the volume.

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**Progressive Medicine, Vol. II, June, 1902.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by H. BART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 440 pages, 28 illustrations. Per volume, \$2 50, by express prepaid to any address. Per annum, in four cloth-bound volumes, \$10.00. Philadelphia and New York: Lea Brothers & Co., Publishers.

The June issue of *Progressive Medicine* contains a series of valuable contributions on subjects of great importance to the general practitioner.

Dr. Wm. B. Coley considers the Surgery of the Abdomen, including Hernia. His article is full and thoroughly practical, illustrating the great field for surgical therapeutics in the treatment of many diseases of the digestive organs which have hitherto been considered as solely medical affections.

Dr. John G. Clark covers the field of Gynecology with great thoroughness. All the new operations and devices for the treatment of diseases of women, as well as advances in gynecological pathology and technique are fully considered.

Dr. Alfred Stengel in his article on the Diseases of the Blood

and Ductless Glands, the Hemorrhagic and Metabolic Diseases, handles these difficult subjects in such a lucid and practical way as to make his contribution of value not only to the pathologist, but also to the physician, who, from the exigencies of his work, may find difficulty in keeping pace with the most recent advances which have been especially remarkable in the study of the blood.

The article on Ophthalmology by Dr. Edward Jackson is marked by its author's characteristic facility of dealing with the subject in such a way as to be of value to the oculist and at the same time to meet the needs of the general practitioner.

As usual, illustrations are employed liberally wherever they can aid in the elucidation of the text. The abstracts are full and give the complete gist of the original papers from which they are taken. Their value is greatly enhanced by the comments of the various editors upon them.

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**Diseases of the Nose, Pharynx and Ear.** By HENRY GRADLE, M.D., Professor of Ophthalmology and Otology, Northwestern University Medical School, Chicago. Handsome octavo of 547 pages, profusely illustrated, including two full-page plates in colors. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.50 net. Canadian Agents: J. A. Carveth & Co., Toronto.

This volume is intended to present diseases of the Nose, Pharynx and Ear as the author has seen them during an experience of nearly twenty-five years. In it are answered in detail those questions regarding the course and outcome of diseases which cause the less experienced observer the most anxiety in an individual case, questions to which an answer is not easily obtained from text-books. In the therapeutic part of the work the author has given detail only to those procedures which have withstood the test of critical experience. Topographic anatomy being a requisite for all surgical work, the author has wisely devoted liberal space to this branch of the subject. The numerous illustrations are exceptionally accurate in their portrayal of the pathological conditions, especially so the two full-page colored plates.

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**A Manual of Practical Medical Electricity, the Roentgen Rays and Finsen Light** By DAWSON TURNER, B.A., M.D., F.R.C.P., Ed., M.R.C.P., Lond., Fellow of the Physical Society; Lecturer on Experimental Physics, Surgeons' Hall, Edinburgh; Additional Examiner in Experimental Physics to the Edinburgh University; Medical Officer in Charge of the Electrical Department of the Royal Infirmary, Edinburgh. Third edition, revised and enlarged. London: Bailliere, Tindall & Cox, 8 Henrietta Street, Covent Garden.

We have before us the third edition of this admirable work, which is an improvement on the previous editions by the addition of Chapters on Roentgen Rays and Finsen Light. There

is one particular advantage that we note in this volume, and that is the thoroughness with which the subject is treated of, in detail. The detail of production of electric energy in its many forms is considered of sufficient importance to be elaborated on, and yet there is no unnecessary repetition. The subjects are so divided that one follows from the simple primary condition through the complex generality of electricity, with a conciseness and clearness that is pleasing to find. It is not possible to take out any particular chapter and review it, simply because they are all so thoroughly interwoven and connected one with the other, that it is only as a book on the whole subject that it can be dealt with. Points that are more easily elaborated by illustration are fully gone into, and the illustrations are numerous and clear, each one bringing out its point in the clearest possible manner. In treating of the subject of Electro-Surgery, under the subject of Strictures, the matter is put very clearly here, and if other authors would undertake to place the matter in this same fair way it would do away with a great deal of prejudice that exists at the present time against the use of Electrolysis. Electrolysis in experienced hands is undoubtedly good treatment, but in the hands of those who do not pay the closest attention to details, and are not armed with the best appliances, it is liable to be a source of great danger. Where Electrolysis is not a success it is very liable to be a source of considerable danger by increasing the severity of the existing disease. In reference to the chapters on Roentgen Rays and Finsen Light, they are fully up-to-date, yet at the same time a little more condensed than we would liked to have seen. They describe the conditions concisely, and one can appreciate the great advantage that in future will be gained by their use. We can thoroughly recommend the book, and compliment the publishers on the manner in which the work is presented.

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*Practical Diabetics, with Special Reference to Diet in Disease.* By W. GILMAN THOMAS, M.D., Professor of Medicine in the Cornell University Medical College in New York city. Second edition. New York: D. Appleton & Co., 1902; Toronto: Morang & Co., Canadian Agents.

A good book and a practical one. The author divides this work into nine parts. The first deals with foods and food preparations. Part II, stimulants, beverages and condiments. Part III, cooking, food preparation and preservation; the quantity of food required. Part IV, foods required for special conditions. Part V, food digestion and conditions which especially affect digestion. Part VI, the general relation of food to special diseases; diseases which are caused by dietetic errors. Part VII, administration of food for the sick. Part



VIII, diet in disease and diet in infectious diseases. Part IX, rations, dietaries. Such is the bill of fare presented to the reader, and it is an elaborate one, varied to meet the requirements of all kinds and conditions of men under all the changing circumstances of life in health and disease, from the cradle to the grave.

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**Quain's Dictionary of Medicine.** By various writers. Third edition, largely rewritten and revised throughout. With 14 colored plates and numerous other illustrations. Edited by H. MONTAGUE MURRAY, M.D., F.R.C.P., joint lecturer on Medicine, Charing Cross Hospital Medical School, and Physician to Out-patients, Charing Cross Hospital; Senior Physician to the Victoria Hospital for Children, Chelsea, and to the Foundling Hospital; assisted by John Harold, M.B., B.Ch., B.A.O., Physician to St. John's and St. Elizabeth's Hospitals, and Demonstrator of Medicine at Charing Cross Medical School, and W. Cecil Bosanquet, M.A., M.D., M.R.C.P., Physician to Out-patients, Victoria Hospital for Children, Chelsea, and Pathologist to Charing Cross Hospital; late Fellow of New College, Oxford. New York: D. Appleton & Co.; Toronto: The Geo. N. Morang Co., Limited, Canadian Agents, 1902.

The object of the publishers and of those responsible for the new edition of this dictionary has been to produce a book that shall serve as a reliable and available work of ready reference for the practitioner and student of medicine.

The general scheme of the book—as planned by the late Sir Richard Quain and his assistant editors—has been preserved, and the special emphasis laid on the diagnosis and treatment of disease has been maintained, although the pathology and etiology have also been very carefully considered and revised.

Some departure from the original plan has been deemed advisable. Many articles—excellent in themselves, but not in accord with the special object in view—have been omitted, while repetitions, as far as possible, have been excluded.

It is never an easy matter to *review* a dictionary; it is doubly difficult to review one such as this. The amount of work done by the editor and his assistants has been enormous. One can realize this in part when he learns that the list of contributors numbers two hundred and eighty-four, including the cream of Great Britain and Ireland. We have only to say in conclusion: the book is a grand one, and should be owned by every practising physician in Canada.

## Correspondence.

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### IS MUSKOKA A GOOD PLACE FOR CONSUMPTIVES?

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*To the Editor of CANADIAN PRACTITIONER AND REVIEW.*

A great many times I have been asked and received written enquiries, as probably others have, in respect to Muskoka as a locality for consumptives. Having for ten or twelve years given a good deal of attention to the meteorological conditions and elevations (from railroad grades) of many localities in Ontario and Quebec, I must state that I think it is not a good locality for such patients.

When it was first proposed to build the Sanitarium of the National Association at Gravenhurst, I offered the Association, through Mr. Gage, the benefit of my little investigations, warned them of the danger of building there, and told them that within twenty miles of Toronto there was a much better locality.

Muskoka is a very desirable place, especially in June, July and August, for the over-worked or worn out neurotic, for persons generally run down, for those seeking rest or pleasure, but it is too damp and otherwise very unsuited for the tuberculous.

For one example: A patient now under my care spent last summer in Huntsville. She was not benefited in any way, evidently, but observed the moist air, with evening and morning mists, almost daily. And who can name a case of well marked pulmonary tuberculosis, say in the early second stage, who has been in any marked measure benefited by residence there? And who, on the other hand, cannot name case after case of patients in the earliest stage who went up there from this city and after a residence of perhaps one or two years came back home and soon died?

A well-known Toronto practitioner remarked to me not long ago that he could always wring water from his shirt after it had hung in his room all night when up there.

A physician who has resided many summers in Muskoka told me but the other day that while there a great many consumptives consulted him and he urged them all to go at once to some drier locality.

It seems to me too much like sending consumptives into the lion's mouth, or "into the jaws of death," to send them there.

The best locality I know of, I may add, where the air is dry and fairly crisp and sparkling, with highly vitalized

oxygen, is on the Gatineau Mountains, north of Ottawa, about midway between the great lakes and the Atlantic.

In the more elevated eastern parts of Algonquin Park and farther north near the great water shed, the conditions are more favorable than in Muskoka. Coming nearer home we have the Caledon Mountains and also pine and oak ridges, less than twenty miles from Toronto, both hundreds of feet more elevated than Muskoka, with a drier atmosphere, a good deal of sunshine, and a soil well adapted for such patients.

EDWARD PLAYTER.

## Obituary.

### ROBERT JOHN GUNN, L. R. C. S., EDIN.

Dr. R. J. Gunn, of Whitby, died at his residence, June 24th, aged 89. He had resided in Whitby fifty-three years, was Mayor of the town on several occasions, and jail surgeon for thirty years.

### EDWARD HENRY HORSEY, M.D., M.P.

Dr. Horsey's many friends were shocked to hear of his death by accident on the evening of July 23rd at the age of 35 years. He was struck by a fragment from a bursting fly wheel in the Sun Portland Cement Works, Owen Sound, of which he was the principal stockholder. His skull was fractured and he died in a few hours. He graduated M.D., in Queen's in 1888. After practising a short time, he dropped medicine and became manager for the Sun Life Insurance Company in Asia. He spent some years in China, Japan and India and returned to Canada about four years ago. After a short stay in Toronto he went to Owen Sound, where he was engaged in several business enterprises. In 1900 he was elected member for the Commons. He was one of the most lovable, popular and able men in Canada. He left a widow, daughter of Dr. Peter Macdonald, Wingham, Deputy Speaker of the House of Commons, and two young children.

## A CONTRIBUTION TO THE THERAPEUTICS OF ANEMIC CONDITIONS.

By DR. HERMANN METALL,

Assistant Physician to the General Polyclinic, Vienna.)

(Translated from the German.)

In the medicinal treatment of the various forms of anemia, whether it be essential chlorosis or the so-called secondary forms arising from severe loss of blood and various diseases (tuberculosis, cancer, etc.), iron has always occupied the most prominent place. In the management of chlorosis, especially, the chief object is the administration of an adequate quantity of iron, since upon this depends the success of all treatment. As to the manner in which iron acts in anemic conditions, that is a secondary matter. Whatever be its mode of action, it remains an empirical remedy and yet one of incontestable value.

According to the unanimous opinion of many authors, the effect of iron in chlorosis cannot be replaced by alimentation. Reinert, Klein, Immermann, Ensli, and others have shown that typical chlorosis cannot be cured in any other way, even by forced feeding. Some of them have made a series of very careful experiments for this purpose, and reached the remarkable result that during superalimentation, extending even over a number of weeks, the quantity of hemoglobin in the blood increased scarcely a few per cent., and remained permanently at this level. That this is actually so we daily convince ourselves in cases of chlorosis in girls of the better classes. These girls, if placed on a full diet, accumulate more fat, while the chlorosis remains practically unaffected—it requires iron. The dietary therefore plays a subordinate part in the therapy of chlorosis (Klein), and is to be regarded only as an important adjunct to the treatment.

I will now devote a few words to manganese, which is employed in combination with iron in some ferruginous preparations for the treatment of anemia. Hannon already directed attention to this method, which is a constituent of healthy blood, and which besides iron has an important bearing on the absorption of oxygen by the blood. In fact, experiments have shown that anemic conditions are most successfully treated with iron in connection with manganese. Chalybeate medication is materially aided and promoted by the addition of manganese. Efforts have therefore been made to introduce combinations of iron and manganese into therapeutics.

After laborious attempts, Dr. Gude, chemist, succeeded in producing such an iron-manganese preparation, which is easily

absorbed by the entire intestinal tract, evokes no concomitant effects, and, as is illustrated in the following histories of cases, has proved an excellent remedy for the formation of blood. The preparation referred to is Pepto-Mangan (Gude). It contains iron and manganese in an organic combination with peptone, and is a clear fluid, resembling dark red wine, of an agreeable, non-metallic, non-astringent taste.

The advantage of this preparation is that it exerts a stimulating effect upon the blood-forming organs, these being excited to greater functional activity, and that the favorable effect manifests itself even within a short time by an increased oxygenation of the blood. At the same time, this chalybeate, as already mentioned, causes no digestive disturbances and does not injure the teeth.

In regard to the daily dose of iron, Quinke maintains that it should range from  $\frac{3}{4}$  to  $1\frac{1}{2}$  grains of Fe. Most clinicians prescribe commonly 4 grains, which considerably exceeds the maximum dose recommended by Quinke. Some of them, like Niemayer and Trousseau, give even 7 grains of metallic iron daily; hence Pepto-Mangan (Gude) should be prescribed in doses of one tablespoonful three times daily for adults, and one teaspoonful twice daily for children up to twelve years, after meals. Sour, fatty foods and red wine should be avoided during its administration. The preparation is much relished by all patients, and it is my custom to administer it to children in water, or, better, in cold milk with the addition of sugar, in which form it is very palatable.

After this brief introduction I will describe a number of cases which have been treated by me with Pepto-Mangan:

CASE I.—Mary B., 16 years old, has complained since a week of general debility and lassitude. She is very pale and restless, has no appetite, and suffers from headache and a feeling of pressure in the stomach. She is constipated, and the menses are irregular. Diagnosis, chlorosis.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 2 . . .	2,480,000	20	49.2	Pepto-Mangan (Gude), one tablespoonful three times daily.
August 9 . . .	3,212,000	25	50.	
August 16 . . .	4,020,000	30	50.5	
August 24 . . .	4,300,000	40	51.3	
September 2 . .	5,000,000	50	53.4	

After a week, the appetite was good, no headache: at the end of the second week, no further disturbances; menses not pain-

ful, and lasting only three days (formerly five days). After four weeks, the patient discharged cured.

CASE II.—Anna H., 23 years old, has suffered for three years from chlorosis, with irregular menstruation, palpitation of the heart, a feeling of weakness, and occasional syncope. Physical examination showed the presence of anemic murmurs over the heart, as well as a venous murmur; no fever or edema.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 4. . . .	3,750,000	35	55.5	Pepto-Mangan (Gude), one table-spoonful three times daily.
August 29. . .	4,010,000	60	57.8	
September 14	4,200,000	70	59.	

Appearance of menses after absence of 12 weeks; subjective disturbances have disappeared.

CASE III.—M. W., 16 years old, has suffered since a year from headaches, dyspnea, tinnitus aurium, vertigo, and gastric disturbances. There was marked pallor of the face and of the mucous membranes; systolic murmurs over the mitral and pulmonary valves, with dilatation of the heart. No fever; spleen not palpable. Diagnosis, severe chlorosis.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 5. . . .	2,250,000	25	52.5	Pepto-Mangan (Gude), one table-spoonful three times daily.
August 13. . .	3,200,000	30	53.5	
August 16. . .	3,350,000	35	55.5	
August 23. . .	3,530,000	40	56.5	
September 1.	4,250,000	45	58.	

The subjective symptoms rapidly subsided, the appetite improved, and the stools became regular. The menses reappeared in the second week of treatment, after having been absent for a year.

CASE IV.—M. P., 15 years old. Menses absent since one-half year; always scanty. Vicarious hemorrhages from the nose. Since three months the patient has suffered from dyspnea, vomiting, cardiac palpitation, general weakness, headaches, feeling of dulness and sleeplessness. Physical examination reveals anemic murmurs, moderate dilatation of the heart, venous murmur.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 5...	2,400,000	20	47.	Pepto-Mangan (Gude), one tablespoonful three times daily.
August 10...	3,600,000	25	47.5	
August 16...	3,850,000	30	48.5	
August 23...	4,250,000	35	49.0	
August 31...	4,700,000	40	49.7	
September 7.	5,000,000	45	52.	
September 14	5,200,000	50	53.	

After the first week improvement set in; at the end of treatment disappearance of all disturbances. Increase of bodily weight, 12 pounds.

CASE V.—J. K., 18 years old. Chlorosis. Anemic murmurs, cardiac dilatation, loss of appetite, insomnia, general lassitude, and headaches.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 10...	2,200,000	35	52.	Pepto-Mangan (Gude), one tablespoonful three times daily.
August 24...	3,000,000	45	55.	
September 12	3,300,000	60	57.	

At the end of the first week appetite vigorous; headaches had subsided. At the end of the fourth week no disturbance of any kind.

CASE VI.—A. N., 19 years old, has suffered from chlorotic disorders since two years. Improvement occurred under a milk diet and a sojourn in the country. Since five months the patient again complains of disturbances: palpitation of the heart, lassitude, headache, vertigo, tinnitus, and constipation; anemic murmurs and venous hum perceptible.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 17..	4,500,000	25	53.5	Pepto-Mangan (Gude), one table. spoonful three times daily.
August 25...	4,100,000	30	54.	
August 31...	4,000,000	35	54.5	
September 7.	3,950,000	40	56.	
September 22	4,200,000	45	57.5	

The subjective symptoms diminished after a few days. The disturbances disappeared, the appetite improved, and the stools became regular.

CASE VII.—J. R., 29 years old, has suffered from chlorosis since two years. Status presentis: General lassitude, palpitation of the heart, a feeling of pressure in the stomach, difficulty in breathing; menses irregular as well as dysmenorrhea. In the last three months all the disturbances have become more intense.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 22...	4,250,000	30	52.	Pepto-Mangan (Gude), one tablespoonful three times daily.
August 26...	4,350,000	35	52.5	
September 5.	5,420,000	40	53.5	
September 12.	5,300,000	50	54.	
September 18.	5,350,000	55	54.5	
September 27.	5,300,000	60	55.5	

The disorders have disappeared, the appetite is good, and the bowels regular: no anemic heart murmurs.

CASE VIII.—L. N., 19 years old, complains of headaches, cardiac palpitation, vertigo; scanty menses.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
August 28...	2,500,000	40	54.	Pepto-Mangan (Gude), one tablespoonful three times daily.
September 13.	3,750,000	55	55.5	
October 1....	4,300,000	70	57.	

The subjective disorders have vanished; menses more abundant.

CASE IX.—J. M., 16 years old, has suffered since two months from palpitation of the heart, dyspnea, feeling of pressure in the stomach, vertigo, tinnitus, and headaches. There is a slight cardiac palpitation, with systolic murmurs and a venous hum. Anorexia and constipation are present. The menses have been irregular since a year.

Date.	Red Blood Cells in Cubic Millimetre.	Hemoglobin per cent.	Bodily Weight.	Therapy.
September 2.	4,500,000	35	50.	Pepto-Mangan (Gude), one tablespoonful three times daily.
September 11.	4,750,000	40	50.	
September 20.	4,850,000	50	51.	
September 29.	4,950,000	55	52.	

Menses regular; bowels normal; no disturbances.

CASE X.—Z. F., 30 years old, had a miscarriage two weeks



previously, with profuse hemorrhage. After a month's treatment completely restored to health, and an increase of weight of four pounds.

CASE XI.—A. N., six years old; rachitis and anemia. Under treatment an increase of weight of two-thirds of a pound. Much better appearance.

CASE XII.—J. W., 30 years old. Pulmonary tuberculosis and anemia. After two weeks' administration of Pepto-Mangan (Gude), an increase in weight of two pounds and an increase in hemoglobin of *fifteen* per cent.

CASE XIII.—K. L., 50 years old. Cancer of the stomach, cachexia, and anemia. During three weeks' use of Pepto-Mangan (Gude) the patient felt better, the appetite had improved, and there was an increase of weight of two-thirds of a pound.

CASE XIV.—A. B., 14 years old. Chlorosis; hemoglobin 40 per cent. After two weeks' treatment, hemoglobin 85 per cent.; disappearance of all disturbances.

CASE XV.—F. K., 18 years old. Chlorosis; hemoglobin 35 per cent.; after two weeks' treatment 50 per cent.

CASE XVI.—E. J., 5 years old. Anemia following scarlatina. After eight days' treatment with Pepto-Mangan (Gude) the patient developed a vigorous appetite, and recovered so rapidly that he could be discharged cured at the end of the second week.

Altogether, twenty-three cases of anemia were treated with Pepto-Mangan (Gude), of which 12 showed a normal hemoglobin per cent. of the blood after fourteen days, five after three weeks, and five after a month. On the other hand, one of the patients who had hereditary trouble (her father having suffered from pulmonary disease) was discharged only improved, the blood, after two months' treatment with Pepto-Mangan (Gude), showing only an increase of hemoglobin to 75 per cent. This was probably a case of tuberculosis which simulated an obstinate or severe chlorosis at its beginning.

Furthermore, two cases of acute anemia after profuse hemorrhages were treated with Pepto-Mangan (Gude). A favorable result was obtained as early as the end of the first week. In one instance the patient felt so well that only the fear of further hemorrhage constrained him to stay in bed for another week. In the case of three women who had miscarried during the early months of pregnancy, and were making a very slow recovery from the resulting anemia, I was able to obtain a complete recovery after four weeks' administration of Pepto-Mangan (Gude). In six other instances of weakness and anemia following acute and chronic disease (tuberculosis, carcinoma, scarlet fever, etc.), a disappearance of the feeling of

weakness, and a considerable improvement of the general health could be observed in every instance.

The histories cited above will afford conclusive evidence of the high therapeutic value of Pepto-Mangan (Gude). Unpleasant concomitant effects and disagreeable sequelæ were *never* observed during the use of the remedy. Eructations, pressure in the stomach, and nausea were never noticed.

In conclusion, I would say that Pepto-Mangan (Gude) is a valuable and reliable blood-building remedy, which can be recommended for general use in appropriate cases.—*Medicinisch-Chirurgisches Central-Blatt, Vienna, Austria, January, 1902.*

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## ERGOAPIOL (SMITH) IN DISEASES OF THE FEMALE.

By CHARLES H. SHEPARD, M.D.  
Physician to Lincoln Hospital, Durham, N.C.

A deep and general interest is attached to all knowledge pertaining to the treatment of common diseases of the uterus, to which women are subject, and a vast literature is the outcome of this profound and focussed interest. We live to-day in an age of transition—a period of change. A great many of the former theories in medicine are fast passing away. New medicines are made, achieve a short-lived success, and then pass on to obscurity. This is true, most especially in medicines for gynecological diseases. Of the newer remedies it is hard indeed to get one that may be depended upon for long. They soon lose their reputation and potency, and are relegated to the past.

We know that all diseases of the womb have not the same etiology nor the same pathology, therefore they should not all have the same treatment. Far too often the general practitioner groups all these diseases together as one and gives the routine treatment. It is not enough to give anodyne medicines for dysmenorrhea no more than it is sufficient to treat alike all forms of dysmenorrhea.

The operation of curettement has a most important place in these conditions, but like other remedial agencies it has its limitation. When we curette the uterus we rid it of a pathologically obnoxious lining membrane, and afford a normal membrane the opportunity to be formed.

The healthy woman with normal genitalia menstruates regularly and painlessly once a month from puberty to the "turn" of life, except that this regularity is interrupted by

pregnancy and afterwards by lactation. Any departure from this rule constitutes an abnormality. Amenorrhœa is less frequently met with than dysmenorrhœa and irregular menstruation. The present age of transition has brought forth what is popularly known as the "new woman," and she has brought with her new ideas and practices which in very many cases retard growth and the natural process necessary for perfect health. For leaving the old landmarks she has to suffer.

The most generally useful medicine in the conditions of amenorrhœa, dysmenorrhœa, irregular, scanty and fetid menstruation, in my judgment, is a preparation of the Martin H. Smith Company of New York, known as Ergoapiol (Smith). In the female ward of the Lincoln Hospital, Durham, N.C., I have used this medicine very extensively, and it has not only never failed to benefit and cure, but I know no remedy with which I could replace it were I deprived of it. Its efficacy may be tested by any physician who properly tries it. I mention a few cases with short description of each, in which it has given the most signal benefit in my hands.

Ergoapiol (Smith) is put up as a small capsule, and is made up of a special form of apiol which is of the very highest quality. Combined with this are some other most valuable hemagogues, and they all go to make a fine preparation. It seems to be a scientific pharmaceutical preparation, non-toxic, tonic, as well as emenagogue. What I have to say of this preparation is based entirely upon clinical experience, and I feel safe in saying that it will bear a clinical test whenever properly administered.

#### REPORT OF CASES.

Case 1.—Mrs. F. was admitted to hospital, September 15th, 1901; married; no children, though she had been married four years. Had not menstruated for seven years. Womb had been curetted several times; suffered from leucorrhœa; pains in right and left iliac regions continuous. Examination showed a very small os, but generative organs were otherwise found to be normal. Another curettement failed to bring on the menses. I then prescribed Ergoapiol (Smith) to be taken one globule three times a day, and afterwards increase to one globule four times a day. After seven days of this treatment she complained of a general feeling of stiffness in her limbs, gaping, and a feeling of malaise. The following morning she found to her delightful surprise that she was menstruating for the first time in seven years. At that time the flow was somewhat scanty, but the treatment was continued through three periods. Each succeeding period was more nearly normal than the one

that preceded it. Now her functions are regular, and I know no reason why she may not become pregnant.

Case 2.—Mrs. S. complained of a continuous, dull, dragging pain, situated in the region of the iliac fossa of the right side. Menstruation irregular, scanty, fetid. Married six years; had never been pregnant. Excessive leucorrhœa, though otherwise she was perfectly normal. Her weight was 140 pounds. Her condition, and the suffering, both physical and mental, which it occasioned her, was rapidly undermining her health. She was becoming emaciated, appetite of no consequence, general weakness. She considered her condition "hopeless." Cardiac weakness, of which she was a victim, contra-indicated curettement, which usually cures "whites" and allows the formation of a healthy lining membrane. Ergoapial (Smith) was prescribed for her, one capsule three times a day. In conjunction with this I gave tonic medicines. After six weeks' use of this remedy, the woman said she was "feeling so good" that she did not need any further treatment. She had increased in weight, and her appetite had become all she could wish. The menstrual flow was increased, and now, five periods having elapsed from the time treatment was instituted, her monthly flow has failed to appear. She does not expect its return for some time—supposing herself pregnant.

Case 3.—Miss S. suffered severe pain each month, beginning a day before the flow came on. The flow was a thick, clotted mass, consisting of membrane and the menstrual blood matted together. She had suffered from puberty, and the suffering became more intense as the years passed on. She was 19 years of age, stout, of healthy parentage. Admitted to Lincoln Hospital, January 15th, 1902. She declined an operation. I afterwards prescribed Ergoapial (Smith) and have continued it for one month. Her next menstruation was free and easy; painless and regular. I doubt not that keeping up this treatment up to another period she will be entirely rid of the hitherto troublesome condition.

Case 4.—Miss W., tubercular history. Menstruation very irregular, sometimes three, sometimes five weeks between periods; very painful; scanty. I prescribed Ergoapial (Smith) one capsule four times a day beginning one week before the menstrual period and continued a week after the period. As a result of this treatment the patient feels a great deal better in her general health; her monthly flow has been rendered painless and increased in quantity. Ergoapial has a tonic action upon the muscular fibers of the womb. Its effect is not transitory but lasting. This superior preparation is decidedly tonic.

Case 5.—Mrs. D., a victim of endometritis. Pain continues

between periods, and is aggravated at periods. Leucorrhœa was very pronounced; pains in the back; "hot flushes," vertigo, headache. Patient would not allow an operation; highly sensitive. Several preparations were tried, but none gave relief until Ergoapiol (Smith) was used. It has entirely relieved the patient, and she is now loudly singing its praises. In this case treatment was kept up for ten weeks.

Ergoapiol has never failed in my hands. It is not possible that it can cure obstructive dysmenorrhœa, but with that exception it is indicated in all the other diseases of the womb where a tonic and sedative action is the requirement.

Case 6.—Mrs. D., widow; aged 33; had three children; youngest ten years of age. She had suffered all her menstrual life severe pains in the pelvis at each period; had to keep in bed a week or more each month; paroxysms of pain were followed by a flow of the "whites;" no anemia; womb found to be flabby and relaxed; pains extended down thighs posteriorly. Had been treated for many years by various physicians of note, but had received only temporary benefit.

Ergoapiol (Smith) was given her, one capsule three times a day, and increased at the time of the flow to four a day. After three months of this treatment her menstrual function became regular, and being entirely well now, she feels that life, after all, is worth living.

I could prolong this list indefinitely with records of cases that have been entirely relieved of these conditions, and I shall be pleased to furnish any information desired as to Ergoapiol (Smith) and its use.

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## SURGICAL HINTS.

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To tap the bladder in very fat men, observe the furrow which runs transversely above the pubic fat, and tap where this line crosses the linea alba.

In severe epistaxis, or after operations in which patients swallow much blood, they are likely to be considerably nauseated. The stomach may be washed out, or else the patient may be given some bicarbonate of soda, or a good dose of pepsin.

In operation upon alcoholic subjects it is often wise to give them a drink of spirits an hour or less before its performance. These people are more restless than others, and often require a greater quantity of the anesthetic to abolish sensibility, but long deprivation of drink, if anything, only tends to intensify these unfavorable tendencies.—*International Journal of Surgery.*

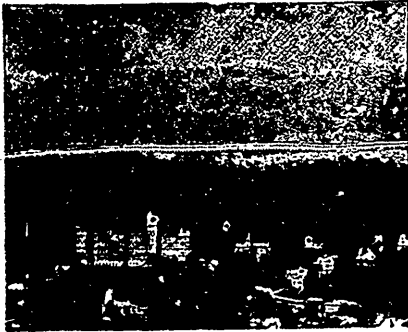
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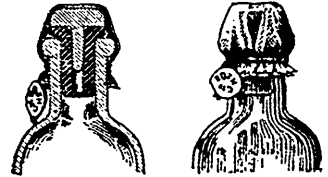
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## Selections.

### Stypticin.

The need of a local hemostatic that would combine promptness and certainty of action with innocuousness has long been recognized. Neither ferric chloride, nor absolute alcohol, nor suprarenal extract are altogether satisfactory considered in this respect.

The almost ideal hemostatic seems to have been discovered in stypticin. This remedy is very popular with gynecologists as an internal styptic in uterine bleeding. It has been successfully used in hemorrhages from the bladder after the introduction of sounds, and dentists speak favorably of its efficiency in the hemorrhage after tooth-extraction, etc.

Dr. R. Kaufmann (*Journal of Cutaneous and Genito-urinary Diseases*, No. 223) confirms the previous reports on stypticin. He uses it chiefly as a local hemostatic in manipulations about the urethra, in circumcision, etc. A piece of cotton may be soaked in the solution of stypticin and applied. No caustic effects need be feared.

The hemorrhage following the extraction of a tooth, while usually ceasing of its own accord, occasionally persists and gives rise to difficulties in checking it. If the patient should chance to be a bleeder the trouble will be quite serious, and the usual styptics will be found unavailing. Stypticin is, however, highly recommended in such emergencies as a prompt styptic. —*Medical Age*.

### Formalin as a Disinfectant for the Hands: An Unpleasant Personal Experience.

Dr. Charles P. Noble, in *American Medicine*, says:—"Desiring to improve upon the present methods of hand disinfection, I was led to experiment with formalin solution as a substitute for bichlorid of mercury solution. Heretofore the method of hand disinfection which I have employed has been to spend 15 minutes in scrubbing the hands with soap and hot water and in cleaning the nails. This was followed by an alcohol bath, and after this the hands were put through a saturated solution of permanganate of potash, a saturated solution of oxalic acid and bichlorid solution 1 to 1,000. In the bichlorid bath the hands and forearms were immersed and allowed to soak. This method of hand disinfection has given very good practical results. The introduction of rubber gloves into surgery caused one unpleasant consequence from the above method of hand disinfection, the sulphur in the gloves and the bichlorid solution, left upon the hands, uniting to make a sulfid of mercury.

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This caused a black discoloration of the nails. The result of a winter's work was that the nails became so black as to be distinctly noticeable and to attract unpleasant attention. It was principally on this account that it was desired to eliminate the bichlorid solution. I was led to try formalin solution principally by the fact that it has entirely displaced bichlorid solution in the practice of Dr. Charles Jacobs, of Brussels, and that of Drs. G. E. and J. Lynn Crawford, of Cedar Rapids, Iowa.

"After having used formalin solution for about a month, a great inflammation appeared at the end of all my fingers, involving the nails. This inflammation was so violent that serum formed under the nails, separating them from the underlying tissue, and it seemed for a time as though all the nails would be exfoliated. Under the influence of rest and elevation of the parts, together with an ointment of ichthyol, prescribed by Dr. H. C. Stelwagon, the inflammation subsided without suppuration. As a consequence, however, the nails separated on an average for about one-third of their length from the distal extremity, but they are now gradually returning to the normal. It was an interesting question as to the cause of the inflammation. The simultaneous involvement of all the finger ends excluded with reasonable certainty ordinary infection as a cause. My previous condition of health, and also an investigation by Dr. Judson Daland, excluded gout or other systemic causes as a possible explanation of the condition. A local irritation was left as the only reasonable explanation. As the use of formalin was the only change which had been made in the method of hand disinfection which had been used for years, it was evident to me that this was the cause of trouble; and on reflection it was recalled that on the two days preceding the attack rubber gloves had been worn during four hours each day in the operating room, and also that on these two days the gloves had been put on filled with a solution of formalin 1 to 500. My usual practice in putting on gloves is to have them filled with salt solution, but on the two days in question the operating-room staff being unusually busy, the gloves were filled with formalin solution to avoid taking the nurse away from other duties. The factors concerned in the production of the inflammation were: First, the use of formalin solution, and second, its prolonged contact with the finger ends, there being enough of the solution left inside the gloves to keep the finger ends moistened in the solution while the gloves were worn. This experience is reported not to warn others against the use of formalin solution for hand disinfection, but to teach the importance of avoiding a prolonged contact with even a dilute solution of this agent."—*American Medicine*.