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MEDICAL MONTHLY

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## Original Articles

### TUBERCULOSIS OF THE SKIN.

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The clinical manifestations of tuberculosis, which are exhibited on the skin, may appear in a number of forms. In the lesions of some of these the tubercle bacillus has been detected, while in others, although the cutaneous disease has not been found to be the site of bacilli, still a tuberculous focus has frequently existed in some other organ of the body. To the first division the name tuberculosis cutis is given, whereas the diseases belonging to the second are sometimes called para-tuberculoses. The latter eruptions are supposed to be due to toxins of tubercular origin.

We are thus able to classify the skin diseases in which the tubercle bacillus is, or is supposed to be, an active causative agent, under two headings, as follows:

*Tuberculosis Cutis*: Lupus vulgaris, tuberculosis verrucosa (verruca necrogenica), scrofuloderma, tuberculosis cutis vera.

*Para-tuberculosis Cutis*: Lichen scrofulosorum, erythema induration of Bazin, acne scrofulosorum, pustular scrofuloderm, pigimentary tuberculide, etc.

Further investigation will probably lead to the detection of the tubercle bacillus in the eruptions of some of the members of second group. Indeed, several dermatologists have already stated that they have detected bacilli in lichen scrofulosorum and erythema induratum.

To prevent undue length of this article, I shall confine myself to a consideration of the tuberculosis cutis.

*Lupus Vulgaris*.—The characteristic lesion of this type of cutaneous tuberculosis is a neoplastic nodule situated more or less deeply in the corium. The disease is, no doubt, due to infection of the skin by the tubercle bacillus, which, however, is always difficult to find in the lesions. The fact that the eruption is usually unsymmetrical, and, as a rule, situated on the exposed parts—face, ears, neck, and hands—would appear to indicate that the bacillus might gain access by means of herpes, slight injuries, such as insect-bites, etc. Indeed, cases of lupus have been recorded following tattooing, vaccination, cold sores, and piercing of the ears. The fact that lupus sometimes results from indirect infection of the skin from deeply-seated tuberculous lesions, such as tuberculous glands or bones, without affecting the intervening tissue, appears to me to be additional evidence that lupus is a result of inoculation of the skin by the tubercle bacillus.

The histological structure of lupus vulgaris is similar to that of tuberculous disease in other organs. The nodule forms in the corium, usually in the lower part, and extends by the formation of new nodules, or by an irregular cellular infiltration of the surrounding tissues. Giant cells are numerous, but epithelioid cells are few. The further course of the process undergoes considerable variation in different cases, or at various periods in the history of the same case. There is always more or less cheesy degeneration and connective tissue proliferation. The epithelium is always involved: over some lesions it is atrophied and desquamating; over others hypertrophied, while over many it is completely destroyed. These variations, no doubt, depend upon the susceptibility of the patient to the disease, as well as the locality of the lesions and the amount of external irritation.

According to the form and degree of pathological change in the lesions, it is customary to speak of several clinical types of lupus vulgaris. Some of the principal ones are as follows:

(a) *Lupus exedens*, *lupus exulcerans*, *lupus vorax*, *lupus rodens*, etc. In this form there is destruction of the epidermis along with necrosis of cells and intercellular substance of tuberculous tissue. (b) *Lupus non-exedens*. In this type of lupus vulgaris the epidermis is involved, becomes scaly, wrinkled, and depressed, but is not completely destroyed; the tuberculous nodule is sometimes absorbed, but as a rule this resorption is accompanied by more or less connective tissue proliferation. Marked hyperplasia of the connective tissue produces bluish-red or white keloid-like bands, in the midst of which can usually be seen some tuberculous nodules. This form of the disease is sometimes called *lupus scleroticus*, or *lupus fibrosis*. (c) *Lupus*



hypertrophicus, lupus papillosus—both the epithelium and corium are hypertrophied and edematous, and the rete-pegs and papillæ enlarged.

The symptoms of lupus vulgaris are, as a rule, definite in character. The disease may be met with at any age, but it generally commences before the age of fifteen, and pursues a very chronic course. The eruption is usually situated on the face, especially the nose, but any part of the surface of body and the mucous membranes of the mouth, pharynx and larynx may become involved. The initial lesion is a dark-red or brown little nodule, usually raised above the skin, but in some cases on its level or depressed. This tubercle or lupoma is variable in size, and pursues a very chronic course. At the end of twenty years it may not be larger than a split pea. It is somewhat translucent, particularly when the overlying skin is slightly stretched. Jonathan Hutchinson compares its contents to apple jelly; however, the most distinctive character of the lesion, according to my mind, is its soft, boggy consistence, in marked contrast to the firmness of lesions of syphilis. The best method of demonstrating this softness is to press firmly on the lesion with a blunt-pointed probe, when the lupoma will readily yield. The disease spreads either by the formation of new discrete lesions or by the peripheral extension of the primary lesion. In the latter case, one or more nodules can usually be made out in the border of the patch.

The secondary changes which take place in the epidermis and corium, determine the further objective symptoms of the disease. When the epidermis is destroyed, the ulcerating form—lupus exedens—lupus exulcerans—is produced. These ulcers are usually covered with crusts, which, when removed, reveal a reddish base of soft consistency. The borders of these ulcers are as a rule soft. These two characters—non-induration of the borders and soft consistence of the floor—are frequently of great value in distinguishing a lupoid ulcer from a rodent ulcer; but a still more distinctive sign of the former disease is the presence of a discrete lupoid nodule in the neighborhood of the ulcer.

In place of liquefying, the epidermis may become scaly, depressed and wrinkled, and at the same time the patch increases in size by the formation of new nodules around its periphery. In this way a cicatrix is produced without ulceration. This scar-tissue may be smooth, but more frequently there are bands of connective tissue, due to fibroid metamorphosis of the lupomata in the diseased area. This form of the disease is sometimes called lupus non-exedens, or lupus exfoliatus; according to my experience it is more frequent than lupus exedens. The two

forms may be present in the same case, even in the same patch. In some cases there is marked thickening of the affected parts. This is due to hypertrophy and inflammatory edema of both the epidermis and the true skin. The surface of the lesions takes on a swollen, mammillated, fungoid appearance. The terms lupus hypertrophicus and lupus papillosus are used to describe these forms of the disease.

Although lupus vulgaris is generally characterized by nodules as one of its symptoms, there are occasionally met cases where the disease is more superficial in character, and then it has somewhat the appearance of lupus erythematosus; both lead to the formation of scar-tissue, but in case of lupus vulgaris the cicatrix is frequently situated at the border of a diseased area, whereas in erythematous lupus it is only found in the central part. Again, if the border of a superficial lupus vulgaris is stretched, small, yellowish, nodules can usually be made out.

The diagnosis of lupus vulgaris is usually not difficult. It has to be distinguished from the following diseases, which may result in the formation of scar-tissue, namely: Syphilis, rodent ulcer, cancer, lupus erythematous, leprosy, and scrofuloderma. The character of lupus vulgaris which should be remembered in distinguishing it from these diseases are the age at which it usually begins, the presence of apple-jelly nodules, the softness of the nodules and lupoid tissue, the slowness of the process, the character of the scar tissue, and the locality of the disease.

In the treatment of lupus vulgaris, the fact that it is a form of tuberculosis and that it occasionally follows, or is complicated by, tuberculosis in other organs, should not be lost sight of. Of 312 cases of lupus reported by Leloir, 32 were preceded by tuberculosis of the glands, 41 by scrofuloderma, and 29 by tuberculosis of bones and joints. Particular attention should be directed to diet and hygiene. The diet should be liberal but great care should be exercised lest it provoke indigestion, as disturbances of digestion invariably aggravate eruptions on the face.

Iron, iodine, calcium salts phosphates, cod-liver oil, are always of great value, both as foods and medicines. Although the internal and hygienic treatments are of value, the external treatment is of greatest importance. As long as lupus tissue remains in a scar, the disease is very apt to relapse. There are a great number of external methods of treatment of lupus, but I shall only mention a few of the most effective.

According to my experience, the most successful method of treatment, is the thorough scraping of the patches by means of a curette, followed by the application for a week of a 25 per cent. ointment of pyrogallic acid. As a rule, the application of the

ointment causes very little discomfort, and the injection of cocaine around the patch will dull the pain while the patch is being scraped.

Another excellent remedy in the treatment of lupus is the solid stick of nitrate of silver. It is unnecessary to scrape the patch before using this caustic, but the stick should be pointed, and a good deal of mechanical force used in the destruction of the pathological tissue. The fact that lupoid tissue is soft favors this, as the caustic stick will not readily penetrate sound skin. The application of caustic paste made according to the formulæ of Hebra, Marsden or Bourgard, gives excellent results in some cases. Cocaine should always be added to the preparation to dull the pain, and the surface treated at one time should not be larger than the palm of the hand, provided the paste contains considerable arsenic. The principle upon which the efficacy of these pastes depend is the well-established fact that pathological tissue is more readily destroyed than normal tissue.

When the lesions are situated on the limbs and trunk, and do not cover too great an area, excision is one of the best forms of treatment. The lupoid tissue should be thoroughly removed, as lupus is very apt to recur in the scar. The healing of the wound may be aided by skin-grafting.

Roentgen rays have been employed in the treatment of lupus by a number of physicians during the last few years. The results appear to have been favorable, but relapses occur, as with other methods.

Of all the newer methods, the application of concentrated light, deprived of its heat-rays, according to the method of Finsen of Copenhagen, promises to give the best results. He has employed it in 553 cases since 1895, and of these 362 were cured, a most encouraging report. Of the remainder, 19 died, and 42 left the institution for various reasons.

*Tuberculosis Cutis vera.*—Although this clinical type of cutaneous tuberculosis is very rare, still it is of peculiar interest, as the histo-pathology of these lesions resembles very closely those of tuberculosis of internal organs. This is what one would naturally expect, as the affection of the skin is usually situated near the border of a mucous membrane, such as the lips, alae of nose, and anus, and is, as a rule, associated with tuberculosis of the adjacent mucous membrane, as well as pulmonary or intestinal tuberculosis. The lesions are shallow, indolent ulcers, with flabby or slightly indurated borders. Their surfaces are often covered with crusts, which, when removed, reveal a reddish-yellow granular surface with a thin, scanty secretion. The ulcers are usually small, but may increase in size by peripheral extension, until they

cover one or two square inches. When situated near the mouth they may extend to the mucous membrane of the cheeks, tongue and palate, but as a rule the ulceration in the mouth is primary to that on the skin. The course of the ulcerative process is somewhat acute, as it generally occurs in the later stages of chronic pulmonary tuberculosis.

The diagnosis is usually easy, as the cutaneous disease is usually secondary to tuberculosis in other organs. In the case of a patient seen by me about four years ago, there was a superficial ulcer about the size of a quarter of a dollar near the corner of the mouth along with laryngeal and pulmonary tuberculosis, and a strumous ulcer (scrofuloderma) on the side of the neck. When the ulcer is primary, it might be mistaken for syphilis. In the absence of other signs, the effect of treatment would probably determine the nature of the disease. If necessary, scrapings from the ulcer should be examined for tubercle bacilli, which are present in considerable numbers in the lesions. In addition, the presence of miliary nodules, which are so characteristic of tuberculosis of internal organs, might be determined. The treatment of a tubercular ulcer is very similar to that of a lupoid ulcer.

*Tuberculosis Verrucosa (verruca necrogenica)* is, from a pathological standpoint, practically the same as lupus verrucosus. The eruption is no doubt due to direct infection of the skin by the tubercle bacillus. The lesions are usually found on the hands and fingers of persons who are habitually handling or dissecting cadavers or other forms of dead animal tissue. Thus the disease is found most frequently amongst physicians, mortuary porters, cooks, and butchers. Cases have been recorded in which the lesions appeared to result from infection by the sputum of a tuberculous patient. The disease usually begins as a flat papule or papulo-pustule. The pustule dries up and forms a crust, which when removed reveals an irregular surface formed by papillæ, with corresponding depressions. The lesions increase in size by peripheral extension, and at the same time become harder in consistency. When the surface of a lesion is irregular, minute drops of pus can frequently be forced out of the depressions by compressing the growth. The lesions are, as a rule, not larger in area than a twenty-five cent piece, but if neglected may extend over a surface several inches in diameter. Involution, commencing at the centre, sometimes takes place, and a spontaneous cure may result, but not without leaving a scar.

The eruption known as lupus verrucosus should be included in this form of tuberculosis of the skin. The lesions are generally situated on the hands, arms or legs, and their clinical characters are very similar to those of *post-mortem* wart.

The condition known as tuberculosis verrucosa cutis (Riehl and Paltau) is also included in this division of skin tuberculosis. The grouping of these verrucous tubercloses of the skin in one division gives a greater diversity to the appearances that the disease may present. The verrucous character is present in all, but there is considerable variation in clinical characters, according to the location, size, age, and amount of inflammation, etc., of the lesion. When the lesions are small, the result of treatment is very satisfactory. Excision of the growths probably gives the best results. I have found scraping of the growth followed by the application for a week of a 25 per cent. ointment of pyrogallol, very effectual.

*Scrofuloderma.*—This term is applied to cutaneous affections which are secondary to tuberculosis of lymphatic glands, lymphatic vessels, bones, etc. The process is, in the beginning, always subcutaneous, but eventually the skin becomes involved, and is destroyed, producing an ulcer with ragged, thin, undermined edges, or a fistula discharging a thin fluid containing necrotic tissue, from an internal focus. From both a clinical and an etiological standpoint we can, therefore, conveniently divide scrofulodermata into three divisions: (1) Ulcers following tuberculous gummata, or tuberculosis of lymphatic vessels; (2) ulcers following tuberculous lymphatic glands; (3) ulcers following tuberculosis of bones.

Tuberculous gummata are generally believed to be due to tuberculosis of the lymphatics in the subcutaneous tissue. They begin as moderately soft, painless nodules, over which the skin is at first freely movable. After a variable time the gumma softens, and the overlying skin is involved, becomes raised, and assumes a purplish hue. Erichsen calls the lesion at this stage a "subcutaneous scrofulous abscess." Later, the abscess bursts, and becomes converted into an ulcer, bordered by a bluish, thin, undermined skin. These ulcers have a tendency to increase in size and pursue a very chronic course. They are generally seen in young people on the face and hands, but they may occur at any age and on any part of the surface of the body. Occasionally a tuberculous gumma becomes of considerable size and pursues a very chronic course without involvement of the skin. In these cases the starting point of the nodule is more deeply-seated than the ordinary tuberculous node. About two years ago I saw Mr. Irving Cameron operate on a patient in St. Michael's Hospital, who had a typical strumous ulcer just above the elbow, and a large tuberculous gumma below the knee. The skin over the latter lesion was not involved.

The second form of strumous ulcer begins as a tuberculous

lymph gland. The gland enlarges, softens, and gradually becomes surrounded by a fibrous envelope; later, the skin becomes involved and ruptures, and an ulcer is produced; but, on account of the depth of the primary focus and the fibrous envelope, the characters and course of the ulcer are considerably different from those of an ulcer following a tuberculous gumma.

The treatment of scrofuloderma varies with the depth of the primary focus, and the characters of the ulcer. The unhealthy, undermined skin, which is generally present at the edge of the ulcer, should be trimmed away, and the tuberculous tissue got rid of, either by scraping or cauterizing. The ulcer should then be dressed with iodoform, and ordinary surgical principles adopted.

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### REPORT OF PHYSICIAN-IN-CHARGE MUSKOKA COTTAGE SANATORIUM.

BY J. H. ELLIOTT, M.B.

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SIR,—I have the honor to submit herewith the Medical Report of the Muskoka Cottage Sanatorium for the year ending September 30th, 1901.

I am pleased to be able to state that we have had another year of progress, and the results have continued to be most satisfactory.

During the summers of 1898 and 1899 our accommodation of fifty beds was augmented by the use of tents. Owing to the increased number of applications this summer, extra accommodation had again to be provided. In the autumn of 1898 patients remained in the tents until the second week in November, and last winter until February. We have found, however, that the heavy snowfalls of winter seriously impair the canvas roof, and that in wet weather it is difficult to keep the bedding and clothing from becoming damp. This difficulty has been overcome by the erection of similar shelters with shingled roofs, board floor and canvas sides; these we find very comfortable for the patients, and we hope to use them throughout the winter. Three have been erected as an experiment, each accommodating two patients. One of the tents used last year has been brought into requisition, and two of the smaller sitting-rooms in the main building have been temporarily fitted up for bedrooms. The permanent accommodation for fifty has been thus increased during the summer to sixty beds. The year ended with sixty-one patients in residence,

the greatest number we have yet reached. As a result, our dining-room capacity is taxed to its utmost.

A new consulting-room has been fitted up, and the room previously used fully equipped as a throat-room and inhalation room. A new compressed air apparatus has been installed, and is found to be most satisfactory. The power is supplied by a water motor.

The interiors of the Wm. Davies and the Jessie Maver Cottages have been thoroughly renovated, and the walls tinted with oil-paints, that they may be washed as occasion requires. The Jessie Maver Cottage also has been painted outside.

A much-needed addition to the Administration Building—a wing for the female help—is now under way. When this is completed we will have at our disposal a number of additional patients' rooms, which for some time have had to be used for the servants.

Generous friends have made several valuable additions to the Library during the year. These gifts have been much appreciated. We hope further additions will be made in the future.

Amongst our most pressing needs we would like to emphasize the following:

1. An infirmary for those acutely ill.
2. A reception-home or hospital for those more advanced cases for whom there is some prospect of improvement, but who require supervision until they can be admitted to the Sanatorium, or who need a term of probation or observation before they can be finally accepted for admission.
3. Further accommodation for the resident staff. There is no sitting-room for assistant physician, nurses or matron.
4. An extension to the dining-room. If this be done, the accommodation required for the staff can be provided in the second story.

As you will see from the tabulated report below, of 99 cases treated, 15 have been discharged apparently cured, and 29 with the disease arrested—that is, in 15 there is a return to perfect health, while in 29 others there is a relative cure—the general health is quite normal, and there are no subjective symptoms other than perhaps an occasional cough or slight expectoration. Of the 29, 14 gave promise of cure, had their finances permitted them to remain, which would mean that 29 out of 99, or almost 30 per cent., could have been apparently cured had a longer stay

been possible. The fact that in 44 of 99 patients the disease has undergone more or less complete subsidence is highly satisfactory considering the class of cases treated.

It is gratifying to note that the average gain in weight has been 13 lbs., and that there has been an average gain of 14 1-2 lbs. in those remaining over three months.

It is difficult to arouse people to the necessity of sending cases early to secure the best results, notwithstanding the fact that we have shown in previous years that of incipient cases 65 per cent. or over are cured, while of the more advanced cases we may look for permanent results in only a very small percentage, and for these results a very prolonged stay is necessary.

These 99 cases were classified on admission: Incipient, 24; Advanced, 43; Far Advanced, 32. Such a proportion of advanced and far advanced cases is not compatible with the best results. With our past results becoming more known throughout our Province and Dominion, our people are beginning to realize that consumption can be cured, and we are in receipt of a constantly increasing number of applications. We hope during the coming year we may be able to restrict our admissions still more to the class of cases for which the Sanatorium was established.

An erroneous idea prevails to some extent amongst the physicians of the Province, that our rejection of a patient means incurability. This is not the case. It is our endeavor to select from amongst the applicants those who give greatest promise of improvement, more especially to select those for whom the shortest time seems necessary, so that our beds may be occupied by as many patients as possible in succession. With this object in view, our standard of admission must necessarily vary somewhat from time to time, depending upon the number and physical condition of applicants.

I would urge that in every possible way we make an earnest plea to the medical profession to use the greatest care in the selection of patients sent for examination. In our endeavor to make our Sanatorium a place where people can recover, we cannot admit hopeless cases, and it is a constant source of surprise to our examining physicians, and to us here, that men and women are sent by their physicians as hopeful cases, when their symptoms and physical signs show them to be in an advanced condition. The refusal of these cases is one of the most unpleasant parts of our work, and the consequent disappointment, to say nothing of the needless fatigue and expense to patients coming from a distance, is often almost heart-breaking.

We have had during the year fifteen visits from the members



of the visiting staff. I take this opportunity to thank them for their unfailing kindness, and for their help and advice in the treatment of our patients.

Dr. J. L. Thorburn has been added to the staff of visiting Laryngologists. It is now arranged that each physician visit us once in three months, so that one of the Laryngologists will visit the Sanatorium each month.

In conclusion, I wish to express my thanks to the members of the resident staff for their faithful devotion to the interests of the Sanatorium, and to your Board for their kind counsel and ready acquiescence in all suggestions made for the comfort of the patients and the welfare of the institution.

Respectfully submitted,

J. H. ELLIOTT, M.B.,  
*Physician in Charge.*

MEDICAL REPORT

*For the year ending September 30th., 1901.*

	Male.	Female.	Total.
Number of Patients in Sanatorium, October 1st, 1900.....	19	28	47
“ “ admitted during the year.....	80	59	139
	—	—	—
Total number during the year.....	99	87	186
Received from City of Toronto.....	29	24	53
“ “ other parts of Ontario.....	61	56	117
“ “ other Provinces of Canada.....	4	4	8
“ “ United States.....	5	3	8
	—	—	—
Total.....	99	87	186

RELIGIOUS DENOMINATION OF PATIENTS.

Methodist..... 63	Anglican..... 39	Roman Catholic..... 14
Presbyterian..... 55	Baptist..... 7	Other Churches..... 8

AGES OF PATIENTS ADMITTED.

Under 15..... —	25 to 30..... 35	50 to 60..... 7
15 to 20..... 22	30 to 40..... 30	60 to 70..... —
20 to 25..... 31	40 to 50..... 13	70 to 80..... 1

Number of patients treated during the year.....	186
“ “ still under treatment.....	61
Number to be reported on.....	125

Divided as follows:

Class I.—Those remaining less than one month.....	26
“ II.— “ “ from one to three months.....	44
“ III.— “ “ over three months.....	55
	—
	125

(Those remaining less than one month need not be considered.)

Of the remaining 99 patients, there were :

Discharged, apparently cured.....	15
“ with disease arrested.....	29
“ with marked improvement.....	26
“ unimproved.....	20
“ failed.....	8
Died.....	1
	99

75 patients gained in weight—average gain, 13 lbs.

12 patients lost in weight—average loss, 4½ lbs.

12 patients neither gained nor lost in weight.

CLASS II.—44 PATIENTS REMAINING FROM ONE TO THREE MONTHS.

CONDITION ON ADMISSION.	CONDITION ON DISCHARGE.						Total.
	Appar-ently Cured.	Disease Arrested.	Much Im-proved.	Station-ary.	Failed.	Die l.	
Incipient.....	4	3	2	0	0	0	9
Advanced.....	1	5	11	1	0	0	18
Far advanced.....	0	1	4	8	4	0	17
	5	9	17	9	4	0	44

Of these patients 32 gained in weight—average gain, 10¾ lbs.

6 lost in weight—average loss, 4 lbs.

6 neither gained nor lost.

CLASS III.—55 PATIENTS REMAINING OVER THREE MONTHS.

CONDITION ON ADMISSION.	CONDITION ON DISCHARGE.						Total.
	Appar-ently Cured.	Disease Arrested.	Much Im-proved.	Station-ary.	Failed.	Died.	
Incipient.....	9	4	1	1	0	0	15
Advanced.....	1	14	4	5	1	0	25
Far advanced.....	0	2	4	5	3	1	15
	10	20	9	11	4	1	55

Of these patients 43 gained in weight—average gain, 14½ lbs.

6 lost in weight—average loss, 5 lbs.

6 neither lost nor gained.

(Maximum gain in weight, 43½ lbs. during a stay of four months.)

SITE OF PULMONARY LESION.

Right lung only affected—Upper lobe only.....	18
Lower lobe only .....	1
Upper and middle lobes.....	7
Upper and lower lobes.....	8
Upper, middle and lower lobes.....	6
	— 40
Left lung only affected—Upper lobe only.....	5
Lower lobe only.....	0
Upper and lower lobes.....	16
	— 21

INVOLVEMENT OF BOTH LUNGS.	Right Upper Lobe.	Right Lower Lobe.	Right Upper and Middle.	Right Upper and Lower.	Right Upper, Middle and Lower.	Total.
Left upper lobe.....	14	0	2	8	4	28
Left lower lobe.....	3	0	1	1	2	7
Left upper and lower lobes.....	21	2	1	5	0	29
	38	2	4	14	6	64

DEFINITIONS OF TERMS EMPLOYED.—*Incipient*.—Cases in which both the physical and rational signs point to but slight local and constitutional involvement.

*Advanced*.—Cases in which the localized disease-process is either extensive or in an advanced stage, or where with a comparatively slight amount of pulmonary involvement the rational signs point to grave constitutional impairment, or to some complication.

*Far Advanced*.—Cases in which both the rational and physical signs warrant the term.

*Apparently Cured*.—Cases in which the rational signs of phthisis and bacilli in the expectoration have been absent for at least three months, or who have no expectoration at all; any abnormal physical signs remaining being interpreted as indicative of a healed lesion.

*Disease Arrested*.—Cases in which cough, expectoration and bacilli are still present, but in which all constitutional disturbance has disappeared for some time, the physical signs being interpreted as indicative of a retrogressive or arrested progress.

*Improved*.—Cases in which there has been some marked gain in the condition of the lungs, or in which there has been marked amelioration of the constitutional disturbances. Cases with simply a slight gain in weight are not placed under this term.

J. H. ELLIOTT, M.B.,  
Physician-in-Charge.

## Reports of Societies

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### TORONTO CLINICAL SOCIETY.

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The regular meeting of the Toronto Clinical Society was held in St. George's Hall, Elm Street, Toronto, on the evening of the 4th of December, the president, Dr. J. F. W. Ross, in the chair.

Fellows present: Aikins, Ross, Cotton, Johnson, Nevitt, Orr, Trow, McIlwraith, McCollum, Harrington, Oldright, Fenton, Pepler, Hamilton, Small, Elliott, Anderson, Lehman, Primrose, King, Leslie, Bruce, and Chambers. Visitor, Dr. Hooper.

#### BLASTOMYCOSIS.

Dr. Graham Chambers presented this patient, a railway engineer, aged fifty years. The present attack began about October 1st of this year (1901). It began as a bluish-red pimple of lower eyelid of the right eye. The eyelids were swollen, and there was great difficulty in seeing. Dr. Chambers examined the patient for the first time on the 23rd of November, when the characteristic warty growths were present, the surfaces for the most part being covered with crusts. The lesions were seen to be on the face, about the nose and upper lip, and on the backs of the hands and fingers; and when presented they had the appearance of dark rounded swellings the size of marbles. Dr. Chambers had diagnosed the condition as one of blastomycosis, although up to that time Dr. McKenzie had been unable to detect the fungus. The patient was taking 150 grains of iodide of potash daily, and the lesions, which were undergoing improvement, were kept dusted with iodoform.

#### MENORRHAGIA.

Dr. R. B. Nevitt read notes of this case, which had occurred in a woman of thirty-five years of age, married for eight years, but no children. She menstruated first at fifteen years of age, and suffered much pain, and at that time she was plunged into cold baths daily. When first seen by Dr. Nevitt fifteen years ago, she was undeveloped, pale, and anemic. She was suffering from almost a constant flow, beginning with a rush and gradually diminishing in fifteen to twenty days, and then ceasing, leaving her weak and exhausted to begin again and pursue the same round. This was going on for two or three years before she was first seen by Dr. Nevitt. At that time he advised rest, with tonics

and astringents. She was examined under anesthesia, and an infantile uterus found with a long cervix, a pin-hole os, exceedingly small, and almost impossible to feel it. The pubes were smooth and unprovided with hair—altogether the genitals of a child. Nothing could be found to account for the normal flow. After curetting the uterus, she slowly improved, and was finally married. Dr. Nevitt then lost sight of her for a year or two, when she turned up again, and she told him that she was troubled in early married life with almost constant flow. Since last June she had about sixteen days in which she has had no flow. Examined about a month ago, and she has developed a little since the last examination. The uterus is still small, but the left pelvis is now occupied with a rounded elastic swelling as large as the fist. All kinds of treatment—by drugs, rest, and topical applications, curettement and electricity—have been employed without lasting benefit.

Dr. E. E. King, in discussing this case, referred to the use of stypticin, which he had used in two cases. Both had been treated with other drugs, but they were absolutely useless. With stypticin he has controlled two very severe hemorrhages.

Dr. Ross stated that he was very much opposed to the operation of hysterectomy in these cases. He has never had to perform it yet for this condition, and he has had some troublesome cases of hemorrhage.

#### EXCISION OF ELBOW.

Dr. William Oldright presented this patient, upon whom he had performed excision of the elbow, the patient having been one of the South African Contingent. The patient had had typhoid fever; blood-poisoning set in in the arm, and ankylosis of the elbow resulted. There was also union of the radius and ulna for about three inches. About the 1st of November Dr. Oldright excised the lower portion of the humerus, and took about three-quarters of an inch off the radius and ulna. Dr. Oldright described the operation and exhibited the patient.

#### A CASE OF MUSHROOM POISONING.

Reported by Dr. A. J. Harrington in *December number of the DOMINION MEDICAL MONTHLY*.

Dr. Oldright showed a pathologic specimen of fibro-myoma of the uterus.

#### CYST OF KIDNEY.

This specimen was shown by the President, Dr. Ross, who also related the history of the case which occurred in a married woman, forty-two years of age, twenty years married and had

three children; no miscarriages. Owing to her feet and legs swelling she thought she had Bright's disease. She consulted her physician, and an examination of the urine, albumen was found. Her only complaint was swelling of the feet, and headaches. Her doctor had also stated that there was a growth in her side. She was examined by Dr. Ross, who came to the conclusion that the mass from its fixity and situation and contour was due to disease of the kidney. At this time there was no pus nor albumen in the urine. Dr. Ross stated that he did not rely upon a tympanitic note in the median line as of any value. The question was whether it was due to pus or a simple cyst of the kidney. Operation was made in September, 1901; made an opening on the left side. This opening was made good and large and the tumor of the kidney was found; a cyst could be made out. The peritoneum was opened forward and the tumor drawn away from the peri-renal fat, and the ureter was tied off. Dr. Ross believes it always wise to bring the ureter out of the wound. The vessels were tied off *en masse*, and afterwards the artery was tied separately. The ligatures from the artery were left hanging from the wound. The patient left the hospital on the 12th of October, and she is at present in perfect health.

#### ECTOPIC GESTATION.

Dr. J. F. W. Ross, for the fourth time, has met with ectopic gestation, twice in the same patient. Dr. Ross then gave the history of one case. In 1898 a woman had hemorrhage, lasting for three weeks. On examination, a mass was found behind the uterus, and a diagnosis of rupture of pregnancy made. Operation was performed, and a blood-clot found shut off by adhesions. A good recovery was made. In June, 1901, the same patient had indefinite pains and flow of blood from the uterus. On careful examination a very small nodule was found on one side of the uterus. It was not easy to feel it, but it could be distinctly made out, and it was separate from the ovary. A delay of two weeks ensued, and patient came back at the end of that time for re-examination. The nodule had enlarged to about double the size. There were no other signs of pregnancy present. Operation followed, and Dr. Ross stated that this was the smallest unruptured ectopic gestation he had ever seen. The patient made an uninterrupted recovery.

#### DOUBLE EXTRA-UTERINE PREGNANCY IN THE SAME PATIENT.

Dr. Ross then reported the following case, which had come under his care since the one above reported. On examination, a blood-clot could be felt breaking down in the pelvis, the mass

being chiefly felt on the left side. She was taken ill with sudden severe fainting while lying in bed. She had a peculiar coloring of the skin and collapsed look. She had very little menstruation in September and October. As soon as this gestation sac was removed, the finger was passed down to the left side, and another one was found on that side, a three and one-half months' fetus, and the right one was certainly active, as well as the left. The peritoneal cavity was washed out rapidly, and salt solution had to be given and the legs bandaged. The wound was closed with through-and-through sutures. At the time of reporting the case the patient was going on to recovery.

GEORGE ELLIOTT,

*Recording Secretary.*

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### Physicians' Library

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*Saunders' Medical Hand Atlases.—Atlas and Epitome of Bacteriology.* A Text-Book of Special Bacteriologic Diagnosis. By PROF. DR. K. B. LEHMANN, Director of the Hygienic Institute in Würzburg, and R. O. NEUMANN, Doctor Phil. and Med. Assistant in the Hygienic Institute in Würzburg. From the second enlarged and revised German edition. Edited by GEORGE H. WEAVER, M.D., Assistant Professor of Pathology Rush Medical College, Chicago. In two volumes: Part I., consisting of 632 colored figures on 69 lithographic plates, and Part II., consisting of 511 pages of text, illustrated. Philadelphia and London: W. B. Saunders & Co. 1901. Toronto: J. A. Carveth & Co., Canadian Agents. Cloth, \$5.00 net.

This work supplies a long-needed want in the field of bacteriology and bacteriologic diagnosis, and proves a most valuable addition to Saunders' Series of Hand-Atlases. As in all the volumes of this commendable series, the lithographic plates are accurate representations of the conditions as actually seen, and this well-selected collection, if anything, is more handsome and useful than any of its predecessors. As an aid in original investigation the value of the work is inestimable.

The text is divided into a general and a special part. The former furnishes a survey of the properties of bacteria, together with the causes of disease, disposition and immunity, reference being constantly made to an appendix of bacteriologic technic. The special part gives, so far as possible in a natural botanical arrangement, a complete description of the important varieties, the less important ones being mentioned when worthy of notice. The

causes of diphtheria and tuberculosis, together with the related varieties, have been given especial attention.

Most praiseworthy is the reformative tendency in regard to the grouping of varieties of bacteria, the strict division of the system especially, the rational naming of the bacteria, etc. The system of nomenclature is entirely original with the authors, and is deserving of the greatest commendation, particularly that of the fission-fungi, which has been handled in a most masterly manner.

As a text-book of bacteriology and bacteriologic diagnosis it is all that could be desired, embracing, as it does, in a comparatively limited space, all the important species and many of the less valuable ones, and discussing them in language concise and easily intelligible.

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*American Edition of Nothnagel's Encyclopedia.—Typhoid and Typhus Fevers.* By DR. H. CURSCHMANN, of Leipzig. Edited, with additions, by WILLIAM OSLER, M.D., Professor of the Principles and Practice of Medicine Johns Hopkins University. Handsome octavo of 646 pages, illustrated, including a number of valuable temperature charts and two full-page colored plates. Philadelphia and London: W. B. Saunders & Co. 1901. Toronto: J. A. Carveth & Co., Canadian Agents. Cloth, \$5.00 net; sheep or half morocco, \$6.00 net.

The translation of Nothnagel's *Encyclopedia of Practical Medicine* into English will prove of great value to the physicians of English-speaking countries. Many members of the profession who are familiar with the German language have been using these monographs for some time and have recognized them as standard authorities on the subjects of which they treat. The first volume, devoted to typhoid and typhus fevers, was written by Professor Curschmann, of Leipzig, who has had exceptional opportunities to study these diseases, and displays throughout the thoroughness which is characteristic of all the great German writers on internal medicine. The American edition even surpasses the German, as it contains all the commendable qualities of the latter and is greatly enhanced in value by the addition of much new matter by the editor, Professor William Osler, of Johns Hopkins University. The following are some of the most important changes necessitated on account of very recent work on the subjects:

The sections on perforation, peritonitis and hepatic complications have been practically rewritten.

To the chapter on bacteriology and pathology considerable new matter has been added, incorporating the important work on the distribution of the typhoid bacillus, especially in the urine, blood and rose spots, as well as the literature on the localized



lesions due to the bacillus, particularly of the bones, meninges, heart, pleura and bladder.

The chapter on the diagnosis of typhoid fever has received several valuable additions, particularly with reference to the recent work in blood cultures and the detection of bacilli in the urine.

The book is probably the most important contribution to the literature of these diseases, and, we believe, will meet with general favor by the medical profession.

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*First Aid to the Injured and Sick.* By F. J. WARWICK, B.A., M.B. Cantab., Associate of King's College, London; Surgeon-Captain Volunteer Medical Staff Corps, London Companies, etc.; and A. C. TUNSTALL, M.D., F.R.C.S. (Edin.), Surgeon-Captain commanding the East London Volunteer Brigade Bearer Company; Surgeon to the French Hospital and to the Children's Home Hospital, etc. 16mo volume of 232 pages and nearly 200 illustrations. Philadelphia and London: W. B. Saunders & Co. 1901. Toronto: J. A. Carveth & Co., Canadian Agents. Cloth, \$1.00 net.

This volume of practical information is intended as an aid in rendering immediate temporary assistance to a person suffering from an accident or sudden illness until the arrival of a physician. The importance of first aid is indisputable as a life-saving expedient, for upon the promptness and efficiency of the aid first rendered the patient depends, in a great measure, the termination of the case. The authors, fully appreciating the urgency of the subject, have succeeded in producing an admirable work of practical emergency procedures, and they have couched it in such clear and unequivocal language that even those entirely unfamiliar with the science may easily grasp the meaning intended. It will be found a most useful book of ready aid, and of invaluable service, not alone to nurses, railway employees, etc., but also to the laity in general, as a book of indispensable first aids.

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*Diseases of the Digestive Organs in Infancy and Childhood.* With Chapters on the Diet and General Management of Children and Massage in Pediatrics. By LOUIS STARR, M.D., late Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania; Consulting Pediatricist to the Maternity Hospital, Philadelphia, etc. Third edition, rewritten and enlarged. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1901. Toronto: Chandler and Massey, Limited, Canadian Agents. Price, \$3.00 net.

The digestive organs of infants and children are very prone to disease, and their successful management plays an important part

in the development of every child. During the last few years our knowledge of the dietetics of both well and ill children has been greatly extended, and there is no one better able to place the subject-matter of these advances before the medical profession than Louis Starr. The present edition has been thoroughly revised and many additions have been made, notably the sections on simple atrophy, infantile scurvy, rickets, lithemia, infectious follicular tonsillitis, adenoids, proctitis and appendicitis. The work is a valuable contribution to the literature of diseases of children, and should prove of great value to every practitioner.

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*A Text-Book of Medicine.* For Students and Practitioners. By DR. ADOLF STRUMPELL, Professor and Director of the Medical Clinic at the University of Erlangen. Third American Edition. Translated by HERMAN F. VICKERY, M.D., Instructor in Clinical Medicine Harvard University, and PHILIP COOMBS KNAPP, M.D., Clinical Instructor in Diseases of the Nervous System, Harvard University; with Editorial Notes by FREDERICK C. SHATTUCK, M.D., Jackson Professor of Clinical Medicine, Harvard University. New York: D. Appleton and Company.

Strumpell's text-book is almost too well known to require special commendation from us. Although this is the third American edition from the thirteenth German edition, the book appears to be gaining in popularity and extending its field of distribution and usefulness, as the author informs us that thus far translations of his work have appeared in the following languages: French, English, Italian, Spanish, Russian, Modern Greek, Turkish, and Japanese. Like the American, some of these translations have had several editions. This wide constituency of distribution is, we believe, rarely attained by medical works.

The task of keeping a work such as this in touch with the ever-increasing advances in internal medicine must be a very difficult one, and we expected on reading the work to find it somewhat antiquated in dealing with some of the subjects. This we found was a mistake, as a perusal of Prof. Strumpell's work at once shows that it is as modern in character as is possible under the circumstances.

The American edition has a slight advantage over the German of several additions supplied by the editor and translator. These notes are on such recent advances as the role of mosquitoes in the transmission of malaria.

We take great pleasure in recommending this book as a thoroughly practical treatise on internal medicine. It is an excellent book for both undergraduate and graduate.

*A Treatise on Surgery by American Authors.*—For Students and Practitioners of Medicine and Surgery. Edited by ROSWELL PARK, M.D., Professor of Surgery in the University of Buffalo, N.Y. New (3rd) edition in one royal octavo volume of 1,350 pages, with 692 engravings and 64 full-page plates in colors and monochrome. Cloth, \$7.00 net; leather, \$8.00 net. Philadelphia and New York: Lea Brothers & Co.

A new edition of "Park's Surgery," the third in five years, speaks well for the book and for the activity of American interest in its subject. This country is now abreast of the world in surgery, and it is owing to such men as Dr. Park and his fellow collaborators that this is a fact. He planned his book well, knowing the needs of student, general practitioner and surgeon, and he secured authorities of the highest standing for its various chapters. The result is that the work represents the best special knowledge on each subject. Surgeons can consult it as a reference book and a safe guide in the perplexities of practice, and they will appreciate the clearness which is such a boon to the student. It is logically built up—first the principles, then the practice—in all departments. Thus it suits students of all ages, pre- and post-graduate. The illustrations deserve mention. Always liberal and elaborate, they have been further enriched in this edition, until the text is illuminated with nearly seven hundred pictures and no less than sixty-four full-page plates in colors and monochrome.

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*A Manual of the Practice of Medicine.* By GEORGE ROE LOCKWOOD, M.D., Professor of Practice in the Woman's Medical College of the New York Infirmary. Second edition, revised and enlarged. Octavo volume of 847 pages, with 79 illustrations and 20 full-page plates. Philadelphia and London: W. B. Saunders & Company, 1901. Cloth, \$4.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

The first edition of this book has been thoroughly revised. Many portions of the work have been entirely re-written, and a number of subjects, such as gastropnoxis, gastric analysis, bubonic plague, and Reichmann's disease, have been introduced. We note in particular that there has been a thorough revision of the diseases of the digestive system. This is very important, and deserves commendation, as many of the treatises on internal medicine are somewhat behind the times in the manner in which they present these diseases, especially the affections of the stomach. The book is written in a concise and clear manner, and we

think that the aim of the author, which was to present the essential facts of the practice of medicine in a concise and available form, has been fulfilled.

The first edition of the book was favorably received, and we believe that this edition deserves a more hearty welcome.

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*A Laboratory Hand-Book of Urine Analysis and Physiological Chemistry.* By CHARLES G. L. WOLF, B.A., M.D., Instructor in Physiological Chemistry, Cornell University Medical College, New York. Illustrated. Philadelphia and London: W. B. Saunders & Company, 1901. Canadian Agents: J. A. Carveth & Co, Toronto, Ont. Price, \$1.25.

The object of the author is to supply to students and practitioners of medicine a book which will prove a guide to the study of Physiological Chemistry, Urinary Analysis and Analysis of Gastric Contents.

The first part of the work is devoted to simple experiments in physiological chemistry. The subjects of carbohydrates, blood, protein substances, and fats, are all considered from a chemical standpoint, and although the exercises are short, they contain sufficient matter for a student commencing the study of physiological chemistry.

The second part of the book deals with the analysis of urine and gastric contents. All the principal tests and methods of analysis are given. Sediments which may occur in urine are well illustrated by many plates.

The book taken as a whole is a good text-book for a medical student, but there are other works which are more suitable for practitioners.

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*The Physician's Pocket Account Book:* Consisting of a Manilla-bound book of 208 pages and a leather case. By J. J. Taylor, M.D. Published by The Medical Council, Philadelphia. Price, \$1.00.

This work is intended for the pocket-book, and when written full may be filed away, and another book inserted in the leather case. Book, without case, costs 40 cents, or three for \$1.00.

The book is used by entering the person's name responsible for the account at the top of the page, and marking all charges and credits in that person's account on that page; when that page is filled, the account may be continued on another.

The system of bookkeeping adopted in the book is very concise, and we should think that it would prove an excellent account book for a busy practitioner.

# DOMINION MEDICAL MONTHLY

AND ONTARIO MEDICAL JOURNAL

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EDITORS:

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

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## THE STRENUOUS LIFE.

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In the *Medical Record* of December 28th last, an article is published by Dr. Allan McLane Hamilton on "The Neurotic Indications of Pre-Senility," in which the author discusses the cause of the early decadence of a large number of persons in the United States who voluntarily, or through compulsion, go through life at a constant high nervous pressure. While regarding the terms "Americanism," "American neurosis," or "American neurasthenia" as somewhat of an affectation, he believes that many on this side of the Atlantic break down at an earlier age than do the people of other countries. He ascribes three causes for the development of this characteristically American disease: the struggle for the rapid accumulation of wealth, for the gratification of an ambition, which is due to competition, and, lastly, and in no small degree, to the stimulation of newspapers. The disease is not confined to the United States; it is, apparently, highly contagious. We in Canada have caught the infection, and in all probability it will soon be as common here as in the neighboring country.

Dr. Hamilton might have gone further in his search for the underlying cause. The race for wealth, the ambition for success,

and the desire for notoriety are all dependent upon the primary idea that these things will bring happiness. The fact is overlooked by the great mass of those enjoying what has been spoken of as the strenuous life that more than the acquirement of wealth or fame is necessary for happiness. Happiness is dependent not alone on the possession of the means of gratifying our tastes or ambitions, but upon the possession of the capacity for enjoyment. We have all known men who have labored and struggled for the accumulation of wealth, who have never relaxed in their efforts, but who always had in their mind's eye the idea that when they had acquired sufficient money they would retire and do certain things which, in their simplicity, they felt certain would bring them something which was worth all the effort—perfect happiness; and yet when the fortune was gained, the labor set aside, and their dreams realized, they have found themselves disappointed. The capacity for enjoyment was dulled or gone. Their inability to enjoy what they had thought would have been all they could have desired in life would probably be set down to old age. But men not old suffer the same experience. Their idea of happiness, and in our modern civilization it is becoming more and more generally accepted, is excitement. The constant cry is for something new. They turn from the excitement of business to the excitement of pleasure. There is little relaxation and no rest. The nervous system is always working at high strain, until finally they find that nearly all things which afforded them pleasure at one time in life no longer do so. With them, too, the capacity for enjoyment is gone. Even the pursuit of happiness becomes a work, and all work and no play makes Jack a neurotic boy.

The Chinese Minister at Washington is reported to have said, comparing the civilizations of the East and the West, that his countrymen had gone through all the so-called higher civilization of our age and found it wanting. We can well believe it. The system which develops a neurotic race cannot prevail for any great length of time. Neurasthenia and procreation of species are incompatible. The future race on this continent will be the descendants of those who conserve their nervous energy and who have not so dulled their nerves by constant irritation that a normal pleasurable stimulus produces no reaction.

### SMALLPOX.

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Smallpox is still alarmingly prevalent in Ontario. Fortunately there have been few deaths, and the disease so far has been of a mild type. We have no guarantee, however, how long this will continue, and in view of the virulent form which has appeared in other places, notably in Philadelphia, we think it well that before it has gained any further foothold, the only efficient means of effectually stamping it out should be adopted, namely, compulsory general vaccination.

Compulsory vaccination is disagreeable, but that cannot be helped. Vaccine can now be procured which has been so carefully handled that there is practically no danger of any untoward effects following its use. That vaccination will protect, we have proof, if any were needed, in the experience of the Smallpox Hospital at Toronto. No one connected with the institution—physician, nurse or attendant, regular vaccination of all of whom is insisted upon—has ever contracted the disease. The same is true of other smallpox hospitals. If vaccination is practically without danger, and is the most efficient method of controlling the disease, it is much better, in our opinion, that general vaccination should be made compulsory at once, and efficiently carried out, rather than to wait to see what will happen, with the almost practical certainty that it will yet have to be resorted to.

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### REGISTRATION OF BIRTHS.

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We wish to draw the attention of the Registrar-General to the fact that it is neither in good taste nor good policy to fine medical practitioners for neglect to report births which they have attended. We know of no class in the community, except physicians, which the state compels to do something for nothing. Neither do we know of any other civilized community which compels medical men to report births without compensating them for the trouble involved.

If we might suggest, we think a wiser and more efficient way of securing complete returns would be by the payment of a small sum for each birth reported. Marriages are reported by issuers of licenses, who are paid a fee for so doing. Deaths must necessarily

be reported to obtain a burial permit, and this is generally done by the undertaker. But physicians are compelled to report births, under penalty of having to appear in court and pay a fine, and no remuneration, or even thanks, is suggested for so doing.

The object in reporting births is to obtain reliable statistics. The physician who reports the birth has quite as much right to expect remuneration for so doing as has the Registrar-General for the compilation of the returns. Surely some way can be devised for obtaining the desired information without subjecting physicians to the indignity of appearing in the police court.

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### Editorial Notes

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MANY practitioners would send patients away for a short rest could they find, especially during the winter months, within a reasonable distance, a suitable place to recommend them. St. Catharines, in addition to its proximity, has a sanitarium which possesses the two essential requirements of such a place: it is well heated and the table and service are excellent. The baths for years have been well known, the spring, according to Hare, being the strongest saline spring on the continent.

DR. LAPHORN-SMITH, of Montreal, has received a letter from Professor Pestalozza, of Florence, on behalf of the Committee of Organization of the Fourth International Congress of Gynecology, begging him to announce to the profession of Canada that the Congress will meet in Rome, from the 15th to the 21st of September of this year. The Committee of Organization consists of Professors Pasquali, Morosani and Mangiagelli, who wish to extend a hearty welcome to their Canadian brethren. The subscription fee is five dollars for gentlemen and two dollars for the ladies accompanying them. The treasurer is Dr. La Torre, 8 Via Venti Settembre, Rome. The subjects chosen for discussion are: (1) The Medical Indications for the Induction of Labor; (2) Genital Tuberculosis; (3) Hysterectomy in Puerperal Septicemia; (4) Inflammatory Changes in the Neck of the Uterus; (5) The Surgical Treatment of Cancer of the Uterus. It is the earnest wish of the committee to have a large attendance of gynecologists and obstetricians from Canada.



### News Items.

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SMALLPOX is abating in Ottawa and Montreal.

PORT ARTHUR has been declared free of smallpox.

UNIVERSITY Federation is on the *tapis* in Nova Scotia.

DR. S. D. FRANCIS, St. Louis, Mo., has been visiting in London, Ont.

SINCE October last, 19,000 persons have been vaccinated in Montreal.

DR. E. P. LACHAPELLE is a candidate for mayoral honors in Montreal.

DR. ANGUS MACDONALD, Montreal, was in Toronto over the holidays.

VANCOUVER, B.C., is to erect a fine new hospital at a cost of \$100,000.

DR. E. P. BENOIT has been appointed physician of the Montreal gaol.

DR. R. A. MCARTHUR, Chicago, spent the Christmas holidays in Toronto.

AN osteopath has been found guilty of practising in Toronto without a license.

DR. WILL C. FAWCETT, has returned to Drayton, N.D., after visiting at London.

AMONGST Treaty Indians in Canada last year there were 2,479 births and 2,240 deaths.

OVER sixty physicians have been appointed in the lumber camps of New Ontario.

DR. GEORGE T. MCKEOUGH, Chatham, Ont., spent the Christmas holidays in Montreal.

DRS. LESLIE AND JENNIE DOW, of Toronto, leave for the China Mission Field on the 27th of January.

THE Toronto Radiant Health Circle has been consumed by the exuberance of its own combustion.

A CHARITY ball was held in the new Medical Buildings of McGill University on New Year's Eve.

LAVAL University will celebrate the fiftieth anniversary of its foundation on the 24th of June next.

THE General Hospital at Mattawa, Ont., was totally destroyed by fire on the 17th of December.

DR. OLD, of Port Colborne, has resumed practice after several months spent in United States hospitals.

DR. J. W. GEOFFRIEN, of Chicago, a graduate of Laval University, has returned to practice in Montreal.

DR. DOUGHTY, of Quebec, has been appointed joint librarian of the Quebec Legislature with Dr. Dionne.

A CATHOLIC order of trained nurses, to be known as the Sisters of Hope, is to be established in Montreal.

THE number of smallpox cases in St. John., N.B., for the last three months of 1901 were 98, with 22 deaths.

THE medical students of the Winnipeg Medical College held their annual banquet on the 18th of December.

A NEW hospital was opened at Fergus, Ont., on the 14th of January. Dr. Groves of that town was the promoter.

PROFESSOR J. T. DONALD has been appointed public analyst at Montreal, in place of the late Dr. J. Baker Edwards.

DR. W. H. PIERSOL, B.A., Toronto, has been appointed instructor in biology and histology in Toronto University.

DR. J. ALEXANDER HUTCHINSON, Montreal, has been appointed Surgeon-in-chief of the Central Vermont Railway.

SINCE the outbreak of smallpox in Ottawa, there have been 208 cases. There are at present 78 cases on Porter's Island.

QUEEN'S University Medical Faculty will assist the movement inaugurated by the students for a new \$30,000 Convocation Hall.

THE barbers of Montreal are endeavoring to bring about an amendment to the charter creating the Quebec Barbers' Association.

KINGSTON General Hospital has been left \$1,000 for the Elevation Fund, by Mrs. Nichol, wife of Professor Nichol of the School of Mines.

DR. TELESOPHORE PARIZEAU, who has lately returned from France, has been appointed professor of pathological anatomy at Laval University.

THE Provincial Board of Health of British Columbia will make a determined effort to see that a pure milk supply is inaugurated for that Province.

DR. W. H. DRUMMOND, Montreal, author of "L'Habitant" and other poems, delivered the first Saturday University Lecture on the 18th in Toronto.

DR. PHILLIPS WEATHERBE, of the Canadian Army Medical Service, Wolfville, N.S., has been appointed supernumerary to the Field Hospital for South Africa.

DR. G. E. R. McCARTNEY, '01, Toronto University, has been appointed house surgeon of the New York City Hospital, his term of office to continue for two years.

SIR JAMES GRANT, Ottawa, was in Toronto during January, delivering a lecture on "How to Live to Prolong Life" in aid of the women's residence, at Victoria University.

DR. A. T. HOBBS, London, Ont., who was formerly assistant at the London Asylum, has been appointed medical superintendent at the Homewood Retreat, Guelph, Ontario.

THE Toronto branch of the Victorian Order of Nurses was established in March, 1898, and since that time 8,658 visits have been made in this city, and thirteen nurses have been trained.

DR. A. J. G. MACDOUGALL, house surgeon to the Toronto General Hospital has been appointed medical attaché to the regiment in charge of the Boer prisoners at Hamilton, Bermuda.

DR. TORRANCE SPARHAM, the oldest practitioner in Brockville, Ont., died on the afternoon of the 11th of January. He was a graduate of McGill and had lived in Brockville over forty years.

THE Victoria Jubilee Hospital had 807 in-patients during the last hospital year and 154 out-patients. The revenue amounted to \$38,091, of which amount pay patients contributed \$18,208.

A CORONER'S jury in Toronto has advised that all cases under Christian Science treatment should be reported to the Medical Health Officer, in order to prevent the spread of contagious diseases.

PRINCIPAL PETERSON, Dean Roddick and Dr. Ruttan will represent McGill University at the annual dinner of the New England Society of McGill Graduates, to be held at Boston on the 23rd of January.

THE births reported as having occurred in Toronto during 1901 were 4,445; marriages, 2,148; deaths, 3,438. Compared with 1900, there were 85 fewer births, 359 more marriages, and 166 fewer deaths.

DR. PETER B. WOOD, at one time a famous twirler in the old International Baseball League, who has resided for some time at Butte and Anaconda, Montana, has returned to Canada to establish in Hamilton.

VICTORIAN NURSES.—The report of the Cottage Hospitals Fund shows the total receipts to have been \$23,000 to date, and the expenditure about \$15,000. The general central fund now amounts to \$11,000.

DR. BRAITHWAITE, the Health Officer of Edmonton, reports to the provincial authorities of Manitoba, an outbreak of measles which assumed alarming proportions in December. There were ninety-eight cases with seven deaths.

THE new asylum at Cobourg was opened on the 4th of January. It has accommodation for 150 patients, who will be females. Dr. McNichol, Cobourg, is the Superintendent, with Dr. Cockburn, of Toronto, as assistant.

SINCE the outbreak of smallpox a year ago in the Province of Ontario, there have been 1,900 cases, of which 750 were in the unorganized districts. Twelve deaths have been recorded, a mortality of only two-thirds of one per cent.

SIR WILLIAM MACDONALD, Montreal, has donated \$125,000 for the purpose of studying botany and domestic science at the Guelph Agricultural College. This is an example for Ontario millionaires to emulate in other educational lines.

BISHOP'S College University Medical Faculty and the Western Hospital, Montreal, are amalgamating. The Western will erect a new hospital and Bishop's will take over the old building and will occupy it about the beginning of the session of 1903.

MONTREAL GENERAL HOSPITAL.—During December, the admissions into the various wards were 175; discharged, 159; deaths, 13; ambulance calls, 64. There was a considerable falling off in outdoor consultations and minor operations.

DR. O. BJORNSON, Winnipeg, and Dr. B. J. Bjornson, North Dakota, have left for a year's study abroad. Both are graduates of the Manitoba Medical College and served for a year as house surgeons in the Winnipeg General Hospital after graduation.

MCGILL Medical Faculty has been donated a large sum of money by Mr. E. S. Bronson, of Ottawa, for researches for a possible cure for tuberculosis. The work will be under the supervision of Professor Adami and will be prosecuted by Dr. A. G. Nichol.

DR. A. E. GARROW recently delivered an address before the McGill Medical Society on "Medical Ethics." At the same meeting Dr. Learmouth gave an address on "Notes from the North Coast of Africa" where he has been since graduation, a year ago.

THE MCGILL Medical Society of Undergraduates, at their last meeting of the old year, debated the subject of the suitability of the Canadian climate for the treatment of tuberculosis. The judges of the debate were Drs. Lafleur, Adami and Hamilton.

THE City Council of Calgary is protesting against the increasing number of consumptives who go to that city in search of benefit from the fine climate, and are calling upon the Dominion Government to erect a sanitarium for their accommodation.

THE Quebec Board of Health, owing to the extensive outbreak of smallpox in that Province, has issued a special vaccination order under which all persons must show successful vaccination, be vaccinated, or pay a fine of \$5.00, with a dollar a day for each day's delay.

NOTRE DAME HOSPITAL, MONTREAL.—The annual report of this hospital shows that during the past year, 2,200 patients received treatment, an increase of 177 over the previous year. The cures were 1,854, 155 incurable, and 134 died. The expenses were \$29,480.54.

MONTREAL Medico-Chirurgical Society.—The following officers have been elected for 1902: President, Dr. George E. Armstrong; Vice-President, Dr. H. S. Birkett; Secretary, Dr. Alfred T. Bazin; Treasurer, Dr. Jack; Trustees, Drs. Perrigo, G. A. Brown and F. J. Shepherd.

DR. W. J. ABBOTT, B.A., of Brockville, Ont., who is at present in England doing post-graduate work, will return about the latter part of January to enter upon his duties at Cornell University, where he has recently been appointed to a professorship. Dr. Abbott is a graduate of Toronto University.

THE Executive of the Medical Defence Association, headed by Dr. Hillier, President, and Dr. Sangster, Secretary, waited on the Ontario Premier recently with regard to a bill they desired to see introduced during the present session of the House, correcting so-called anomalies of the Ontario Medical Council.

DR. GORDON BELL, Provincial Bacteriologist to the Manitoba Board of Health, and Dr. Holmes Simpson, chairman, left Winnipeg for St. Paul on the 13th of January to attend a meeting of medical men convening in that city in order to discuss the smallpox question, there being several centres for infection between the two cities.

DR. N. A. POWELL, President of the Ontario Medical Association entertained Dr. W. H. Drummond, the author of "L'Habitant" and "Johnny Corteau" on the evening of the 17th of January. A large number of the profession received invitations to meet Dr. Drummond and a very happy and pleasant evening was spent with the doctor-poet and his host.

DR. J. GEORGE ADAMI, professor of pathology in McGill University, read a very able paper on the Classification of Tumors at an open meeting of the Toronto Pathological Society on the evening of the 4th of January. At the conclusion thereof a hearty vote of thanks was accorded the eminent pathologist from Montreal, moved by Dr. I. H. Cameron, seconded by Dr. George A. Bingham.

DR. A. B. ATHERTON, Fredericton, N.B., who was at one time a practitioner in Toronto, is defendant in Burns v. Atherton to the extent of \$5,000. It appears that the plaintiff came to Dr. Atherton with a dislocation of the shoulder of five months' duration. In attempting to reduce it, rupture of the axillary artery occurred and a subsequent amputation of the arm performed. It is for the loss of the arm that the plaintiff claims damages.

A JUDGMENT of interest to physicians of the Province of Quebec, and incidentally also to the profession of Ontario, has just been handed out by Mr. Justice Dorion in the Circuit Court. The Quebec College of Physicians and Surgeons brought suit against Dr. Auguste Bourbonnais, M.P. for Soulanges, for the amount of arrears of his annual \$2.00 assessments to the Council. The learned Justice ruled that a doctor must pay his annual contribution or cease the practice of his profession entirely. Judgment, therefore, was given plaintiff for \$24.00 with costs.

PHYSICIAN LOSES HIS SUIT.—At the last sitting of the Division Court at Smith's Falls, Ontario, a local physician sued a veterinary surgeon for medical service rendered the family of the

latter. At the trial, objection is said to have been made by the defendant's counsel that *no physician could recover any fees for his services unless at the time of suit he was able to produce and did produce a certificate issued by the Registrar of Toronto that he was a duly qualified practitioner.* The judge gave judgment for the defendant with costs. Have you paid your \$2.00 assessment?

SIR WILLIAM HINGSTON is celebrating his professional jubilee. A short time ago a large number of his friends and conferees waited on him, and presented him with his portrait in oil. Sir William graduated from McGill University in 1851, and from Edinburgh University in 1852. He organized the first Board of Health in the Dominion, is a past-president of the Canadian Medical Association, an Honorary D.C.L. of Bishop's College University, an honorary LL.D. of Victoria University, Toronto, and a vice-president of the St. John's Ambulance Association. Sir William has also been the recipient of marks of honor from the Supreme Pontiff, our late sovereign, Queen Victoria, and the Federal Government.

JONATHAN HUTCHINSON, F. R. S., General Secretary of the New Sydenham Society, has requested Messrs. P. Blakiston's Son & Co., of Philadelphia, the American agents of the Society, to announce the publication of "An Atlas of Clinical Medicine, Surgery and Pathology," selected and arranged with the design to afford, in as complete a manner as possible, aids to diagnosis in all departments of practice. It is proposed to complete the work in five years, in fasciculi form, eight to ten plates issued every three months in connection with the regular publications of the Society. The New Sydenham Society was established in 1858, with the object of publishing essays, monographs and translations of works which could not be otherwise issued. The list of publications numbers upwards of 170 volumes of the greatest scientific value. An effort is now being made to increase the membership, in order to extend its work.

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A NOTE ON THE KNEE-JERK IN CHOREA.

Gordon (*British Medical Journal*) describes a modification of the knee-jerk found at times in chorea. With the patient recumbent, if one raises the knee, allowing the heel to rest on the couch, and then tests the knee-jerk in the usual way, the foot rises more or less smartly, but, instead of falling back, remains suspended for a variable time and then slowly sinks back to the initial position. In the author's experience when this condition is found present it is peculiar to the disease.—*Archives of Pediatrics.*

### Selected Abstracts

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#### TREATMENT OF RUPTURE OF THE UTERUS.

The writer (Cristeanu, C., *Annales de Gynecologie*, 1901, Vol. LV., p. 251) is able to record a series of three cases of complete rupture, in which abdominal hysterectomy was performed with success in each instance. The histories of these cases are briefly as follows:

CASE 1.—A multipara had been in labor many hours, with the child's head remaining above the pelvic brim. The pains then suddenly ceased, but without any grave symptoms such as hemorrhage or syncope.

On examination a few hours later, a complete rupture of the uterus was found, and the fetus had escaped into the abdominal cavity. The child was extracted by version, but with much difficulty, owing to prolapse of coils of intestine. Fourteen hours later the patient had a greatly distended abdomen, frequent bilious vomiting, and a pulse of 135 per minute. Abdominal section was performed. Complete laceration of the lower segment of the uterus, with rupture of the left uterine artery, was found. The peritoneum in both iliac fossæ was much torn; the pelvis contained blood-clots adherent to coils of bowel, and also meconium. Total abdominal hysterectomy was performed, followed by thorough cleansing of the abdominal cavity and vaginal drainage. The patient, though very ill for 48 hours, made a good recovery.

CASE 2.—A multipara, with a history of difficult deliveries, was suddenly seized during labor with intense abdominal pain, vomiting and vaginal hemorrhage. The fetus was found to have escaped from the uterus, the fetal head being fixed above the brim of the pelvis. Abdominal section was performed at once. A large quantity of blood clot and meconium escaped. The fetus and placenta were extracted. Complete laceration of the left side of the uterus was present, with large tears of the peritoneum in both iliac fossæ. Total hysterectomy was performed, and the peritoneal lacerations carefully sutured. Vaginal drainage. The patient, though she had lost much blood, made a good recovery.

CASE 3.—A patient, aged 27, with a history of two difficult labors at term, admitted into hospital in a very grave condition, with a pulse almost imperceptible. The uterus lay in the right iliac fossa, firmly contracted; the fetus was plainly felt in the abdomen, lying to the left side. *Per vaginam*, the cervix was fully dilated, and the head lay at the pelvic brim. Version was performed, and the head extracted by forceps with considerable



difficulty. A few hours later the abdomen was opened. A large quantity of serum, with blood clots and meconium, escaped. Extensive laceration of the left side of the uterus was found, the cellular tissue was infiltrated with blood, and the peritoneum of both iliac fossæ widely torn. The uterus was completely removed, the peritoneum carefully sutured, and vaginal drainage established. This patient was extremely anemic, and had rather a tedious convalescence, with offensive vaginal discharge, owing to some local necrosis. She, however, made a good recovery.

These cases are of great interest. In each case the rupture was complete, and the general symptoms were very grave. In Case 2, though operated upon three and a half hours after the rupture, the coils of bowel showed inflammatory exudation, evidently the result of infection. In each case the operation was carried out when the patient was in bad condition, and injections of serum were necessary to enable them to withstand the procedure. In each instance, also, very extensive injuries of the uterus, the large vessels, the round ligaments (torn in two cases), and the pelvic peritoneum were found at operation, together with meconium and blood clot in the pelvis and amongst the coils of bowel. It is certainly impossible to gauge the amount of injury done in cases of uterine rupture without an exploration of the abdominal cavity.

Rupture of the uterus may also be considered as a penetrating wound of the abdomen. A direct channel exists from the vulva and vagina into the abdominal cavity, and hence infection is extremely liable to occur, and this accounts for a great proportion of the fatal results. Hemorrhage also, which may be going on into the abdominal cavity from a ruptured uterine artery, is often a cause of rapid death, and this can only be treated by abdominal section. Up to the present time (excluding these cases), 24 cases of rupture of the uterus treated by total abdominal hysterectomy have been published, and the mortality of these is 65 per cent.

In a recent paper by Frantz (*Monats. fur Geburt. und Gyn.*, October, 1900), four cases of hysterectomy for uterine rupture are recorded, with two recoveries.

The results of expectant treatment, or by gauze packing and vaginal drainage has been generally unsatisfactory, though in a recent paper Herbert Spencer related four cases of recovery by gauze packing only, and maintained that abdominal section was very rarely advisable, and if operation were necessary he would prefer the vaginal route.

M. Cristeanu is naturally strongly in favor of total abdominal hysterectomy in all cases of complete rupture. If success is to

be obtained it must be carried out within a few hours of the accident. The operation of suturing up a uterine wound is difficult and unsatisfactory. Porro's operation has the advantage that it can be quickly performed, and it is suitable if the body of the uterus only is ruptured. It has the drawback, however, that vaginal drainage cannot be so well established as after the total hysterectomy. An argument brought forward by the writer in favor of hysterectomy is that if the woman recovers from a complete rupture and again becomes pregnant, there is very great risk of cicatrix in the uterus again giving way, and so exposing her to a recurrence of all the dangers of rupture. He quotes Krukenberg's figures, who collected 13 cases operated upon by Cesarean section, in which at a subsequent labor, the cicatrix ruptured and the child escaped into the abdominal cavity.

If the fetus has partially passed into the peritoneal cavity, Winckel (*Die Therapie der Gegenwart*, 1901., Vol III.) advises that it should be extracted by the vagina, together with the placenta. Immediately afterwards abdominal section should be carried out. When the fetus is lying completely in the abdominal cavity the fetus must be extracted by abdominal section.

If the tear of the uterus is simple and not much lacerated, it should be closed by catgut suture. If the tear is extensive, he advises Porro's operation. In two cases which he records the abdominal cavity was carefully closed without drainage. If however, infection is present, or likely to have occurred, total hysterectomy, followed by vaginal drainage, is preferable to Porro's operation.—*Medical Chronicle*.

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#### RENAL TENSION AND ITS TREATMENT.

This is the title of a very cleverly-written article delivered before the British Medical Association by this well-known surgeon (Dr. Reginald Harrison). Patients suffering from some obstruction to the free outflow of urine frequently have a congestion of the kidney and a consequent tension of its tissues and capsule. This tension and passive congestion may be the starting point of some of the pathological changes in the kidney which are included under the term of Bright's disease. In certain of these cases surgical intervention is justifiable in order to obviate this serious condition. Until recently our knowledge of the various pathological conditions of the kidney associated with albuminuria was gained almost exclusively from *post-mortem* examinations, and consequently by means wholly imperfect and unreliable. Eminent authors who have written upon the many conditions of the kidney, found as the result of inflammation of its

substance, have enumerated the various exudations and infiltrations without any reference to the question of tension of the capsule as an etiological factor. The analogies here he compares to those of intra-ocular tension in certain diseases of the eye—such as glaucoma, for instance. In an inflamed testicle there is not infrequently transient as well as permanent evidence of damage as the result of tension of the capsule. Puncture of this limiting membrane is frequently followed by instant relief of pain and structural damage further averted. By this line of treatment it is possible to abort the inflammatory process to such an extent as to leave a fairly useful organ. So it may be in the case of an inflamed kidney. Not all cases, however, would be benefited by the adoption of such treatment. In the acute variety of nephritis that sometimes follows in the wake of scarlet fever, and which is accompanied with blood in the urine, albumin, casts, and epithelium, the tendency is towards spontaneous recovery and complete restoration of the function of the kidney. These cases are not included in the list of those that would call for surgical relief. In a certain group of cases commencing in an acute manner like the preceding, but where convalescence is delayed and the signs of nephritis, as evidenced by the presence of albumin and casts in the urine, continue, it is justifiable to resort to operative procedure and relieve the tension by a slit or puncture in the capsule. There is another indication of tension in connection with renal inflammations and congestions which should not be ignored in determining what may be required to meet the emergencies so occasioned, and that is the general tension that is thrown upon the heart and general circulatory system. This form of tension sooner or later supervenes in this disease, although the explanation of it is not so universally understood. The excretion of urine may be likened unto the generation of steam for motor purposes. To secure the production of steam, a circulatory apparatus is required, and a boiler made up of a number of tubes, by means of which water can be quickly heated and steam formed. Should some of these tubes become damaged or blocked up so as to render them useless, the temporary loss is compensated for by a rapid circulation of the water that remains. So it may be said to be with the kidneys. When the uriniferous tubes become damaged and cannot fulfil their function longer, they are blocked, and increased circulatory force and pressure is excited. A certain amount of blood is forced through the kidney in each twenty-four hours in order to remove certain effete and unnecessary ingredients from the system. The force necessary to accomplish this will be relative to the amount of resistance offered.

The treatment of tension of the kidney surgically, according to the author, has frequently been followed by increased urinary secretion as well as general effects upon circulation. He gives the following indications for operative procedures:

1. Progressive signs of kidney deterioration, as shown by the persistence of increased albumin when it should be diminishing or disappearing from the urine, as in the natural course of inflammatory disorders ending in resolution.

2. Suppression of urine, or approaching this state.

3. Where a marked disturbance of the heart and circulatory apparatus arises in the course of inflammatory renal disorders.

The operation of exposing and incising the kidney is comparatively free from danger. The patient should be prepared and placed in the position for lumbar nephrotomy. An incision through the loin is made parallel with and a little lower than the last rib. In spare subjects the incision need not be more than three inches in length. Those who are fat may require one longer. The various tissues are cut until the perirenal fat comes into view. This can be opened up by probe or fingers, when the kidney will come into view and can be readily recognized. The capsule can then be incised along the convex border. Should the tension be due to the presence of stone, the kidney substance will require to be punctured and the stone removed. A drainage-tube should be carefully inserted so as to be in contact with the kidney. The drainage is a necessary part of the treatment, and may be left in for a week or ten days. The wound will heal up quite readily after the tube is removed.—*Post Graduate*.

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#### SYMPTOMS OF TYPHOID FEVER IN INFANCY AND CHILDHOOD.

Griffith (*Journal of the American Medical Association*) stated that most cases of this disease, when affecting the very young, are of the ambulatory type. The child is hardly indisposed, although anorexia and headache are sometimes noted. In a minority of patients vomiting may usher in the disease and fever may be high at the outset.

The mortality of typhoid in childhood is not far from 3 per cent., and roughly speaking, the younger the child the better the prognosis. Thus the mortality is less in the first than in the second quinquennium.

As in the adults, the roseola is commonly but not universally present. In some cases the rash is very abundant, covering the whole integument.

Enlargement of the spleen is doubtless constantly present, although not always discoverable.

Epistaxis is often present, although exact statistics are wanting.

The course of the disease is distinctly shorter in the young, and the average duration is about seventeen days.

Diarrhea is much less frequently present in the child, while on the other hand, vomiting—rare in the adult—is of common occurrence, not only as an initial phenomenon, but throughout the disease, and it has even been seen as a terminal symptom in cases ending fatally. Tympanites and hemorrhage are of rare occurrence in the child, and the same may be said of perforation. The nervous phenomena are not marked in childhood.

Finally, as a point of great practical significance, it should be stated that the onset of typhoid in the child may simulate meningitis, to a more characteristic extent than in the adult.—*Archives of Pediatrics.*

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#### A CASE OF DOUBLE BIRTH PALSY.

Dr. J. F. Terriberry (*New York Academy of Medicine*, May, 9th, 1901) presented a case of this kind. He said that injury to the brachial plexus gives rise to various forms of palsies. Duchenne had been the first to call attention to birth palsy, or, as he called it, to obstetrical paralysis. Conditions which interfere with the delivery of the shoulders predispose to birth palsy, the immediate cause often being the use of the finger or hook in the axilla. Compression of the plexus by the umbilical cord had been mentioned by some writers, but his own belief was that it could only act indirectly by delaying delivery. In the Duchenne type, the one generally found, the arms fall by the side in complete extension. The movements of the fingers are usually perfect, and there is little or no disturbance of sensation. The most severe cases were met with in connection with vertex presentations. The electrical reactions varied with the degree of the palsy and could not be satisfactorily determined until the infant was a month or six weeks old. The injury varied from a slight contusion to complete division of the nerve. Birth palsy might be distinguished from cerebral palsy due to hemorrhage on the surface of the brain by the presence of convulsions, the spastic state of the limbs, particularly on motion, the exaggeration of the tendon reflexes and the absence of sensory symptoms. It was often stated that recovery is complete, but this had not been his experience; on the contrary, while he had ordinarily observed marked improvement he had never seen complete restoration to the normal. If reaction were obtained with the faradic current

in the nerve and muscles of the affected limb at the end of the third week, one was justified in stating that the child would get almost complete use of the arm. Absolute rest of the affected part should be secured for from two to four weeks. This was best obtained by wrapping the arm in cotton and lifting it up so that there would be no dragging upon the brachial plexus. The application of the galvanic current for a few minutes daily and the systematic use of massage at home were important adjuncts to the treatment.—*Pediatrics*.

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#### PULMONARY INCOMPETENCE IN MITRAL STENOSIS.

For some years Bryant has collected notes on functional pulmonary incompetence (J. H. Bryant, "Guy's Hospital Reports") and dilatation and atheroma of the pulmonary arteries, as complications of mitral stenosis, and these he now publishes. In this valuable paper he gives records of sixteen cases which have occurred in his own experience in Guy's Hospital, and the results of *post-mortem* examinations in nine of these cases.

He rightly attributes to Dr. Steell the chief credit for drawing attention to pulmonary incompetence in mitral stenosis, and also briefly reviews the work of other observers on the same question. It was recognized by Hilton Fagge (Reynolds' "System of Medicine," Vol. IV., p. 664) that "increase of tension in the pulmonary vessels soon leads to changes in their walls, which become thickened and hypertrophied," and other observers have noted the same fact. Bryant says: "I have never performed, or seen performed, a *post-mortem* examination on a case of advanced mitral stenosis without finding thickening, dilatation and atheroma of the branches of the pulmonary arteries in the lungs." This was so in all the nine cases, of which *post-mortem* notes are now published, and there was also distinct evidence that the pulmonary artery and the pulmonary orifice itself were dilated in these cases.

It has been known since the days of Hunter that the pulmonary sigmoid valves do not do their work as well as the aortic valves, and more recently Gibson (*Edinburgh Medical Journal*, Vol. XXV., p. 979) has shown that the former valve cannot competently hold a column of water higher than six inches, whilst the aortic valve is competent up to twice the pressure. Gibson also found that the pulmonary valve became quite competent under higher pressure, of even 72 inches, if it was constricted slightly by a cord tied round the artery exactly at the level of the valve.

The marked structural changes found in the branches of the pulmonary artery may be looked upon as the result of the increased tension produced in the pulmonary circulation by the obstruction at the mitral valve, and from the above-mentioned experiments it is not difficult to imagine that the pulmonary artery and valve should become dilated and allow functional regurgitation to take place in a similar way to the incompetence of the aortic valve met with when there is dilatation of the first part of the aorta, and without any pathological change in the valve itself.

Syphilis does not play as important a part in producing pulmonary artery degeneration, as Whittaker believes to be the case ("Dis. of the Heart and Pericardium," *Twentieth Century Practice of Medicine*, Vol. IV., p. 282).

The most important physical sign of functional pulmonary incompetence is the presence of an early diastolic murmur, which is most frequently heard in the third left intercostal space, midway between the left sternal line and the left nipple line; but it may be heard in the second or fourth spaces in the same line. Some physicians are of opinion that this early diastolic murmur heard in the above-mentioned situations is created at the mitral valve itself. Bryant considers this interpretation to be most unlikely, for he has never heard the crescendo or mid-diastolic bruits produced at the mitral valve in these spaces, and he cannot see how a stenosed mitral valve could produce an early diastolic murmur in this position.

Mitral stenosis, without doubt, is very occasionally indicated by an early diastolic murmur at the point of cardiac impulse, and between the impulse and the left border of the sternum; but there does not seem any justification for interpreting the early diastolic murmur, which is audible most frequently in the third left space midway between the left border of the sternum and the left nipple line, as being the direct result of the mitral lesion. That this murmur is the result of dilatation of the pulmonary artery and functional incompetence, is a much more satisfactory explanation, and it is borne out by the very definite morbid changes which are found in the pulmonary artery and its branches in necropsies on advanced cases of mitral stenosis.

In the concluding remarks it is pointed out that, although there may be a distinct murmur indicative of functional pulmonary regurgitation during life, the *post-mortem* examination may fail to show any incompetence of the valves or dilatation of the pulmonary artery, but that this absence of *post-mortem* evidence of regurgitation in some cases is no proof that the incompetence did not exist during life. This is because the elasticity of the

pulmonary artery has not been permanently injured by the increased pulmonary tension, and that as soon as the tension is relieved the vessel contracts to its normal size.

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THE ETIOLOGY OF TABES DORSALIS.

G. M. Holmes denies that tabes is a syphilitic disease, as the term is usually applied, because (1) The anatomical substratum has not the character of a syphilitic change; (2) Anti-syphilitic treatment is unanimously admitted to have little influence on the course of the disease, and may do positive harm; (3) Tabes generally occurs many years after syphilitic infection, and is seldom associated with true syphilitic processes; (4) Even the strongest supporters of the dependence of tabes on earlier syphilitic infection must admit that cases occur in which syphilis may be certainly excluded. Further may be mentioned the rarity of tabes among prostitutes, who have almost all had syphilis, and among people and tribes where syphilis is extremely common, as in Japan (Grimm), Bosnia (Gluck), and among the colored population of the United States (Burr, Trennen). He inclines to the compensation theory of Edinger. His explanation starts with the theory of Weigert and Roux that the various constituents of a tissue are in a state of equilibrium so co-related one to the other that no cell can disappear without the surrounding tissue growing to fill its place, and when one constituent becomes weaker or less resistant, the energy of growth of its neighbors represses it still further. But, should the proof of the accuracy of the Weigert-Edinger theory for the whole nervous system succeed, it is necessary that the possibility be proved that certain tracts under normal conditions are worked more than others, and that these tracts degenerate when stress, in the form of overwork, either relative or absolute, is associated with a disturbance of the general metabolism with deficient nutrition. There are undoubtedly a small number of nerves which are constantly or very frequently at work, or at least much more constantly in action, than any of the other nerves of the body. These are the sensory nerves from the muscles which take an important part in the regulation of muscular contraction, and are constantly transmitting those stimuli by which we can become aware of the condition of our muscular system or the position of our limbs. These nerves are almost constantly at work, and if the hypothesis be right, these must suffer, and their degeneration is clinically expressed by loss of muscular tone and the deep reflexes, with ill-directed movements, without loss of motor power—ataxia. On similar grounds can be explained the sensory disturbances. These disturbances of



sensation would naturally be found in the regions of the body where the nerves are most irritated by the pressure of the clothes or other means; and in tabes we find the scattered, and often irregular, patches of anesthesia most constant on the soles of the feet or round the waist. The same explanation also suffices to account for the eye symptoms, symptoms referable to the bladder and rectum, etc.; in short, it will account for all the features peculiar to the disease. Hence, Edinger's theory, to the exploitation of which the whole paper is devoted, postulates the action of predisposing agents by which the nutrition or power of repair in the nervous system is affected; and, secondly, that on the soil suitably prepared by such noxious agents, function, normal or excessive, sows the symptom-complex.—*Dublin Journal of Medical Science.*

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#### PERITYPHLITIS IN CHILDHOOD.

Solaro (*La Pediatria*) believes that perityphlitis is not uncommon in childhood, 15 per cent. of all cases occur beneath the age of puberty. Operative perityphlitis is still more frequent, one child in every four submitting to operation. There appears to be some difference between the perityphlitis of childhood and the appendicitis of adult life, in that the cecum is more likely to be the seat of the malady in early life, while the appendix is the more readily involved with advancing years and development. Perforative peritonitis in childhood is more likely to proceed from a cecal lesion than in a corresponding situation in the adult. The fact remains that in the majority of cases of infantile perityphlitis the lesion really proceeds from a diseased appendix.

The appendix is not a more insignificant structure in the child than in the adult, as elaborate measurements show that the process is relatively twice as long in the child (in proportion to the length of intestine), as it is in the adult.

The appendix has a relatively large calibre in childhood, so that calculi from stagnation do not occur up to the age of five years. The period of maximum growth occurs near the age of puberty, but calculi are equally common at any period between the ages of five and twenty years. By reason of these peculiarities, appendicular colic and perityphlitis from retention of calculi are rare in tender years. The appendix readily participates in affections of the cecum, from simple extension. The richness in the follicular structure of the appendix exposes it to infection by continuity. Generally speaking, it may be said that with the exception of diminished frequency in the occurrence of the obstructive and calculous forms of appendicitis, this disease is much

the same in the child as in the adult. Relapse is especially frequent in childhood. Perityphlitis appears to be very common in tender years, the exudation filling the pelvic connective tissue with production of pelvic abscess. A traumatic origin seems to be very unusual.

Characteristic of the appendicitis of childhood is the atypical character and the absence of one or more classical symptoms. The management does not differ from that of adult life, and operation in the interval gives 100 per cent. of favorable results. —*Archives of Pediatrics.*

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#### THE TREATMENT OF ACNE.

In general, it may be remarked that the etiology of each case requires careful study. The part played by digestive and sexual disturbances in the production of acne is well known, and often gives a clue to the treatment.

The different varieties of acne demand different treatment, which is thus outlined by Prof. Charmeil (*Rev. de Therap.*): Ordinary "blackheads" must be first of all mechanically expressed by means of the small instruments in use for this purpose. To soften the skin and aid the procedure, the part should be washed with water as hot as can be borne, medicated with an alkali, like sodium or potassium carbonate, in 5 to 10 per cent. strength; sodium bicarbonate, 5 per cent.; ammonium chloride, 5 to 20 per cent., or sodium borate, 5 per cent.

These solutions are well tolerated by sensitive skins. If more energetic remedies are desired, soaps medicated with resorcin or naphthol are serviceable, or a paste like the following:

Precipitated sulphur.....	2½ dr.
Resorcin.....	75 grn.
Zinc oxide.....	½ oz.
Wool-fat.....	5 dr.
Petrolatum.....	1 oz.

Or analogous combinations of naphthol, salicylic acid, ichthyol, etc., may be prescribed.

It is advisable to sterilize the skin by means of alcoholic lotions containing mercuric bichloride 1-2 to 2 per cent., or resorcin, 5 to 15 per cent., to be applied at bedtime on cotton lightly soaked in the solution. This formula is well tolerated:

Resorcin.....	1 dr.
Cologne water.....	1 pint

These lotions will prevent pustulation to some extent. At the same time constipation should be corrected, a plain diet prescribed,

avoiding pastries and seasoned foods. In the neurotic, hydrotherapy is useful.

In the pustular variety of acne, sulphur lotions are indicated, as in the following formula:

Precipitated sulphur.....	6	dr.
Spirit camphor.....	2	oz.
Rose water.....	6½	oz.
Distilled water.....	7	oz.

Shake before using, apply at night with a hairbrush, and wash off with hot water the next morning.

If the skin is intolerant, a simple antiphlogistic treatment with mild antiseptic solutions should come first.

If the pustules are not conspicuous, as on the neck or back, they may be painted with tincture of iodine, which will often arrest the inflammatory process. In the face, the same effect will be obtained from a saturated solution of boric acid in alcohol.

Internally, brewer's yeast in doses of 1 to 2 teaspoonfuls before meals is good in some cases. Furunculous or phlegmonous acne justifies surgical intervention with a fine scarifier, etc. Acne rosacea is greatly benefited by washing with hot water. Internally, the vaso-constrictors are beneficial:

Ergotin.....	1	grn.
Quinine hydrobromate.....	1	grn.
Fl. ext. witch-hazel.....	2	min.
Belladonna leaves.....	1-12	grn.

Make one pill. Four such pills daily, two with the two principal meals.

In most cases scarification will become necessary.—*Merck's Archives*.

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#### CHLOROSIS: ITS MORBID RELATIONS AND THE TOXICITY OF ITS SERUM.

Leclerc and Levet (*Lyon Med.*, August 4th, 1901) have carefully investigated the family history of 36 cases of chlorosis during the last five years, in order to ascertain the connection between chlorosis and tuberculosis. In 1890 Jolly concluded from an examination of 54 cases that in the majority of instances a personal or family history of scrofula or tuberculosis was to be found. The 36 cases now recorded, however, show that tuberculosis has not more influence in the causation of chlorosis than have other pathological states. Thus two-thirds of the parents of the patients suffered from some definite morbid condition; neuropathy, 10 cases; gout, 7; tuberculosis, 5; diabetes, 3; neph-

ritis, 3; rheumatism, 2, etc. In less than a third of the cases the brothers and sisters have presented various pathological states: Tuberculosis, 8 cases (3 in the same family); chlorosis, 5; neuropathy, 2; asthma, 2; albuminuria, 2, etc. Only one of the 36 patients became tuberculous. It is concluded that the influence of hereditary tuberculosis is only exerted by enfeebling the stock. Since the study of the morbid relationships of chlorosis has thrown little light upon the etiology, the authors, struck by the analogy of the auto-intoxications, for example, myxedema, determined to test the toxicity of the blood. This was done by means of intravenous injections in rabbits, in five cases of chlorosis. The number of c.cm. per kilogram required to kill the rabbits was, in the case of blood taken from healthy people, 15; in the five cases where the blood came from chlorotic patients, 15 in one case, 11 in three cases, and 8 in the other. The toxicity of the blood serum is then generally increased, and chlorosis may provisionally be regarded as an auto-intoxication.—*British Medical Journal*.

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#### GASTRIC ULCER AND HYSTERIA.

Guido Bigi (*Gaz. Med. Lombard*, June 9th, 1901) discusses the theories as to etiology of gastric ulcer, and relates a case in which a woman of 26 had hematemesis after a severe fright. She had indubitably hysterical symptoms; after almost three months a second severe hematemesis occurred, and from that date the other symptoms of gastric ulcer began to appear. After the first hemorrhage the lacerated mucous membrane was restored but not after the second. He suggests that the process of formation is comparable to the production of a neurotic edema or even a bullous urticaria on the skin. In hysteria the gastric mucous membrane, like that of the lung or any other viscus, is liable to hemorrhages arising from the direct influence of the neurosis; our knowledge of trophic affections of the skin enables us to state that the process has a general tendency toward necrosis. The hysterical process being thus actually a gangrenous one, when it is situated on the gastric mucous membrane, the gastric juice is able to maintain as a permanent ulcer the solution of continuity produced by an original hemorrhage. Gilles de la Tourette and others have shown that half the clearly diagnosed cases of gastric ulcer have a hysterical etiology. This must be remembered if one wishes to carry out a suitable and rational treatment.—*British Medical Journal*.

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**Special Selections**

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**THE DIFFERENTIAL DIAGNOSIS OF SMALLPOX.\***

BY J. MACCOMBIE, M.A., M.D. ABERD.,  
Medical Officer at the Brook Fever Hospital.

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When I was asked to read a paper on smallpox to the Hunterian Society, it appeared to me that the differential diagnosis of that disease would be a subject of interest to the members of the society, and that perhaps my observations might prove helpful to those whose opportunities of observing smallpox have been limited. The diagnosis of smallpox presents difficulties, first, in the pre-eruptive stage and, secondly, in the eruptive stage.

**THE DIAGNOSIS OF SMALLPOX IN THE PRE-ERUPTIVE STAGE.**

In the pre-eruptive stage difficulties often occur in connection with prodromal rashes, which may simulate scarlet fever and measles. Prodromal rashes resembling scarlet fever are usually best marked on the trunk, the abdomino-cruial triangle—a triangle the base of which is on a level with the umbilicus and the apex, about eight inches below the symphysis pubis—and the flexor surfaces, and they simulate scarlet fever closely in punctate appearance; but the absence of eruption for the most part on the extensor surfaces, the face, the neck, and the temples, and the exemption from faucial inflammation and submaxillary glandular enlargement, should warn one of a diagnosis of scarlet fever, especially if backache be a pronounced symptom. In other cases there is a copious crop of petechiæ in the abdomino-cruial triangle and other flexures. Now, in scarlet fever petechiæ are rarely noted in the abdomino-cruial triangle; more often they appear in other flexures.

Some hemorrhagic cases of smallpox show a vivid red erythema involving the whole of the skin of the trunk and the limbs, with petechiæ in the abdomino-cruial triangle and other flexures, and deep purple or black subcutaneous hemorrhages appear similar to those noted in purpura. Such cases are not infrequently diagnosed as scarlet fever, especially before the appearance of the flexure petechiæ and purpuric spots. The eruption is not at first punctate, like that of scarlet fever, but may quickly assume a pseudo-punctate character on the groins and other flexures, owing to the appearance there of crops of small, deep red petechiæ. The

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\*A paper read at a special meeting of the Hunterian Society, Nov. 13th, 1901.

faucial symptoms are unlike those of scarlet fever, and the initial symptoms of smallpox are usually well marked, especially the lumbar pain; but in the earlier stages of these rashes the diagnosis is extremely difficult, and even those with special knowledge of infectious diseases may make a mistaken diagnosis.

The prodromal rash that resembles measles counterfeits very closely the eruption of that disease. It disappears on stretching the skin, but it is only slightly, if at all, raised, and therein lies the great difference between it and measles. It reaches its height within 24 hours, of its appearance, and fades quickly, either before or soon after the appearance of the characteristic eruption of smallpox. The eruption envelops the whole skin more quickly than does that of measles, and in most instances it is not preceded by catarrhal symptoms; not infrequently, however, there is considerable conjunctival suffusion.

A valuable aid to the differential diagnosis of smallpox in the initial stage and measles is the presence or absence of Filatow's spots; if these be present the case is in all likelihood one of measles. Filatow's spots are situated for the most part on the buccal mucosa opposite the molar teeth, and less markedly on the mucosa opposite the other teeth. They are very small, raised, whitish dots, of about the size of a small pin's head, generally on a reddened base. They are usually discrete, but sometimes a confluent patch is seen. They appear in the majority of—some observers say all—cases, and they disappear usually within one or two days of the appearance of the eruption. Be it remembered that I am speaking of the pre-eruptive stage of smallpox, because in the eruptive stage the eruption of smallpox on the buccal membrane might possibly be erroneously regarded as Filatow's spots. These are, however, much smaller than the buccal smallpox spots, and they are arranged for the most part on the mucosa opposite the teeth and gums, whilst the spots of smallpox are distributed generally, more particularly affecting the palate, fauces, pharyngeal walls, and tongue.

In addition to these prodromal rashes, there are many erythemas affecting circumscribed areas of the skin, and in appearance these often simulate scarlet fever and measles. I have little time to speak of these, though they afford valuable aid to the diagnosis of smallpox. I may say, however, that circumscribed punctate prodromal eruptions showing on the groins, the sides of the trunk, or the lumbar regions, or on the flexures of the arms and legs, or morbilliform or patchy non-punctate erythema affecting usually the extensor surface of the arms, the hands, the legs, or the feet, if the initial symptoms of smallpox be present, are often sufficient warranty for suspecting the onset of smallpox and

for taking measures accordingly. It is important to remember that smallpox prodromal rashes are extremely rare in persons under ten years of age, whilst the majority of cases of scarlet fever and measles occur under that age.

*Erythema multiforme* may cause difficulty. Usually initial symptoms resembling those of smallpox are absent. When present, it is desirable to keep the patient under observation till the third or fourth day of disease, when the diagnosis will be rendered certain by the appearance or non-appearance of the eruption of smallpox.

*Typhus fever*.—At first sight it does not appear likely that this disease would be mistaken for smallpox, and if the observer will recollect that in typhus fever the eruption usually appears on the fifth day of disease, and that it is not raised, a mistaken diagnosis should not occur.

*Influenza*.—Only severe cases of influenza will be mistaken for smallpox, and then the prostration is perhaps more complete from the first than in smallpox. Pains behind the eyes and pains in the limbs are usually very pronounced symptoms in influenza. If an erythematous eruption be present the diagnosis is obscured, but the non-appearance of smallpox papules on the third day of the disease should clear up the diagnosis.

*Ptomaine* rashes from shell-fish, etc., are not unlike morbilliform erythemas of smallpox; but the absence of backache, with the history of rash appearing concurrently with the onset of the symptoms and inquiry as to diet, should obviate any mistake.

*Rotheln and copaiba rashes and lichen*.—In these the initial symptoms of smallpox are absent.

*Lumbago*.—In this condition the absence of pyrexia and headache should be sufficient to exclude the diagnosis of smallpox.

#### THE DIAGNOSIS OF SMALLPOX IN THE PAPULAR AND VESICULAR STAGE.

Here it is desirable to enumerate the prominent initial symptoms of smallpox and to describe the eruption thereof. The prominent initial symptoms of smallpox are headache, lumbar pains, often rigors, anorexia, vomiting and malaise, and pyrexia. The duration of these symptoms before the eruption of smallpox appears is usually 48 hours. And these initial symptoms are usually equally pronounced in vaccinated and in unvaccinated subjects, and in mild and severe cases alike. The modification of the disease caused by vaccination does not appear until the eruptive stage. In *unvaccinated* patients, the eruption is in its very earliest stages macular. The macules speedily become papules, and are then hard and raised, and in the course of 24 hours have a distinctively shotty feeling, and show commencing vesicu-

lation. The eruption takes from one to three days to come fully out, the length of time depending upon the abundance of the eruption. The vesicles increase in size, and at the end of five days they attain their full growth, when they are round and about the size of a small pea with flattened top, and they mostly show depressed centres. They are of pearly appearance and are filled with clear serum. They are multilocular, and do not collapse when transfixed with a needle. In the pustular stage many of the pustules become dome-shaped, instead of being flat or depressed.

The eruption of smallpox in *vaccinated* subjects is macular or papular at first, and within a few hours of its appearance much of it is distinctly shotty. Some of the papules may show minute vesiculation at the end of the first day, and on the second and third day the vesicles often reach their full growth. They are circular, often small, and generally more or less conical—not flattened or depressed, or showing only a minute depression. On the face the vesicles may be irregular in outline and not unlike spots of acne, but they do not show a central dot. The vesicular fluid is at first clear, but on the second and third days it becomes opaque, and many of the vesicles desiccate with no further evidence of pustulation; many of the papules never become vesicles. In other cases the eruption approaches more nearly to the eruption of smallpox as seen in unvaccinated subjects; but in a large proportion of cases of smallpox in vaccinated subjects the evolution of the eruption is more rapid than is the case with the eruption in unvaccinated subjects. The distribution of the eruption in both vaccinated and unvaccinated subjects is as a rule most abundant on the face and extremities, less so on the trunk, and usually there is more eruption on the back than on the chest and abdomen. The eruption is generally present on the palate, the fauces, and the tongue, and usually in direct proportion to its abundance elsewhere. The temperature is high in the initial stage, but it begins to fall shortly after the appearance of the eruption, and when the eruption is fully out in most cases it falls to normal; in severe and confluent cases, however, it may not fall under 100 degrees Fahrenheit.

The diagnosis of smallpox in the eruptive stage is often extremely difficult, consequently many mistakes occur, cases of smallpox being diagnosed as some other disease—very often chickenpox or measles—and cases of other diseases being diagnosed as smallpox.

*Chickenpox.*—The disease most frequently mis-diagnosed for smallpox in the eruptive stage is chickenpox. In this disease the absence of initial symptoms is in striking contrast to their pres-



ence in smallpox. In a very few cases, however, especially in adults, there may be initial symptoms of backache, malaise, and some pyrexia, lasting from 12 to 48 hours, and followed by eruption. These are most exceptional, and usually the first thing noted is the eruption of vesicles on the trunk, the limbs, or the face. If observed from the very commencement these are at first macules, which in an hour or so become papules, and in a few hours vesicles. Some of the vesicles attain their full size within 8, 12, or at most 24 hours. The vesicles are then usually glistening, hemispherical, or dome-shaped or transparent. On transfixing with a needle the contents escape and the vesicles collapse. The shape of the vesicles is elongated, elliptical, or circular on the trunk and extremities, and irregularly round on the face and the scalp. On the forearms, the hands, the legs, and the feet they are often circular, and smaller than those on the trunk. In these latter positions the vesicles, being small, look not unlike the vesicles of modified smallpox, and in addition they have often a more or less shotty feeling. In a large number of cases typical chickenpox vesicles will be found only on the trunk, not on the face or extremities; as a matter of fact, the distinctive shape and appearance of the vesicles of chickenpox become less and less characteristic towards the distal ends of the extremities. Often within eight or thirteen hours, always within 24 hours, of the appearance of the eruption, some of the chickenpox vesicles have reached their full growth, and are then as large as the vesicles of smallpox in unvaccinated subjects at the fourth or fifth day of the eruption, and as large as, or larger than, the vesicles of smallpox in vaccinated subjects at the end of the third day of the eruption. If the eruption be copious, many of the chickenpox papules abort, many of the vesicles do not attain their full growth, never becoming larger than a small pin's head. In some few cases the vesicles fill only partially with fluid, are flattened, and are of a dull white or tallowy color; but in these the distribution of the eruption is markedly that of chickenpox, and the elongated or elliptical shape of many of the vesicles is pronounced. In point of distribution the eruption of chickenpox is, as a rule, most abundant on the trunk, less so on the face, the scalp, the thighs, and the arms, and still less so on the forearms, the hands, the legs, and the feet. On the palate and the fauces the eruption is present in many cases, but usually it is sparse. Pyrexia in chickenpox is usually synchronous with the appearance of the eruption, and the temperature may or may not fall when the eruption is fully out. In cases where the eruption appears in successive crops there is usually a distinct rise in temperature with each crop.

What, then, are the diagnostic points between chickenpox and

smallpox? There are (1) the distribution of the eruption; (2) the shape of the vesicles; (3) the rate of growth of the vesicles; and (4) the unilocular character of the vesicles of chickenpox as compared to the multilocular nature of the vesicles of smallpox.

From what I have just said it will be noted that the distribution of the eruption of chickenpox is, as a rule, the opposite of that of smallpox. In shape some of the vesicles of chickenpox are elongated or elliptical; in smallpox the majority of the vesicles are circular. The typical vesicles of chickenpox attain their full growth in a few hours and are then dome-shaped, distended with fluid, transparent, and they collapse on being transfixed. In smallpox, whether in vaccinated or unvaccinated subjects, the vesicles do not attain their full size on the first day of the eruption, and that is a fact of crucial importance in the differential diagnosis of the two diseases. Observation of the eruption on the face, the arms, and the hands only should never be relied upon for the diagnosis of chickenpox, for upon those parts the eruption simulates that of smallpox closely, and very many errors in diagnosis have been made by so limiting the observation. There should be no failure to examine closely the whole eruption.

Though statements are made to the effect that the vesicles of chickenpox, when at their full growth and distended with serum, show depressed centres, just like smallpox vesicles, this is not the case. The unruptured chickenpox vesicles are not depressed in the centre, but the ruptured vesicles may be. The chickenpox vesicle ruptures naturally or forcibly by scratching or friction, a portion of its contents escapes, and it collapses centrally. In the centre a tiny scab of dried serum forms, occluding the opening and preventing the further escape of serum. It is then that the ruptured vesicle shows a depressed centre, but on close examination a small dried scab in the centre, showing that the vesicle has ruptured, will be found. This ruptured vesicle may be noted within twelve hours of the appearance of the eruption. I have only once seen an unruptured vesicle of chickenpox with a depressed centre, and the cause of the depression of that particular vesicle was that in its centre there was a thick long hair—a small mole-hair, in fact—and the epidermis forming the envelope of the vessel was held down by the hair follicle, thus causing a depression. The vesicle was situated on the abdomen.

Frequent mistakes are made in diagnosing smallpox in unvaccinated children as chickenpox, such mistakes often resulting in outbreaks of smallpox. If regard be had to the differential diagnostic points that I have endeavored to emphasize, no such mistake should occur.

*Measles.*—Confluent smallpox on the first or second day of

eruption is not infrequently diagnosed as measles, and *vice versa*. The observer is usually misled by the appearance of the eruption on the face, the arms, and the neck. In confluent smallpox the skin in these situations is often intensely hyperemic, swollen, and studded with raised pink or purple papules, accompanied in many cases by conjunctival suffusion. The patient's aspect and the appearance of the eruption are very like those of measles, but close observation will show that the papules are more raised than are the papules of measles, and by drawing the finger firmly across the forehead, the eruption will be felt to be hard and shotty, while in measles, though slightly resistant, it is soft and velvety. That is the diagnostic point. Probably also in smallpox some of the papules will show commencing vesiculation.

*Syphilitic eruptions.*—Usually the scaling and pustular eruptions are mistaken for smallpox. The coexistence of a papular, scaling, and pustular eruption, its symmetrical appearance, and the history of the case should negative smallpox. If the specific eruption be ushered in by very high fever it is to be noted that the papules are not shotty but flat, and careful inquiry and inspection will in most cases resolve the doubt. Here most errors in diagnosis are due to the observer omitting to examine the whole of the eruption, and to insufficient inquiry as to the history of the case.

*Herpes.*—Small clusters of herpes, wherever situated, may simulate vesicles of smallpox, but the absence of initial symptoms and full development of vesicles on the first day should obviate any mistake.

*Eczema and impetigo.*—In these conditions, also, smallpox is negated by the absence of initial symptoms, nor do the vesicles or pustules bear much resemblance to those of smallpox. Yet a considerable number of cases of impetiginous eruptions are diagnosed as smallpox, even in the out-patients' departments of the general hospitals.

*Pemphigus.*—In pemphigus, the initial symptoms are absent, and the bullæ are larger than smallpox vesicles and are filled with a clear fluid; they collapse on being pricked.

*Urticaria papulosa.*—In this disease the wheals are small, of about the size of a split pea, somewhat hard to touch, and of a dull white color, and those on the extremities are sometimes not unlike smallpox vesicles. They attain their full size almost at the moment of their appearance, and either have no redness at the base or the usual erythema is present. The initial symptoms of smallpox are absent.

*Acne.*—The initial symptoms of smallpox are absent in acne, and the eruption affects the face, the shoulders and the back for

the most part. The pustules are acuminate, sometimes indurated, and they show a central dot. It is well to recollect that the eruption of modified smallpox on the face is sometimes not unlike acne, and it is desirable always to inquire as to the initial symptoms and as to the presence of eruption elsewhere than on the face.

*Rheumatic sudamina.*—In these cases there is the history of rheumatism attended by sweating with the sudden appearance of the eruption, which is most marked usually on the trunk. In the majority of cases the vesicles are small, of about the size of a large pin's head, and that, with the history of the case, is sufficient to exclude a diagnosis of smallpox; but in rare instances the vesicles are large and look not unlike modified smallpox vesicles. I have myself been deceived by an eruption of this character.

*Glanders.*—The initial symptoms in glanders are unlike those of smallpox, nor is the onset so sudden. The eruption is sparse, showing as red indurated papules, which rapidly increase till they reach the size of a pea, when they become pustules. There is fetid nasal discharge, and the constitutional symptoms are usually severe. The history of the case, the nasal discharge (an exceedingly rare thing in smallpox), and the fact that the severe constitutional symptoms are disproportionate to the amount of eruption, should negative the diagnosis of smallpox.

*Pyemic skin eruptions.*—Those eruptions which are mistaken for smallpox occur mostly in cases of ulcerative endocarditis. There is usually a comparatively sparse petechial and pustular eruption on the trunk and the extremities. The petechiæ vary in size from that of a lentil to that of a pea, and are irregular in outline. The gradual onset of the symptoms, the date of appearance of the eruption, the great prostration, and the severity of the constitutional symptoms, *qua* the amount of the eruption, should negative smallpox.

The foregoing are the most important, but not all the diseases that are mistaken for smallpox, and all those I have mentioned are instances of mistaken diagnosis that passed through my hands in the years during which I was in charge of a smallpox hospital and during the time that it was my duty to diagnose the cases of smallpox before they were sent to the hospital ships.

The difficulties in the diagnosis of smallpox in the eruptive stage are most marked in cases where the eruption is modified by vaccination, especially if there be a very sparse eruption. In smallpox the initial symptoms of headache and backache, rigors, and anorexia and pyrexia are almost invariably present. Indeed, the occurrence of at least some of the initial symptoms is one of the most constant features of smallpox, even of the mildest type,

and the eruption appears in almost every case after the duration of initial symptoms of about 48 hours. The peculiarity of the eruption of modified smallpox is that its evolution is quicker than is that of the eruption of unmodified smallpox—that is to say, the papules quickly become vesicles and the vesicles soon show signs of pustulation, so that on the second day of the eruption there are definite vesicles, which by the third day are, in many instances, cloudy and opaque. The vesicles are often small and more or less acuminate, frequently not showing depressed centres, and bearing little resemblance, except as regard their circular outline, to the larger, bolder, and clearer vesicles of unmodified smallpox, which show flattened or depressed tops.

It has always appeared to me that many of the mistakes in diagnosis are due to disregard of the significance of the initial symptoms of smallpox. When a patient presents a history somewhat as follows: Headache, lumbar pains, anorexia, rigors, and perhaps vomiting and pyrexia, these symptoms lasting about 48 hours, when a papular shotty eruption appears on the face and the extremities, and to a less extent on the trunk, the temperature falling on, or shortly after, the appearance of the eruption, such a case is in all probability one of smallpox; but if a papular, vesicular, or pustular eruption appears on a person, and the initial symptoms just mentioned have been absent, then most probably such a case is not smallpox.

In the diagnosis of smallpox, the following rules should be observed: (1) It should never be forgotten that the initial symptoms of smallpox are most constant both in vaccinated and unvaccinated subjects. (2) When called to a case the practitioner should never take for granted that the eruption on the trunk is like the eruption on the face and extremities, but in every case he should examine the whole eruption. Disregard of this precaution leads to many mistakes. (3) It should not be assumed that because a case of smallpox has occurred in a house, therefore a vesicular eruption appearing on another inmate of the same house about the same time is smallpox. I have known cases of chickenpox and smallpox occurring simultaneously in the same house, and smallpox and enteric fever cases in the same family at the same time. (4) It should be remembered that in a very large number of vaccinated subjects smallpox is so mild that as soon as the eruption—consisting sometimes of not more than half a dozen spots—have appeared, the patient feels well. (5) Care should be taken to avoid ascribing the spots on the face in a mild case to digestive disturbances, and sending the patient to the seaside for a little change of air. This may not be the custom, but it is done. A very remarkable instance of mis-diagnosis

of this character came under my notice many years ago. The housekeeper of a gentleman in the suburbs was admitted under my care suffering from black smallpox, from which she died. She had ridden in omnibuses and trams to a general hospital in the south of London, was admitted there, and was sent to me on the following day. I learned from her that her master had been ailing a little time before, and had been sent to the Isle of Wight for a week's change of air. I saw him some days after his return. He had had a mild attack of smallpox, the spots being ascribed to some digestive disturbance. I asked him to show me his feet, and under the thick skin of the sole of one foot I found an unruptured smallpox pustule.

General practitioners may be assured that they are not the only members of the profession who make mistakes in the diagnosis of smallpox; the physicians of general hospitals are mortal, and err in this way, and even the smallpox experts, with their special knowledge of the subject, are sometimes puzzled, and deem it advisable to keep cases under observation till time and the course of the disease resolve the doubt.

Mistakes in diagnosis are more frequent proportionately in times when smallpox is not prevalent. For instance, during the years 1898, 1899, and 1900, 176 cases in London were certified to be those of smallpox. Of these 98 were correctly and 78 incorrectly diagnosed. Why, it may be asked, do mistakes so frequently occur in the diagnosis of this disease? The answer is that smallpox is now so erratic and uncertain in its occurrence that many of the younger members of the profession have had little or no opportunity of observing it so as to familiarize themselves with its diagnosis. The result is that only a few men, having special knowledge and experience of smallpox, are to be found in London, and these are mostly in the service of the Metropolitan Asylums Board. Surely it is most desirable that in view of the great interests involved, facilities should be afforded to the profession for obtaining an expert's opinion in cases of doubtful diagnosis. I would venture to suggest that the Metropolitan Asylums Board should appoint a smallpox consultant, whose opinion in cases of doubtful or difficult diagnosis should be at the service of the general practitioner and of hospital and infirmary physicians. In this way many cases of smallpox that are mis-diagnosed as chickenpox, measles, and other diseases, might be correctly diagnosed and the untoward results of a mis-diagnosis be avoided, while the incorrect diagnosis of smallpox in many cases of chickenpox, measles, and other diseases might be obviated, whereby the patients would be saved much inconvenience and the physicians much worry.

Another point of the utmost importance arises in connection with the diagnosis of smallpox. It is this: In what way can the present prevalence of smallpox be best utilized for the purposes of medical education? An opportunity is now presented to the hospital authority entrusted with the clinical teaching of infectious diseases in London, for the clinical demonstration of smallpox to the senior medical students, medical officers of health, and general practitioners. All patients certified to be suffering from smallpox are removed at present to the Metropolitan Asylums Board's wharf at Rotherhithe. They are detained there a short time, and are then transferred to the hospital ships. There is, therefore, at the wharf ample material ready for demonstration, and the patients are for the most part in the early stages of the disease, when the eruption is particularly suited for the demonstration of the diagnostic points of smallpox. In addition, much may be learned from the cases of mis-diagnosis sent there. Some facilities have been afforded by the Metropolitan Asylums Board to medical officers of health for seeing smallpox at the wharf and at the hospital ships. The systematic clinical teaching of smallpox, however, has not yet been undertaken, although there appears to be no sufficient reason for delay. I feel sure that the Metropolitan Asylums Board will recognize its responsibility and its duty in this matter, and that it will speedily utilize to the fullest extent the smallpox material at its disposal at the wharf and at the hospital ships for the clinical demonstration of that disease to students and practitioners.—*The Lancet*.

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#### THERAPEUTICS OF OREXINE TANNATE.

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Dr. Jos. Kuck, of Wiesbaden, speaks very highly of orexine tannate, introduced by Prof. Penzoldt, about ten years ago.

Orexine tannate is a yellowish powder, tasteless and odorless, insoluble in water, freely soluble in acids, and consequently in the gastric juice. No serious or permanent after-effects have ever been recorded, although the drug has been extensively employed.

In doses of 8 gr. orexine produces strong craving for food. All gastric functions are stimulated by the drug, especially the secretion of hydrochloric acid. All cases of diminished gastric secretion are therefore indications for treatment with orexine, but also loss of appetite from any cause, as well as conditions of emaciation and debility. Thus orexine is useful in the convalescence of febrile diseases, in tuberculosis, scrofula and rickets, anemia and chlorosis, neurasthenia and hysteria, nervous dyspep-

sia, etc. Of all stomachic remedies, orexine seems to be the best. Improved appetite, increase of bodily weight, and enrichment of the blood, follow its use. Numerous authorities praise the drug particularly in pediatric practice. Indigestible articles of food are tolerated much better if a little orexine is taken along.

The drug will occasionally relieve heart-burn, cardialgic pain, and in one case on record it acted as a teniafuge. In surgical practice, orexine in doses of 5 to 6 grains, is recommended for vomiting after anesthesia. Its action in the uncontrollable vomiting of pregnancy is almost specific.

Contraindications for orexine are gastric hyperacidity and gastric ulcer. It should also never be given with iron, as an inky compound will be formed. The doses are 3 to 12 grains, according to age, twice daily, 1 to 2 hours before meals, in water or broth. This medication may be continued for five days, then interrupted for several days, and again resumed. The drug probably acts by direct stimulation of the gastric cells.

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#### PLANTAR REFLEX AND BABINSKI'S SIGN.

Babinski was the first to record the pathological alteration in the plantar reflex, whereby in certain cases mild irritation of the sole of the foot produces not plantar flexion, but dorsal flexion of the toes, and especially of the great toe. The cause assigned by Babinski for this alteration of the plantar reflex is in almost every case some lesion of the pyramidal tract; recognized exceptions are epilepsy, strychnine poisoning, and other diseases producing exaltation of reflexes, and normal infancy. H. Schneider (*Berl. klin. Woch.*, Sept. 16th, 1901) took advantage of the opportunity to record the Babinski phenomenon in nearly a hundred cases of disease of the central nervous system. He states that this phenomenon may be caused in two ways; first, by interruption of the pyramidal tract or disease of the motor cortical area, thus destroying the normal plantar flexion, which is a cortical reflex; second, by diseases which either increase the irritability of the motor cells of the spinal cord, or diminish the irritability of the cerebral cortex. Briefly stated, Babinski's phenomenon is the substitution of a spinal for a cortical reflex. It is due to the relative suppression of the cortical reflex, a phenomenon which may or may not involve distinction of cortical centres, and which may or may not point to a lesion of the pyramidal tract. In conditions producing general heightening of spinal reflexes a diagnosis of pyramidal lesion cannot be based on Babinski's sign.—*Medical News*.