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THE CANADIAN PRACTITIONER AND REVIEW.

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Original Communications.

1. A NEW METHOD OF CUTTING URINARY CALCULI. 2. A CASE OF UNUSUALLY LARGE CALCULUS REMOVED BY SUPRA-PUBIC SECTION.*

BY GEORGE A. PETERS, M.B., F.R.C.S. ENG.,

Associate Professor of Surgery and Clinical Surgery, University of Toronto; Surgeon Toronto General Hospital; Surgeon Victoria Hospital for Sick Children, Toronto.

The following is a method of cutting stones of all kinds, hard and soft, which the author has found to be of great use and of equal simplicity. So far as can be ascertained the method is new and original.

The stone is first of all dipped for a moment into melted paraffin wax. This gives it a very thin coating of the wax, (Fig. 2 E) and prevents the sticking of plaster-of-Paris in which it is to be embedded. As a means of holding the stone absolutely immovable while it is being sawn, the aid of a horseshoe, as shown in the accompanying illustration (Fig. 1), is brought into use. The horseshoe is placed upon a board with its middle exactly over a line (Fig. 1 A) previously drawn longitudinally upon the board. This line is to serve as a constant fixed indication of the centre of the stone. The heels of the horseshoe may be tilted up by means of a short block (Fig. 1 B) placed crosswise under the shoe, so that they will about subtend the centre of the stone. The horseshoe is then nailed firmly into position on the board. The stone (Fig 1 C)

*Presented at a meeting of the Toronto Pathological Society, November 2, 1901.

is now taken into the hands of the operator and carefully centralized opposite the line drawn on the board. Plaster-of-Paris cream is then run round it and over it in such a way as to embed the stone completely to the extent of not less than half an inch of covering at any part, and in such a manner that the embedding plaster also embraces the heels of the horseshoe (Fig. 1 D). The plaster is then allowed to set firmly, and if it can be left for several days until it is thoroughly dried so much the better, as it is found that the saw works more easily in thoroughly dry plaster. The stone is sawn directly through the plaster which embeds it in the line previously marked on the board, and a second cut is made through the plaster between the stone and the heel of the horseshoe. (If the stone is very large and hard, the board may be fastened in a vice, and the

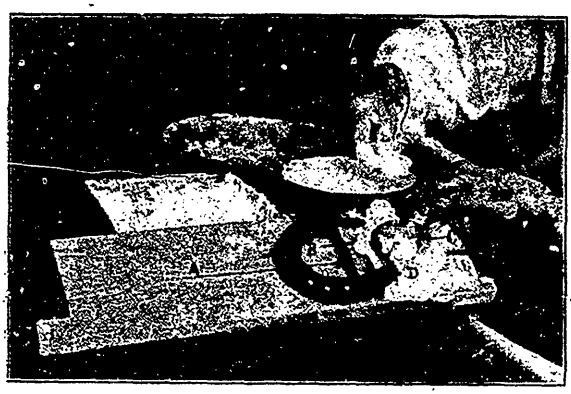

FIG. 1.

saw cut made through the board also. This serves very materially to steady the saw.) This section thus liberated can then be readily detached from the board, and will be found to contain one-half of the stone, which can be easily lifted out of the embedding plaster, part of which may be cut away (Fig. 2 F). The removal of the stone from the plaster is facilitated by plunging the whole into hot water for a few moments, when the paraffin wax becomes softened and the stone can thus be easily separated from the plaster. The last trace of wax is then melted off by holding it under a hot water tap, or putting it into a basin of hot water for a few moments. The cut surface of the stone may be polished rapidly and easily by grinding it on a ground-glass surface. In the case of very hard stones the polishing process is facilitated by using powdered pumice stone or emery, though this is seldom

necessary. In order to get a highly polished surface the stone should finally be rubbed on dry, plain glass, and later on some woollen fabric which will bring up the polish of the stone. The author has found this method of cutting to be perfectly applicable to the hardest oxalate of lime, as well as to the softest phosphatic stones, and even to gall-stones. It is impossible for the stone to fracture. The only case in which any difficulty was ever experienced was one in which a very hard oxalate of lime nucleus was surrounded by a layer of phosphates of very loose formation, around which again was a more dense phosphatic layer. During the sawing of this stone the nucleus worked loose in the centre. The section was, however, satisfactorily completed.

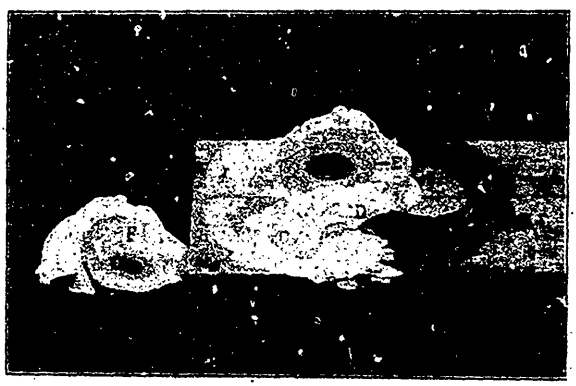

FIG. 2.

An ordinary carpenter's saw with a fair amount of "set" answers admirably. It should have no thickened back, as is found on most surgical saws.

CASE OF UNUSUALLY LARGE CALCULUS.

The specimen used to illustrate the method of cutting described above is a urinary calculus of unusually large size for this era and this country, where stone is not common. Its circumference in the longest diameter is 7¼ inches; in the shorter diameter 5¾ inches. It is of a fairly symmetrical oval shape, being slightly larger at one end than the other and somewhat flattened. Its weight at the time of removal was 6 ounces and 230 grains.

The host was a farmer, Mr. A., otherwise strong and healthy, age 39. He had been the subject of symptoms of stone in the bladder from the age of about 9 years. At times it produced

much pain, but latterly the symptoms had largely subsided, and he really suffered but little. This was explained at the time of operation by the fact that the stone had become partially encysted, and thus was immovable in the bladder.

The calculus was removed by supra-pubic cystotomy on the 1st of June, 1901. On opening the bladder the stone was found with its large end upwards, and its smaller end embedded to a slight extent in the fundus of the bladder behind the prostate. The wound in the bladder wall was made large enough to allow the stone to be removed without undue laceration. After removal the bladder was flushed out and stitched up with two rows of chromicized catgut sutures. The method employed for distending the bladder before operation was that advocated by Greig Smith, viz. by attaching the tube of a reservoir at an elevation of about 2 ft. to a catheter introduced into the bladder, and after stitching up the incision, the bladder was tested for the accuracy of the suturing by allowing it to become distended through the catheter. A tube surrounded by a layer of gauze was used for drainage down to, but not into, the bladder. The patient had no bad symptoms whatever, and the bladder wound healed by first intention, so that at the end of ten days there was no leakage whatever. But shortly after this a very small leakage occurred and persisted for some time, ultimately healing, however, and leaving a good, healthy retentive bladder.

On section the stone proves to have been in the first instance an oxalate of lime calculus. There is a nucleus of very firm, laminated dark brown oxalate about $\frac{1}{8}$ of an inch in diameter and bounded by a very dark crenated line of the same salt. Outside of this is another layer $\frac{3}{8}$ of an inch thick, showing oxalates apparently of very much looser formation with striæ radiating towards the centre. On the outside of this central oxalate portion is a laminated crust varying from half an inch to an inch in thickness extending to the circumference and consisting probably of a mixture of urate of ammonium and phosphates. The X-ray photograph of the stone shows these laminæ most markedly, with various spots which are found on section of the stone to be probably due to the more dense phosphatic substance which is found irregularly distributed between the laminæ.

If we were to attempt to read what Mr. Jonathan Hutchinson calls the "record written in stone" in this case, one might plausibly surmise the following history, which is, of course, in this case the actual one: A lad, from 4 to 7 years of age, suffers habitually from derangement of the digestive organs, with imperfect assimilation. Lateritious deposits are common in his urine in winter, while in summer he suffers from scalding

and burning pain after passing urine indicating excretion of oxalates in excess. By and by he has renal colic and perhaps passes per urethram a few small jagged oxalate of lime calculi. The passage of these calculi is accompanied by blood in gross or microscopic quantities.

One day a stone drops down from the kidney but fails to escape from the bladder, and becomes the nucleus of the specimen in question. It now grows slowly by accretion. The white oxalate crystals absorb the pigments of urine and become brown almost to blackness. It is probable that the blackest part of the specimen consumed 15 or 20 years in its growth; that the looser, more chaotic, radiating layer outside of this formed in another 5 or 6 years; and that the deposits of the layer of urates and phosphates forming the crust, occupied the remainder of the 30 odd years of the life of this calculus. The sprinklings of phosphates throughout the stone may possibly indicate attacks of mild cystitis, calling for rest and resulting in cure. If one should predicate a marked oxalate "diathesis" in this individual, the change from the precipitation of oxalate of lime to the deposit of urates does not indicate a marked diathetic reversal, for Hutchinson points out that "conditions as regards derangement of digestive power similar to those which produce uric acid, may under slight alteration of diet, produce the oxalates" and *vice versa*.

It is an extraordinary fact, as exemplified in this case, that, though the oxalate calculus is rough and very heavy, pain and hemorrhage are not, as a rule, prominent symptoms.

I have spoken of this stone as one of unusual size because it is one of the largest, if not the largest, that has come under my observation in this country as having been removed by operation. Stone is rare in Canada as compared with European and Asiatic countries, and it is but due to the medical profession in Canada to say that when present it is usually discovered and removed before it reaches any such dimensions as this specimen exhibits. But this is a small stone compared to some recorded cases. Hutchinson gives the following as some of the largest removed during life: A stone measuring in girth 16½ x 12½ inches, Utterhavens: Hunter, (Madras) weight 25 ounces; Morrison, (Northumberland) weight 1 pound 6¾ ounces: Sir Henry Thompson, weight 14 ounces, (avoir).

102 COLLEGE ST., TORONTO

CANCER OF THE RECTUM.*

By EDMUND E. KING, M.D., TORONTO.

urgeon St. Michael's Hospital, the Toronto General Hospital, Home for Incurables, the House of Providence.

Cancer of the rectum is a disease which starts insidiously, advances rapidly and surely, not necessarily giving rise to any startling or painful symptoms to call a patient's attention to a most serious malady before it has produced an almost incurable condition. Cancer of the rectum differs in no respect from cancer in general. The widespread ravages of cancer lead only to one goal if neglected, yet are amenable to treatment when recognized early enough. "When early enough" is most likely best defined by saying while it is yet a local disease. After it has spread into the lymphatics, and possibly been deposited in the liver or other distant parts, the chances of cure by operation are materially decreased, yet even comparatively extensive glandular enlargement should not deter us from an attempt at removal as completely as possible. That one can have cancerous disease without pain is in no part of the body more completely verified than in the rectum. That no disease is more distressingly painful during its ultimate course than cancer of the lower gut is equally true. If we can only educate our patients in general to take advice early for piles, if we can only impress upon ourselves the necessity of not neglecting to examine every case of rectal trouble, and not prescribe in a cursory manner for all diseases of the rectum, we will soon arrive at that point where cancer of the rectum will be recognized in the early, local, and curable stage. By a widespread cutting operation, removing all the diseased, and well into the healthy, tissue, it may be entirely cured up to a comparatively late period in its existence. The removal should be complete, yet there is no necessity to sacrifice normal tissue beyond a just sufficiency.

I believe the day is close by when we will not only advocate, but insist upon, the more radical operations being undertaken at a more early period than ever before. Statistics now show results far more favorable than formerly. An operation that may cure, and positively will render the remainder of the patient's life more comfortable is not only justifiable, but is, in my opinion, demanded.

Any operative interference other than that which tends to a complete removal of the growth is only palliative, and in no

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* Read before the Toronto Medical Society, 1900.

sense curative. Palliative operations are often more than justified because they relieve the pain, and allow the end to be more peaceful.

The operation of colotomy in cases of cancer of the rectum has, in my opinion, been performed too frequently at a time when removal of the growth was possible, notwithstanding that the operation of removal of the growth was a very formidable undertaking. The patient is thus debarred from a chance of cure, and permitted to live with the disease progressing to its ultimate fatal end. The operation of colotomy is by no means free from danger, it is *dernier resort*, and should, in my opinion, only be done to relieve distressing symptoms either of obstruction or pain, or both. In recent years a very great change has taken place in the opinion of operating surgeons as to the extent of gut involvement that is removable, and the more radical operations of Kraske and Kocher, with their modifications, have opened up a very wide field, and extended our grasp on the surgery of the rectum beyond the keenest hope of a few years ago. The Kraske operation has been held responsible for many failures which never should have been placed to its discredit. The operation was devised with the hope of obviating the necessity of destroying the normal function of the lower end of the rectum and sphincter in those cases in which the cancer had not already involved their structure. Yet we find report after report speaking of the Kraske, or sacral operation, in which the growth and the whole portion of the healthy gut below, including the sphincter, had been removed, and a sacral anus formed, while there was a large portion of healthy gut and sphincter yet in a normal state. This was not Kraske's original intention, nor his practice.

Possibly my experience has been too small to permit me to criticise those who make their greatest endeavor to remove all the glands that may be found enlarged in the neighborhood of the operation; but, in all my operations, including the cases which I report to-night, I have only removed those glands which came immediately into the field, or were easily detected by the finger, without rummaging about and possibly setting up foci of infection by unnecessarily prodding and poking here and there. I think that the gland enlargement may be due as much to inflammatory irritation as to the direct infection from the malignant growth, and that those glands which are simply enlarged from inflammatory conditions will subside without any malignant development. I am satisfied that there are cases in which it is absolutely impossible to perform any radical operation; but those cases are comparatively few, and it is to be hoped will become fewer.

Michael G., age 67. Family history free from cancer. He has served in the British army in India; had ague. Has never had syphilis. Been a free liver for years, and indulged in intoxicants freely.

In January, 1893, he first noticed a soreness about the anus and extending up the rectum; this rapidly got worse, and free hemorrhage accompanied each movement of the bowels. In April, 1894, he went into Toronto General Hospital, and was operated on twice during a three months' stay, leaving there in June, 1894, with the wound still open. In December, 1894, he came into my service at St. Michael's Hospital, with pain, bleeding, and a growth at the anus extending up the bowel a short distance, less than one inch. I thought it possible to remove the growth without doing a wide operation, but was not successful. The continual passage of feces over the operated area delayed healing, yet he was discharged from the hospital in July, 1894, with a partial control of sphincter. In January, 1895, he was re-admitted with a return of the growth. This time I did a colotomy as a precautionary measure before excising the growth, which was done freely. He was discharged in July, 1895. He was free from any return and comfortable, with a water pad truss, until February, 1897. In July, 1897, there was a growth at the margin of the skin and mucus membrane about $\frac{1}{2} \times \frac{3}{4}$ inch, which looked suspicious; this was removed. On microscopical examination it was found not to be carcinomatous. The continuity of the gut was restored in August, 1898. He has remained free from any recurrence. There is a contracted fibrous ring around the lower bowel opening which acts somewhat in the capacity of a sphincter. He was well and free from any recurrence in January, 1901.

Lizzie McL., age 28. Maternal grandfather had epithelioma of lip, removed, cure; died from other cause many years after. Otherwise, family history good.

When about seven years of age she was hit with a large stone on the hip. This accident was followed by pain and swelling in a few days, which increased in severity. She was confined to bed for a year before she was able to go around. In about six months she was again obliged to lie up, and an abscess developed and broke in the groin. The discharge continued, and one place after another broke down around the hip until there had been four or five sinus openings, one closing before the second would open. She was in bed about a year and a half or two years at this time. The wound on the hip, which had always discharged a little, even while able to go about, healed up for a few months, then her left shoulder broke out and was very sore for some months. Another abscess developed

half way between the hip and the knee. She was so completely depleted that her recovery was dispaired of. She slowly recovered, and her shoulder and hip healed. She maintained fair health for a long time, then her right arm got sore and kept her in bed for three months; was up for three months, then in bed again with the other arm three months. Up again, and had good health in every way until about four years ago, when in January, 1894, she took la grippe, and the hip got bad again and kept getting worse. She went into St. Michael's Hospital in my service.

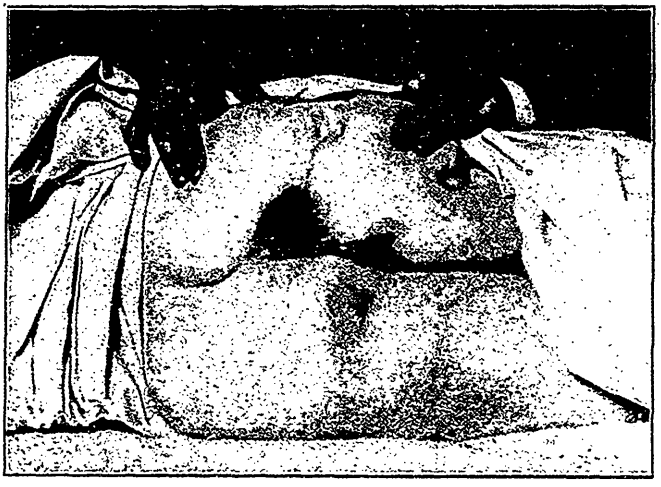
When I first saw her there was a very large fungating mass on the left side involving the anus, extending nearly to the great trochanter, high up in the rectum, involving the labial

wall and the vulvæ. (Fig. 1.) A hard substance was found to project into the bowel throughout the growth, which proved to be part of the coccyx. In all probability this irritation was the exciting cause of the growth taking on a malignant character in the rectum. The operation was most formidable and the mass of tissue removed enormous. The greater and lesser sciatic notches were exposed, and a large area had to be left to granulate. She made a slow but uneventful recovery, and gained flesh rapidly. A small recurrence was removed during the first year, but otherwise she remained free from recurrence. The condition after the second operation is well seen in the illustration (Fig. 2). The urine always contained some albumin and about the time of the second operation she developed uremic symptoms, with convulsions and blindness. These symptoms

were by free bleeding and treatment, since which time she has been able to get about and do light work without recurrence of cancer, but a marked victim of Bright's disease.

Mrs. C., age 74, Scotch. Family history good, free from cancer.

She had the usual diseases of childhood. Menstruation began at the age of 14. She had several attacks of inflammatory rheumatism, with many joint involvements, before she was 25. Family, three children and one miscarriage. Always suffered from obstinate constipation. At the age of 68 she had a severe fall, falling down thirteen steps and bruising herself in the glutial region very badly. In April of the succeeding year she developed severe pain over the left iliac region and lower



part of spine; a great tenderness over the left side from rib to ilieum, tenesmus was very distressing. This was relieved by something breaking in the bowel, followed by a free discharge of pus. She at once took advice. A cauliflower growth was found in rectum and immediate operation advised. She was admitted to Toronto General Hospital, April 15th, and operated on by one of the staff. A portion of the lower bowel and anus was removed (said to be $\frac{1}{2}$ x 2 inches). She made a good recovery, with loss of pain and tenesmus for over one year, although stools passed involuntarily. In July she was admitted to the Home for Incurables for recurrence of the cancer, and came under my care. On examination I advised another operation, which she acquiesced in. The recurrence was removed and patient did well, but in three months a

growth was found at edge of anus and removed; this, on examination, proved not to be cancerous. In December, 1897, there was undoubted recurrence in the bowel, and a third operation performed, removing a large area of the posterior wall of the rectum. The peritoneum was opened but the recovery was uninterrupted. The growth recurred in the skin and spread to the valvæ, but as you will see the bowel is free from any recurrence. (Specimen shown.) If more skin had been removed at the time of the last operation it is quite possible that the recurrence would not have occurred. It is very satisfactory to note, however, that the bowel is entirely free from any involvement in the recurrence.

John K., age 56. Father died, age 90, mother over 80. Grandparents on both sides died of old age. One sister lived to be 58 years of age, in good health. Two brothers died in childhood, and one brother living. Patient never had any serious illness, although when following his trade as shoemaker he always complained of severe pain over the sacrum. About ten years ago he had what he terms weak spells, which came over him whenever he did any heavy li ting. There was no trouble with the stomach or bowels until about eighteen months ago. In 1898 he noticed that large quantities of blood passed with each evacuation of the bowels. This he attributed to piles, and took no advice upon the matter. In August, 1899, he first took advice, when the serious nature of his trouble was recognized, and he came under my care in September of the same year. I operated on October 11th, for the removal of a cancerous growth involving the anus and lower 3½ inches of the bowel.

The Operation.—After making an incision around the anus, and following up the growth, it was found that it would be necessary to extend the incision; this was done along the median line and the coccyx removed. After getting well above the growth it was excised and the gut brought down and sutured to the upper angle of the incision. On December 5th, a granulating, suspicious-looking mass was noted at the upper end of the wound, involving the skin and mucous membrane junction. It was feared this was a recurrence, and on the same date I excised this area. On microscopical examination it proved not to be a recurrence but a granulating mass.

[NOTE.—In October, 1901, I endeavored to secure for the patient some control over the bowel movement by twisting the rectum. The adhesion made the dissection difficult, but I succeeded in releasing the gut and making nearly a complete turn. The wound healed nicely, but it is too early to speak of results.]

Mrs. C., age 54. Nothing special in family history. Married

at the age of 24. Has had two children, living and healthy, confinement normal. Menopause complete at 43. Six years ago had nervous prostration with catarrh of mucous membrane throughout the intestinal tract. She had generally suffered from constipation, but was regular for some months previous to passages being accompanied by blood, the latter condition being preceded by days of continual backache. Natural discharge of bowels became fragmentary and finally obstructed. She gradually lost flesh and strength, and sought advice believing that her malady was of a more serious nature than she had thought. I saw her in consultation with Dr. B. Field in the latter part of September, and advised an immediate operation, which was agreed to. The condition was found on examination not to involve the sphincter, nor the lower three inches of the rectum. Pretty nearly as high as the finger could reach, without chloroform, there was an annular constriction of the bowel, hard and irregular, in the posterior portion of which was situated a small opening. It was possible to pass the finger tip only into this opening, and impossible to feel the upper end of the growth. One could make out that the growth was movable, also it presented the idea that it did not involve many inches of the gut. By palpitation from above through the abdominal wall, I was satisfied that the growth did not extend to the pelvic brim. Below the growth there was a great ballooning of the bowel. Her general condition was one of marked cachexia and considerable emaciation.

The operation, a modification of the Kraske incision, was done and the whole rectal tube freed, when it was found that the growth was about 3½ inches long, its lower border beginning three inches from the sphincter and involving the whole circumference of the rectum. The bowel was shut off above and below the growth by clamp, and the intervening portion excised. The weakened condition of the patient's pulse at this point was such that we abandoned our original idea of suturing the walls of the intestine, and we resorted to Murphy's button. There are two varieties of buttons, good and bad, as Dr. Murphy very aptly pointed out when he was in Toronto two years ago. Unfortunately, in the button that we used the spring was weakened. There was no trouble in adjusting the button and approximating the ends of the gut and closing the large sacral wound, leaving drainage above and below. The anterior and lateral walls of the gut united well, but the button lost its grasp at the posterior wall, and at this point it failed to unite. A small fistula still exists. This has since entirely closed. The large wound became infected, although not so much as one would anticipate, and was slow in healing. There was nothing to note particularly in her subsequent

recovery, which she made slowly but well. I examined her yesterday, that is the 21st January, a very short period undoubtedly after the operation, but I am very gratified to report that there is at present no evidence of any recurrence of the growth. There exists, at the point of union, however, a projection from the anterior wall of the gut like a curtain or valve (a reduplication) that is acting as a barrier to the free movement of the bowels. The force from the sacral curve is expended against the upper portion of this valve, and consequently the stream does not pass along the canal freely. The lumen of the gut at this portion will admit my thumb, and is to-day more patulous than when she left the hospital in December.

She speaks of a peculiar condition, and says that she feels as if there existed two ani; and she has an anesthetic area in the rectum which appears to be equal approximately to the removed portion. She has normal control over the bowel movements. The sensation of having evacuated the bowel completely is experienced before the act of defectation is complete. The passage of feces over the anesthetic area producing no sensation, the act is considered complete; but as soon as these feces reach the sensation area below a second desire is produced, followed by movement.

In making a report of the foregoing cases, I have endeavored to show the true conditions as they have presented themselves. The frequent repetition of operations may, to some minds, militate against the advisability of the procedure, but when we look at the results, I am satisfied that the operations were more than justifiable. I believe that we will learn to cut wider as our experience widens, and that in the future we will have fewer recurrences. In these cases, if a cure cannot be attained, the relief from pain, nauseating odors, and other distressing symptoms, are sufficient to justify us in operative interference. In many cases in which cure is not possible, but relief from symptoms is probable, I am satisfied that the procedure should be undertaken, and the period of extended life made more bearable. We must pay more attention to rectal cases; we must examine them more thoroughly and earlier, and just as soon as the diagnosis is made, operate—remove the disease freely. The late discovery of rectal cancer is a blot on the reputation of some physician, and I believe in the future, if we make our examinations earlier and more thorough, that these blots will be fewer and further between.

61 QUEEN ST. EAST, TORONTO.

PELVIC LESIONS IN RELATION TO THEIR DISTINCTIVE EFFECTS UPON MENTAL DISTURBANCES.

By A. T. HOBBS, M.D., London, Ont.

The gradual evolution of the treatment of the insane unfolds factors in etiology that hitherto were unsuspected or given but little credence to as possible disturbers, either directly or indirectly, of the mental equilibrium of the sane. The surgical treatment of organic disease in patients mentally deranged was followed by mental phenomena so marked that the inference was reached that there must exist a relationship between certain physical lesions and mental disease, as the removal of the former was succeeded by an improvement or subsistence of the latter. This occurred so frequently that it could not be dismissed as mere coincidence, but it positively determined that these bodily lesions were in themselves responsible for the initiation or maintenance of insanity *per se*.

Until within recent years female lunatics received precisely the same attention and treatment as that accorded to male lunatics. That insane females possessed either an ovary or a uterus was either overlooked or ignored, and the possibility of either of these sequestered organs being grossly diseased seems never to have been contemplated by those into whose charge was committed the care of the insane. In explanation it must be said that without close observation or systematic gynecological investigation it was practically impossible to definitely state that pelvic disease existed, much less could be diagnosed in a female lunatic. For this reason, and because of the woman's mental infirmity, with its accompanying delusion, or mania, or stupor, or dementia, which rendered her unable to rationally complain of physical distress as would a sane woman, it was hard to convince the majority of alienists that 15 or 20, or 25 per cent. of all insane women were suffering from one or more pathological lesions of the organs of the reproductive system.

A consideration of the statistics of institutions devoted to the care of the insane will show, by comparison of sexes and of their civil state, that among their lunatic populations there are more single than married men, and more married than single women. Why is there this preponderance of the single in the one sex and of the married in the other? The solution

of this, I believe, is that single men lead more irregular lives than married men, and as a result are more liable to dissipations and exposures leading up to disease with subsequent mental as well as physical collapse; also that married women preponderate over the single of their sex, owing to their liability to injury and disease entailed by maternity, with its sequence of ill-health and nerve depreciation, ending up so frequently in mental degeneration. That this is true, as experience has shown, should it not emphasize the necessity of a systematic examination of at least all married female insane when under treatment to determine the presence or absence of gynecic complication, whether the patients are residents or not of institutions or sanitariums?

The result of pelvic examination of a large proportion of the female population at the Asylum for Insane, London, disclosed at least the presence of organic disease or abnormalities in 25 per cent.

The gynecological examinations were uniformly conducted with the aid of an anesthetic. Experience has taught us that the most suitable and reliable anesthetic for the insane was ether, preceded by the inhalation of nitrous oxide gas. This is the only method of any value of arriving at a proper diagnosis of the existence and nature of disease of the pelvic organs among the female insane.

As a result of these investigations it was found that 253 out of 1,000 females who were residents of the institution during the past six years had some pelvic disease or abnormality that needed gynecological treatment. Medical and other treatment only temporized with these lesions, and was found difficult to carry out and non-productive of result. The only success obtained in combatting these diseases was that obtained through surgical means.

The surgical methods employed were those that are in daily use by all reputable surgeons for treatment of similar lesions in the sane. Many a patient required two or more operations to complete the treatment in her case.

To ascertain the proper value of the results succeeding the removal of the different lesions, the cases will be classified into groups, the principal gynecological lesion in each patient determining the position in the classification.

I. Ovarian Disease.

The total number of cases who received treatment for disease of the ovaries and tubes was 41. The treatment in each necessarily varied according to the disease or the complication present. To accomplish this it was found necessary to perform in

seven, hysterectomies—four by the abdominal route and three per vaginam; in 25 cases single or double oöphorectomy was done, and in the remaining nine a part of one or both ovaries was preserved after removal of the diseased portions. Following these operations for ovarian disease there occurred two deaths, or 5 per cent., both dying of complicating pneumonia, one on the seventh and the other on the twelfth day after operation. Good physical recoveries resulted in the remaining 39, or 95 per cent.

The subsequent mental history in the 39 patients who survived the operation was very good. The time of mental recovery varied from three months to one year.

The mental classification is summarized as follows:

	Cases.	Recoveries.
Acute mania	11	7
Chronic mania	23	9
Epileptic mania	2	0
Folie Circularie	2	1
Psychocoma	1	1
Acute melancholia	3	2

This gives a total of 20 recoveries, or 49 per cent. The duration of the insanity in these 20 averaged eighteen months. Over and above this there were 10 patients, or 25 per cent., who showed a distinct mental improvement, although the average length of insanity in these 10 exceeded three years.

The history of these ovarian cases disclosed heredity in 16, or 39 per cent. From this it will be seen that the introduction of modern surgery immensely benefited 30 women, representing 73 per cent. of the ovarian cases, by the reduction of disease tissue or of the removal of the entire organ whenever found necessary.

II. Abnormal Displaced Uteri.

It was found on examination of 66 patients that the main lesion presented was a displaced uterus. The abnormal position of this organ varied from simple retroversion to complete procidentia. To correct the pathological positions of this organ it was found necessary to shorten the round ligaments in 54 patients, to suspend the uterus perventrum in 7, as well as to perform total extirpation in 7 others where the procidentia was complete.

These patients did not all do well, as death succeeded operation in two, one dying from secondary hemorrhage induced by the patient pulling out the ligatures, and the other from bedsores two months after treatment. Both of these occurred after vaginal hysterectomy.

A synopsis of the mental condition and recovery rate of these 66 patients is tabulated below.

	Cases.	Recoveries.
Acute mania	20	15
Chronic mania	22	3
Epileptic mania	1	0
Puerperal mania	7	4
Acute melancholia	9	5
Chronic melancholia	1	1

From this table it will be seen that the mental condition was restored in 28, or 42 per cent., with an average duration of insanity of 1 year and 10 months. Besides these recoveries, in 15 others, or 23 per cent., the mental condition was more or less improved after correcting the displaced organ. This makes a total of 43 patients, or 65 per cent., whose condition both physically and mentally responded to proper treatment. Of these 66 cases, who had a mal-position of the uterus, it was found that 32, or 48 per cent., were tainted by hereditary insanity.

III. Tumors, Malignant and Benign.

Gynecological examination of 16 insane women disclosed as a complication of their insanity an acquired growth. Of these 9 had fibroid tumors of the uterus, 2 showed cervical epitheliomas, 1 a sarcoma of the body of the uterus, 2 had tuberculous disease of the pelvic organs, and 2 had inflammatory deposits in and around the uterus. For the treatment of these foreign bodies there were performed 8 abdominal hysterectomies, 1 vaginal hysterectomy, 1 myomectomy, and 3 celiotomies, with use of saline lavage in the tubercular cases.

Following operation in these 16 patients there resulted 1 death from exhaustion on the third day. The other 15, however, made good physical recoveries.

As to the mental features and number of recoveries, the accompanying table will show:

	Cases.	Recoveries.
Acute mania	1	1
Chronic mania	11	1
Epileptic mania	1	0
Chronic melancholia	3	0

It will be seen by this analysis that only 2, or 12 per cent., recovered their reason subsequent to the removal of these physical lesions The average duration of insanity in these 2 recoveries prior to operation was three years. There were 6 others, representing 37 per cent., whose mental status was improved. These latter, however, showed an average duration of insanity of over 5 years. Only 3 out of the 16, or 19 per cent., disclosed any heredity.

IV. Diseases or Injuries of Uterine Cervices.

In 60 patients the main lesion which demanded surgical relief was a diseased or injured cervix. Nearly all of these cases were complicated by either a sub-involuted uterus or an endometritis. In 19 of these 60 cases there was in addition to the cervical lesion a complete or incomplete tear of the perineum. For the necessary relief of the diseased cervices there was carried out 52 amputations, 5 trachelorrhaphies, and 3 underwent treatment by the method described by Dudley for the relief of stenosis of the internal os. Restoration to bodily health occurred in all. The accompanying table shows the mental state, and the recovery rate of these 60 patients is appended.

	Cases.	Recoveries.
Acute mania	17	12
Chronic mania	30	5
Puerperal mania	3	0
Epileptic mania	1	0
Folie circularie	2	0
Chronic melancholia	3	1
Acute melancholia	4	0

Following uterine and cervical treatment there was complete mental relief in 19, or 31 per cent. These showed an average insanity duration of 15 months. Besides these recoveries 14 others, or 23 per cent., improved mentally. A history of heredity in these cervical cases complicated 21, or 35 per cent., of the whole number.

V. Diseases of the Uterine Body or its Lining Membrane.

On examination of 52 patients it was deemed necessary to curette for the reduction of a sub-involuted uterus, or the correction of an endometritis. Some of these when under previous observation were noted as being menorrhagic, or were suffering from dysmenorrhea. All these patients so treated improved in physical health. The mental results were as follows:

	Cases.	Recoveries.
Acute mania	23	14
Chronic mania	15	1
Puerperal mania	3	2
Acute melancholia	5	3
Chronic melancholia	4	3
Puerperal melancholia	2	2

From this table it will be seen that the mental recovery rate was 25, or 48 per cent., and their average length of insanity was 10 months. Besides this, 11, or 21 per cent., showed mental improvement, their insanity averaging 3½ years.

The question of heredity showed itself in the histories of 15, or 29 per cent., of the 52 patients so treated.

VI. Injuries to the Perineal Body.

Lacerations of the perineum of all degrees, accompanied by varying prolapse of the vaginal walls, was found to be the main lesion in 18 patients. Most of these cases had also to some extent sub-involution of the uterus, which was corrected at the same time as the repair of the trauma to the perineum. The surgical treatment benefited these patients materially, as was observed by the rapid improvement in general health and subsequent mental tone. The classification of the mental disease and subsequent history of these 18 cases was as follows:

	Cases.	Recoveries.
Acute mania	6	2
Chronic mania	4	0
Puerperal mania	2	1
Acute melancholia	4	3
Chronic melancholia	2	1

This summary shows that 7, or 39 per cent., recovered mentally, succeeding the restoration of the injured perineum, and complications. The average duration of their insanity was only 9 months. Of the others, 3, or 17 per cent., improved whose duration of mental enfeeblement exceeded 9 years. Heredity complicated only 4, or 22 per cent., of these 18 perineal cases.

It is necessary to state that the six divisions as given are somewhat imperfect, as often an ovarian case was complicated by a displaced uterus, or a displaced uterus had in addition a lacerated or diseased cervix, or a diseased cervix was often accompanied by a tear of the perineum. A more limited classification may be devised by taking the ovarian lesions as one, the uterine displacements and diseases of the body and cervix together as a second, the injuries of the perineum as a third, and the tumors as a fourth class. This arrangement will summarize as follows: Of ovarian disease there were 41 cases, with 20, or 49 per cent., recoveries; of uterine lesions there were 178 cases, with 72, or 40 per cent., recoveries; of injuries to the vaginal outlet there were 18 cases, with 7, or 39 per cent., recoveries, and there were new growths in 16 cases, with 2, or 12 per cent., recoveries. From this division it will be noted that the pelvic lesions having the greatest effect upon mental alienation were those in which there existed changes in the ovarian structure causing an interference with ovarian function. The next most potent pelvic factor was disease of uterus, and third most important was injury to the via vaginalis, while fourth and last new growths did not seem to disturb mental stability except in a small percentage of cases.

Two simple divisions may be made of the whole number by grouping together all ovarian and uterine lesions as inflamma-

tory. This will show that out of 209 cases supposedly inflammatory that 92, or 42 per cent., returned to their normal mental state. Then group all the remainder, including new growths and injuries to the perineum as non-inflammatory, and these will make a total of 34 cases with a recovery rate of only 9, or 26 per cent.

An epitome of the various mental diseases which were the main lesions in the 253 patients illustrates briefly the phases of lunacy that were the most susceptible to alleviation on the removal of gynecic sources of irritation.

The acute insanities were naturally the most amenable mentally to favorable treatment of pelvic ailments as the post-operative results already given have shown. In the acute mental affections the recoveries from mania took the lead with a percentage of 61, then followed melancholia with 58 per cent. of recoveries, and puerperal insanity the last, with 53 per cent.

In the chronic class melancholia yielded much better results to surgical treatment than mania, there being 46 per cent. recoveries in the former to 25 per cent. recoveries of the latter.

Of the four cases of folie circularie, or circular insanity, only 1, or 25 per cent., was mentally restored.

Finally, of the 5 patients treated by these surgical methods 91 were complicated by a hereditary tendency, or a percentage of 36.

In the former presentations of this work before medical societies some doubt was expressed as to the correctness of previous similar statistics and we were said to be ultra-enthusiasts in this gynecological work. It was claimed that "we looked for disease and found it." In addition to this there were some who endeavored through their criticisms to imply that we were guilty of unnecessary surgical interference.

These criticisms go beyond the rubicon of legitimate argument and tend to cast odium upon the work that was done.

Regarding the want of faith in our statistics, I desire to place on record the following facts, which will confirm in a great measure the figures and deductions already given in detail.

For the past 30 years annual reports were presented to the Provincial Government of all official statistics in connection with the varying movements of the population of London Asylum. These statistics are substantially correct and are subject to government periodical supervision. The official records show that for the bi-quintennial period previous to the introduction of systematic surgical treatment the average annual rate of discharges of patients recovered and improved calculated upon the admissions, was for the male residents 35, 23 per cent., and for the female 37.5 per cent.

For the third quintennial period, during which gynecological

surgery was in vogue in addition to the ordinary methods of treatment, it was found that the annual rate of discharges among the men differed very little from that of the previous two quintennial periods, being 35.92 per cent. It was discovered, however, that the women during the third quintennial period had advanced from 37.5 per cent., the average of the previous 10 years, to 52.7 per cent., or a gain in the discharge rate among the women of 35 per cent. This was certainly due to the surgical treatment of pelvic disease which existed so largely among the female population, as the other methods of combatting disease were practically the same as in previous years. An official analysis was also made concerning the number of re-admissions of those who had been discharged during this third quintennial period. It was found that although many more women had been discharged than men the number of re-admissions were the same for each sex, being 19 women and 19 men. This undoubtedly verifies the stability of the mental cases who recovered after the removal of complicating utero-ovarian disease, and still further qualifies the assertion that these diseases play an important part in the etiology of insane women.

The charge that unnecessary surgical interference had been done in these cases is absurd as well as untrue, as prior to operation the patient's family physician was consulted and asked to be present at each operation. This invitation was often accepted and unqualified approval of the work done was uniformly expressed by these visiting physicians. In addition to this the written consent of the nearest relative was always obtained to even the most minor of operations. These were some of the safeguards which surrounded these patients from unnecessary surgical interference.

The value of gynecological, as compared with general, surgery is proved by the results obtained after operations for the radical cure of hernia. In 39 patients of both sexes who were afflicted with either a ventral, umbilical, inguinal, or femoral hernia, a radical cure was attempted, and I am pleased to say with almost uniform success as regards the obliteration of this physical lesion. The mental results succeeding the operation for hernias were almost *nil*, as no mental recovery occurred, although decided improvement in the general tone of these patients was observed.

In conclusion, let me say that there should be no doubt in the minds of physicians—general and special—as to the benefits that would accrue from the introduction and proper observance of aseptic gynecological surgery in institutions devoted to the care of the insane. Also that the state should see that its wards are properly safeguarded against unnecessary operations, such as the removal of normal ovaries for their possible effect

upon a disturbed mental condition. That this has been done occasionally by surgeons I have reason to know, and the results have been decidedly harmful not only to the patients but to the establishment of gynecology as one of the regular methods that should be employed in institutions where so many women are incarcerated, and who, without the aid that gynecology can give, are doomed to suffer untold misery as long as their existence endures.

Selected Articles.

GASTROPTOSIS.

By ALEXANDER McPHEDRAN, M.D.,
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This condition is so frequently encountered and is in many cases accompanied by such marked discomfort that its consideration is of much importance. With the displacement of the stomach there is also always displacement of some of the other viscera, sometimes of all of them, general splanchnoptosis. It occurs at all ages and in both sexes. In a boy of 7, examined since January 1, 1901, the greater curvature of the stomach was a little below the umbilicus, and the right kidney could be easily palpated during inspiration. He was rather anemic, had an irregular appetite, and was not vigorous. In his case the position of the stomach may have been congenital.

In regard to gastroptosis two errors are common: first, the opinion that the condition is infrequent; and second, that when it does exist, it must necessarily give rise to grave disturbance, and form part of that medley of symptoms known as Glénard's disease. That the condition is very common any one can verify for himself by careful examination of patients presenting symptoms of malassimilation with or without digestive disturbances. Not infrequently, ptosis of the stomach is met in persons presenting no such symptoms, just as many persons have prolapsed kidney without any discomfort arising therefrom.

The symptoms may be local or general, or, more commonly, both combined. Local symptoms arise from digestive disturbances, especially from gastric motor insufficiency with consequent prolonged lodgment of food in the stomach. In most of these cases there is also excessive secretion of HCl, causing epigastric distress, acidity, flatulence, and general depression. These symptoms may be very slight in degree or they may be severe, at times causing much distress. In these cases relief is obtained by stimulating gastric peristalsis, so that the stomach is emptied before each recurring meal; by suiting the diet both as to quality and quantity to the powers of the stomach; and endeavoring by means of massage, exercises, suitable medicines and hygienic conditions, to restore the stomach, as well as the general physical state, to a normal

condition of function. The following case may be briefly cited to illustrate these statements:

M. E. S., aged 51, five feet eight inches in height, but only weighing 128 pounds, had been ailing for some years with epigastric distress, flatulence, debility, irregular appetite and constipation. Five hours after a light breakfast "splash" was easily demonstrated in the epigastrium. The tube was passed and five ounces of grumous material containing pieces of white-of-egg and remains of bread were removed from the stomach. The stomach was inflated and the lesser curvative found to lie below the umbilicus HCl was present but in deficient quantity. The right kidney was easily palpable. The abdomen was almost flat so that an abdominal support would be of little use. His diet was restricted to one egg and a piece of toast for breakfast, a glass of warm milk at 11 o'clock, a little tender meat, or fish, and one vegetable for luncheon, a cup of soup or fluid beef at 5 o'clock, and a dinner at 7 o'clock similar to the luncheon. The abdomen was well massaged morning and night after the patient drank a glass of hot water. This was followed by systematic exercise of all parts of the body, and especially of the abdomen. Strontium bromid was given before meals and strychnin with some antiseptic such as resorcin, bismuth naphtholate, sodium salicylate, etc., after meals. As soon as the epigastric distress was relieved dilute hydrochloric acid was substituted for the bromid. He improved satisfactorily, and in a few months his weight was 150 pounds. The lesser curvature of the stomach was raised somewhat above the umbilicus, but care as to diet was necessary to prevent retention of food in the stomach, as shown by the splash.

When constitutional symptoms are marked, the condition is really one of neurasthenia with symptoms of digestive disturbances predominating. In the treatment of these cases the patience of both patient and physician is certain to be taxed. The treatment is that of neurasthenia, plus such measures as are necessary to correct the digestive derangement. The latter can often be overcome and the digestive function restored to a fair degree of efficiency long before the symptoms referred to the stomach are relieved, or the general neurasthenic condition materially improved.

It is usual to direct a well fitting abdominal support for such cases; if the abdomen is prominent, in which condition the walls are relaxed, such a support does good, and in many gives a great sense of relief. It supports the abdominal contents and tends to prevent further prolapse. In many cases, however, the abdomen is flat, or even retracted. In these a support is of little, if any, service. In fact, in a number of

cases it proves irksome. In all cases, probably massage and suitable exercises of the abdominal muscles constitute the most effective means to relieve the symptoms and restore the stomach to healthy function. By these means the circulation in the abdominal viscera is improved and peristalsis stimulated, consequently renal excretion is increased and the processes of digestion and assimilation improved.

The prognosis in gastroptosis is fairly illustrated by the following case:

J. R., aged 27, a draughtsman. Last autumn he was very neurasthenic from overwork, and was thin, anemic and much depressed. The stomach was prolapsed so that the greater curvature was three inches below the umbilicus, as shown both by the gastrodiaphane and inflation. There was a moderate degree of hyperacidity. The treatment consisted in a regulated diet similar to that directed for M. E. S., massage exercises, out-door life without fatigue, and strychnine with antiseptics after meals. He worked hard all winter supervising the repairs of an electric road. On examination this spring the stomach was found to be above the umbilicus and its digestive power much improved. His general condition is good, although he remains thin.

The following conclusions may be offered:

1. Gastroptosis frequently exists without giving rise to any discomfort. So long as the functions of the stomach are performed efficiently no symptoms will arise from its abnormal position.

2. The symptoms of gastroptosis are due to the protracted retention and composition of food in the stomach with the local irritation and constitutional poisoning resulting therefrom.

3. In the condition known as Glénard's disease the gastroptosis or splanchnoptosis plays only a part, often a minor one, in the production of the symptom-group. In not a few instances the splanchnoptosis is rather the result than the cause of the condition.—*Abstract American Medicine.*

THE TREATMENT OF NASAL CATARRH BY THE GENERAL PRACTITIONER.*

By EUGENE C. UNDERWOOD, M.D.,
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I have long entertained the view that the general medical practitioner neglects to treat his patients for catarrh and sends them to a specialist when he could successfully manage these himself. In fact, the treatment of catarrh is very simple and the results which follow correct and systematic treatment are very satisfactory. In practice, two forms of chronic nasal catarrh are met. These are hypertrophic rhinitis and atrophic rhinitis.

The hypertrophic form is more generally seen, and is characterized by a thick mucous discharge from the nose, great liability to colds, obstruction of one or both nostrils, which forces the patient to breathe through his mouth, nasal intonation of the voice. There is more or less headache and the sense of smell is lost or impaired. There is dryness of the throat, deafness and other symptoms showing the extension of the disease to neighboring organs. Exostosis of the osseous structures often is seen.

Atrophic rhinitis (ozena) is characterized by a sense of dryness in the nose and throat, a thick, purulent discharge and the expulsion of discolored crusts and an offensive putrid odor. The sense of smell is impaired and the patient is weak and anemic.

The mucous membrane is dry and glazed, but in advanced cases ulceration and necrosis are present.

The treatment consists of applications directly to the diseased area and the administration of such internal remedies as will correct any co-existing disease or morbid state. In some cases where there is occlusion by exostosis the resources of surgery must be invoked.

Let me examine more in detail the treatment of the types of nasal catarrh.

In simple chronic hypertrophic rhinitis the results of treatment will be most flattering. In a case attended with no constitutional disease nothing is necessary beyond having the patient spray the nasal mucous surface with a solution composed of equal parts of water and hydrozone every three hours.

If the case has persisted some time and the patient has an amount of mucous discharge, I have him take twenty drops

* Abstract from St. Louis *Medical and Surgical Journal*.

of balsam of copaiba four times daily. The hydrozone is not only a disinfectant and germicide, but its curative action on the inflamed mucous membranes is speedy and is not equalled by any other drug I have ever used. When the patient is anemic I have him take iron, and any other drug is used when it is called for by any associated disease or morbid condition, but the hydrozone spray is used in all cases.

In the atrophic variety we shall have to use the same local application. The hydrozone at once overcomes the offensive odor and takes off the purulent crusts.

These cases must be treated with cod liver oil, iron and such other remedies as will bring up the general health.

Here are a few clinical histories:

Mr. R. H. M., aged 60, had been a sufferer for two years. There was no exostosis, but when he had a cold he could breathe only through his mouth. He was in good general health, so I had him buy an atomizer and use a spray composed of equal parts of distilled water and hydrozone. He sprayed the mucous surface of the nose every three hours. On this he made rapid improvement and in three weeks had no further symptoms.

S. M. T., age 18, had chronic hypertrophic nasal catarrh in which the mucous discharge was very abundant, and this was associated with dryness of the throat and constant desire to hawk and spit. She used the hydrozone and water spray, and took fifteen drops of balsam copaiba three times daily. I had the pleasure of seeing this young woman go along to complete recovery in a period of six weeks.

Mrs. R. J. C., age 49. This lady had atrophic rhinitis and as soon as she came near you the putrid odor asserted itself. Her general health was lowered. I had her use the hydrozone and water spray, and take cod liver oil internally. She spent last winter in Cuba, and has just gotten home greatly improved in general health and her catarrhal disease is better.

She says the spray effectually destroys the disgusting odor and that scarcely any discharge now appears.

I expect to see this patient entirely well in several months.

THE TREATMENT OF SYPHILIS, WITH SPECIAL REFERENCE TO THE BEST METHODS OF ADMINISTERING MERCURY.*

By WINFIELD AYRES, M.D.,

Genito-Urinary Surgeon, Bellevue Hospital, O.D.P., New York; Instructor in Genito-Urinary Diseases in New York University and Bellevue Hospital Medical College; Instructor in Genito-Urinary Diseases in the New York Post-Graduate Hospital, etc.

The author calls to mind the fact that mercury has been used in the treatment of syphilis for over 400 years, and there are few physicians to-day who do not use it in some form. Although the method of treatment with mercury is still discussed, he is firmly of the opinion that there is no hope of eradicating the disease unless the full dose is given constantly for something like three years. The treatment should begin just as soon as the diagnosis can be made. There is no ground for supposing that enucleation of the chancre has the effect of aborting the disease. If a positive diagnosis cannot be made from the appearance of the initial lesion, general tonic treatment should be instituted.

In some cases the protiodide controls the symptoms, but in the majority it is of very little use. Experiments with mercurol were conducted at Bellevue Hospital for eight and a half months, with 180 cases; the histories of ninety-five of these are recorded. The remainder could not be kept under observation, and are therefore passed over. The dosage of the mercurol, regulated either by reaching the point of tolerance or control of the disease, varied from one half to six grains. In sixty-four of the ninety-five cases the disease was controlled as follows: In two weeks, eight; three weeks, twelve; four weeks, fourteen; five weeks, six; six weeks, five; seven weeks, two; two months, eight; ten weeks, two; three months, five; and four months, one. The remainder are marked thus: decidedly improved, seventeen; improved, eight; no improvement in two weeks, three; no improvement in four weeks, one; and no improvement in three months, two. The latter were all dispensary patients and it is uncertain whether they took their medicine regularly.

The writer states that his plan was to increase the dose steadily from one grain until the symptoms were controlled, or until there was a slight tendency on the part of the teeth and gums to become tender. If the symptoms were not controlled before the physiological effect of the mercurol made itself felt,

* Abstract of an original paper by the author, in *The Lancet* (London, Eng October 19th, 1901.

small doses of potassium iodide were added, and in every case where the mercurol was taken according to directions, with the exceptions noted above, the symptoms were controlled.

In sixty-seven out of the ninety-five cases tabulated, no other medicine than mercurol was given. In fifteen out of the remaining twenty-eight, the addition of iodide of potassium was found to be sufficient to control the disease, while in six others the addition of an iron tonic sufficed for this purpose.

The cases are not reported at length, but a few of the more remarkable results and some cases in which other medicines failed to control the disease are briefly mentioned.

Case 1 had been taking bichloride for one month with very little improvement. Under mercurol, three grains maximum dosage, the symptoms were under control in five weeks.

Case 2 had been under biniodide of mercury (one-sixteenth of a grain) and potassium iodide (five grains), which caused iodism. His symptoms were controlled in one month under half a grain of mercurol.

In Case 3 unguentum hydrargyri had failed to control the disease. The patient was put on mercurol and the dosage pushed up to six grains three times a day. The disease was thoroughly under control in seven weeks.

Case 4 had been on three-eighths of a grain of biniodide of mercury and twenty grains of potassium iodide for two months. The medicine caused nausea and vomiting. Having been put on mercurol and the dosage gradually increased to five grains three times a day, the symptoms were controlled in three weeks.

Case 5 had been taking hydrargyrum bichloride (one-twelfth of a grain) three times a day, under which an eruption on his face had faded, but the eruption on his body still persisted. His symptoms disappeared in two weeks under a maximum dose of three grains of mercurol three times a day.

Case 6 had been on bichloride of mercury (three-sixteenths of a grain) for three months, in spite of which he had palmar syphilide of an eczematous variety. All appearances of the disease disappeared after he had been one month on mercurol, his maximum dose being three grains three times a day.

Case 7 had been taking one-quarter of a grain of mercurol and fifteen grains of potassium iodide, with the result that the eruption had decidedly improved, though not to the extent that it should have done. There were thickened red patches on the face, covered with scaly eruptions. The symptoms almost entirely disappeared within three weeks under a maximum dosage of five grains of mercurol three times a day and fifteen grains of potassium iodide.

Case 8 had been treated with inunctions of mercury, under

which the eruptions disappeared, but the pains in the bones still persisted. He was relieved in three weeks under a maximum dosage of four grains of mercurol three times a day.

Case 9 had been taking other forms of mercury for six months. The form which had done him most good was bichloride. Yet one-fifth of a grain did not entirely control the disease. He had been taking that for two months when he was placed on mercurol. The dosage in his case was pushed up to six grains three times a day, and at the end of seven weeks all his symptoms had disappeared.

Case 10 had been taking medicine off and on for two years, but his symptoms never disappeared entirely. After being two weeks on mercurol (two grains three times a day) with the addition of potassium iodide, all symptoms had disappeared.

Ayres, in conclusion, states that he uses mercurol in his private practice to the exclusion of all other drugs. His experience is that he gets better results. He has found no form in which mercury can be given with such good results as in that of mercurol.

Women in Medicine.

Two important historical works have recently been published in Paris on this subject, one by Melanie Lipinska, and the other by Marcel Baudouin. The latter was undertaken in honor of the semi-centennial of the admission of Elizabeth Blackwell to the medical profession, January 23rd, 1849. Woman's progress during the last decade has been remarkable. In Russia there has long been complete equality between men and women physicians, and women have recently won their cause in Hungary, Austria and Germany, and the prejudices against the admission of women to the medical profession are rapidly subsiding even in France. Spain still refuses to recognize medical women, although two and three centuries ago several Spanish women acquired some fame by their practice of medicine. Women physicians are now recognized in Belgium since 1890, in Italy since 1878, in Portugal since 1886, in Mexico since 1887, in Sweden since 1870, in Switzerland, Roumania, Bulgaria, in this country and Australia. Baudouin relates the history of Henrietta Faber, who practiced medicine in Havana for years, disguised as a man. She married in 1820 and was at once prosecuted and condemned to ten years of imprisonment. Medical women were numerous in ancient Greece and Rome and in Italy during the Middle Ages.—*Journal American Medical Association.*

REPORT OF PHYSICIAN-IN-CHARGE MUSKOKA COTTAGE SANATORIUM.

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 50 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 roof, 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 50 has been thus increased during the summer to 60 beds. The year ended with 61 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 storey.

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 out 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 14½ 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 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 a 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 applications.

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 15 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. D. 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 1, 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
" " " 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 17
" 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 " lost " " — " loss, 4½ lbs.
12 " neither gained nor lost in weight.

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

CONDITION ON ADMISSION.	CONDITION ON DISCHARGE.						
	Apparently Cured.	Disease Arrested.	Much Improved.	Stationary.	Failed.	Died.	Total.
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, 10⅞ lbs.
6 lost " " — " loss, 4 "
6 neither gained nor lost.

CLASS III.—55 PATIENTS REMAINING OVER THREE MONTHS.

CONDITION ON ADMISSION.	CONDITION ON DISCHARGE.						
	Apparently Cured.	Disease Arrested.	Much Improved.	Stationary.	Failed.	Died.	Total.
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 " " — " loss, 5 "
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.

Progress of Medical Science.

MEDICINE.

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

Permeability of the Intestinal Wall with Respect to Bacteria.

Posner and Lewin have observed that after mechanical occlusion of the end of the intestine, there occurs, in from twenty-four to forty-eight hours, an invasion of the blood and of the organs by bacterium coli. Markus claimed that the lesions of the lymphatics due to the occlusion of the intestine were the cause of this invasion and that the bacteria passed through these little openings and not through the intestinal wall. By new experiments Posner and Cohn have confirmed the possibility of the passage of the bacteria through the intestine in consequence of this simple mechanical occlusion. This is proven both for the bacterium coli and for the bacterium prodigiosum. The differences in the results depend perhaps on the fact that Markus did not let his animals live long enough. In a single case of pyocyanic infection, the passage of the bacteria was noted in a few minutes after the occlusion.

The permeability of the intestine is always a pathological fact due either to mechanical causes or to the presence of pathogenic bacteria. The occlusion produces congestive disturbances which diminish the vitality of the intestine, but does not produce solutions of continuity.—Translated from *Berl. Klin. Woch.* by HARLEY SMITH.

Therapy in Cardiac Diseases.

If in the physiology and the pathology of cardiac diseases something new has been studied and recently affirmed, the attempts at innovation in the therapeutic field have been almost fruitless and the greatest cardiac remedies, digitalis and caffein, have shown more and more their superiority over other drugs.

Rummo has studied well the heart remedies. He divides them into drugs which act almost exclusively on the muscular element (strophanthus, helleb-re); drugs which act almost exclusively on the nerve element (sparteine, caffeine); drugs which act specially on the muscular fibre (digitalis, oleander, upas antiar); and drugs which act specially on the nerves (convallaria).

Benas Lewy has recently been investigating the value of digitalis in aortic insufficiency, From his researches it appears that in this disease (conformably with Corngou's views), digitalis prolongs the diastole, allowing a greater quantity of blood to gather in the left ventricle to the detriment of the arteries, favoring the disease. On the other hand, it strengthens the systole, for which purpose it is well to combine it with atropine.

In all the other valvular troubles and in diseases of the heart muscle, in the stage of failure of compensation, digitalis occupies the first place among the drugs; on this point all authorities are in accord. There is some difference of opinion as to the mode of administration and the dosage. Tincture of strophanthus, like digitalis, stands in the front rank among heart remedies. It cannot, however, always take the place of digitalis, but often is of great help when the use of the latter has to be suspended. Caffein, in the daily dose of ½ gramme, acts as a diuretic and may be advantageously combined with digitalis. Besides stimulating the cardiac fibre, it acts on the vaso-motor centres and directly upon the secreting elements of the kidneys. Convallaria, odonis vernalio and other preparations, though frequently recommended, do not deserve a place among cardiac remedies. Diuretin may sometimes be combined with digitalis. Recently Stockes has suggested the addition of calomel and powdered opium in cases where intestinal troubles appear. So much for drugs.

As for the hygienic treatment in insufficiency of the cardiac muscle, we must insist on rest, so much recommended by Rosenbach, so as to spare the tired organ as much as possible. We often see patients, at the beginning of cardiac insufficiency keep their beds for several days and without the aid of any drugs obtain the return of relative comfort and of the cardiac equilibrium. This observation has been forgotten by Oertel and his followers when they laud his new cure, consisting of mountain climbing and gymnastics and carbonic acid baths. In mild cases and at the beginning of cardiac insufficiency, it is true that carbonic acid baths may give relief, diminishing the peripheral circulatory resistance, stimulating the cutaneous nerves and accordingly lessening the work of the cardiac muscle. But when the insufficiency is relatively advanced, and degenerative features show themselves, then (as Leyden, Litten and Gibson have observed) gymnastics and mountain climbing and other methods of mechanical treatment are not only useless but hurtful, in that they favor the wearing out of the heart muscle. Radioscopy has confirmed the opinions of those who oppose the mechanical treatment. The cases which have received benefit from such treatment have been cases of cardiac

neurasthenia, of mild arhythmia or nervous arhythmia, as the school of Engelmann call them.

We may therefore affirm as a general rule that in heart troubles, whether chronic or arising as a sequel of infectious diseases, digitalis, rest, and in mild cases carbonic baths, constitute the only efficient treatment.

When the heart fibre is by these means strengthened, if the signs of want of compensation no longer appear, then it is time to have recourse to mechanical treatment, Oerkel's climbing and Schott's gymnastics.

In concluding, we must refer to the prophylaxis of myocarditis and the serum-therapy of endocarditis.

As for the former, we need only say that as myocarditis generally follows acute articular traumatism, we must, besides treating rigorously such disease, also avoid the relapses by administering in the intervals of the disease, daily, sodium salicylate, and adopting all the hygienic treatments included in Naunheim's gymnastics.

As for the serum-therapy of endocarditis, we wish to say that Douglas Powell in twelve cases has tried injections of anti-streptococcic serum, obtaining three cures, two improvements and seven deaths (25 per cent. cures). In all these cases he made a bacteriological examination of the blood and having discovered either streptococci or staphylococci, he used the corresponding serum, the fever disappearing in from eight to fourteen days after the first injection.

This method of treatment needs many more trials, but it gives much reason for hopefulness. As far as the dose of serum is concerned and the number of injections, Powell remarks that that depends on the individual reaction and on the quality of the serum.—Translated from *Giornale Internazionale delle Scienze Mediche* by HARLEY SMITH.

OPHTHALMOLOGY AND OTOLOGY.

IN CHARGE OF G. STERLING RYERSON, J. T. DUNCAN AND J. O. ORR.

The Use of the Ophthalmoscope in Nephritis.

Edward Jackson (*New York Medical Journal*) says: In cases of renal disease the ophthalmoscopic examination follows closely in importance the clinical and microscopical examinations of the urine. Noticeable changes are found in fifty per cent. of such cases; and distinct albuminuric retinitis occurs in not less than ten per cent. In these latter cases the ophthalmoscopic appearances are easily recognized, are as pathognomonic of the general disease as any set of symptoms

known in medicine, and have the most definite prognostic significance. Of the men showing albuminuric retinitis in Haale's clinic, all died within two years.

To look for it thoroughly requires the use of a mydriatic. Atropeni, however, should not be used, as it takes two weeks for the pupil to resume its normal condition after its use. A brief mydriatic, such as cocaine, four per cent., or homatropine, one-fifth of one per cent., should be instilled forty or fifty minutes before the examination is to be commenced.

What to look for.—The most constant ophthalmoscopic symptom is alteration of the retinal veins, which are dilated and tortuous, especially those about the macula. Next, hemorrhages may be found anywhere in the retina, they may even extend into the vitreous. There is swelling and opacity of the retina in spots, or around the optic nerve. The color of the patches may vary from a dirty-red to a snow-white, or a gray-blue. White spots arise from fatty degeneration. These are most characteristic when arranged in rows, radiating from the centre of the macula. The optic nerve may be reddened and opaque, or swollen so much as to resemble choked disc.

Strabismus.

In a valuable paper on Strabismus, J. Morrison Ray (*Journal of Medical Association*) (American) studies 100 cases. 76 of these were monolateral squint, in all of which the squinting eye was defective in visual acuteness; 24 were cases of alternating squint, in which the visual acuteness was practically the same in each eye. Of the 76 cases, in 21 of them improvement in the acuteness of vision in the defective eye by the use of proper glasses, was observed.

The following conclusions are the summing up of the paper:

1. The effect gained in the treatment of squint, whether by a cycloplegic or glasses, or operation, is largely, or we might say wholly, cosmetic.

2. Glasses should be adjusted to the eyes of squinting children at as early an age as possible.

3. Binocular single vision is not present in more than seven per cent. of cases of squint.

4. Cosmetic results can be obtained and maintained where the fusion power is absent.

5. In alternating squint, if the hypermetropia is of high degree, the chances for producing parallelism are better than when the hypermetropia is low.

6. The effect of a tenotomy is greatly influenced by the amount of abducting power present in the corresponding externus. This should always be specially noted in the alternating variety.

7. Two tenotomies on the same internus is bad surgery, since it invariably leaves a sunken caruncle, and later, divergence.

Cycloplegics in the Estimation of Refraction.

Chacon (*Gaceta Medica de Mexico*), in a paper read before the Mexican Academy of Medicine, demonstrates that in estimating the refraction of Mexican people, he has found it necessary to resort very frequently to the use of cycloplegics. Chavez agrees with him, and instances several cases in which an artificial myopia had been overcome and the true refraction—hypermetropia—determined only after the use of a cycloplegic. This simply points to the fact that the only safe method to adopt in almost all cases is the use of some cycloplegic. J. T. D.

Myopia or Shortsightedness.

This may be said to be of two kinds:

1. It is an innocent condition in many persons, continuing through many years without much change, and not leading to disaster of any kind.

2. In others, myopia is a progressive or pernicious condition which reaches a higher and higher degree as time goes on, is accompanied by damage to the tunics of the eye, and leads sooner or later to serious impairment or loss of sight.

An interesting discussion took place on this latter condition at the late meeting of the British Medical Association (*British Med. Jour., October 19th*).

Mr. Priestley Smith first remarked that these two classes are not always sharply distinguished from each other, there being many cases of myopia which cannot be placed at once in either class. This is where the difficulty of diagnosis and prognosis comes in. In attempting to forecast a case Mr. Smith considers the following data:

1. The age of the patient.
2. The grade of the myopia.
3. The condition of the choroid and retina.
4. The constitutional condition.
5. The evidence relating to heredity.
6. The occupation of the patient.

1. Under this heading the remark is made, "the younger the patient, the more likely is the myopia to increase in degree." Age alone, however, justifies no inference.

2. Other things being equal, the higher the myopia the more likely is it to increase. A high myopia in a child is of very evil augury. But in adults we can form no forecast, even from the grade of myopia and the age taken together, unless we take into account the next paragraph, No. 3.

3. The changes which occur in the choroid and the retina are, in the order of their occurrence: first, the typical myopic crescent; second, the patchy themicrig of the choroid in the adjacent region; third, pigmentary and hemorrhagic changes in the retina, and, in some cases, detachment of the retina. The presence of any of these changes adds to the gravity of the prognosis.

4. Under this section Nettleship is quoted as saying of myopia, "General enfeeblement of health . . . seriously increases the risk of its progress."

5. The tendency to myopia is very frequently hereditary, although some observers hold that inherited myopia is commonly an innocent disorder. Heredity, however, confers no immunity from pernicious complications.

6. Occupation. The future of many myopic eyes depends on the way in which they are used. Prolonged and habitual close work does harm. Patients who must, or will, continue such work in excess, are encouraging their myopic to run a pernicious course. The amount of risk must be estimated from paragraphs 1, 2 and 3, viz., the age, the amount of myopic, and the fundus changes. To give a bad prognosis by way of warning is sometimes the best way to prevent its fulfilment.

Mr. Henry Power, in discussing Mr. Smith's paper, remarked that in the case of a myopic child he was very particular that he should be seated near a window, where good light would fall upon his book. Second, he tries to prevent the child holding his head too near the book; third, the diet must be full and sufficient.

Mr. Henry Eales advises, where the power of accommodation is good, full correction of the myopia by glasses for all purposes, even in the higher degrees.

Mr. E. D. Bower considered that reading with an insufficient light was a most important factor in developing myopia, and also that, in moderate or high degrees of myopia, to read without glasses led to its increase.

Mr. T. Thompson believed that it was of the utmost importance to correct myopia by glasses as early and as fully as possible, in order to encourage the holding of the books at a proper distance.

Foreign Body in the Eye for Eighteen Years.

Alvin A. Hubbell (*Ophthalmic Record*) reports a case in which a foreign body was lodged within the eyeball for eighteen years, and then successfully removed. The case altogether is a remarkable one. The piece of cast iron was lodged in the lens, iris and cornea. The lens had become absorbed, and there had been occasional attacks of inflammation and

"corneal ulceration" in the eye. Nevertheless, the author considers that there is a possibility of serviceable vision in the eye. And in the other eye three distinct attacks of sympathetic inflammation had occurred, each of which had passed away without impairing the vision of that eye. J. T. D

LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF J. PRICE-BROWN.

Epileptiform Convulsions Caused by Shoe-button in the Nose.

J. S. Steele (*Laryngoscope*, October, 1901). A boy aged 6½ years had for two years been suffering from nasal catarrh and epileptic convulsions. Although fat and well nourished, he was reported to have grown stupid during the past two years. He had for the whole of that time been subject to daily convulsions, often having six or eight in a day. There was also a large sore spot on the back of his head, caused by falling backwards at the onset of the convulsions.

On examination of nose a button was found in the left nasal passage, between the middle turbinated and septum. It was covered by a hard crust, and after the removal of the latter, was extracted. Cleansing treatment of the nose, together with electro-cautery operation upon the hypertrophied tissues, was followed by rapid improvement in every way. In the course of a few weeks the catarrh, as well as the convulsions, disappeared, and the child regained his accustomed brightness.

Report of two cases of Serous Disease of Maxillary Sinus.

W. E. Casselberry (*Jour. of Laryn. Rhin. and Otol.*, September, 1901). Case 1 occurred in a man three months after the removal of nasal polypi. It followed an acute influenza. Transillumination gave diminished clearness of the left side. Aspiration yielded a syringeful of clear straw-colored mucoserous fluid, which partially coagulated on standing. The microscope revealed epithelial and lymph cells. Later on, suppuration developed, necessitating the opening of the anterior wall, curettment and washing. Complete recovery.

Case 2. A woman, aged 62 years, had bilateral nasal polypi with consequent mouth breathing. Both middle turbinateds greatly enlarged and in a state of polypoid transformation. Transillumination showed infra-orbital crescent on each side diminished. Aspiration of left maxillary sinus yielded syringeful of viscid transparent fluid. The left middle turbinated was then excised. Subsequent aspiration and irrigation on same side was entirely negative, indicating cure.

On the right side, during a period of four weeks, five successive punctures into the antrum were made, each yielding similar transparent fluid to that obtained from left side. But the middle turbinated, not having been resected, the accumulation of serum continued to be repeated. A resection was then made of the degenerated right middle turbinated body, with a large polypoid mass and polypbuds. Reaccumulation of fluid at once ceased; and examination of both antra three weeks later proved that they were both cured.

The writer concludes that transillumination is indecisive, and that the diagnosis must be based on aspiration. Also, that in treatment it is essential to remove the obstruction of the ostium maxillare; and to attain this end enlarged middle turbinated bodies should be resected and polypi removed.

Tonsillotomy Rash.

Wyatt Wingrave (*Jour. Laryn. Rhin. and Otol.*, October, 1901) says that while "surgical rash" is familiar to all, its association with the removal of tonsils and adenoids is not so widely known. When occurring, the eruption generally appears on the second or third day. It may be either papular, roseolous or erythematous in type, and attacks the neck, chest or abdomen, sometimes the face. It lasts for two or three days, occasionally for four or five. Then it gradually disappears without desquamation. Sometimes it is associated with intense itching; but the constitutional disturbances are usually very slight.

Hemorrhage after Tonsillotomy.

Seifert (*Wiener Klinische Rundschau*, November 15th, 1901) points out some of the dangers following tonsillotomy. He quotes Lichtwitz, who found Lœffler's bacillus in 40 per cent. of his cases. Sometimes alone, or in conjunction with staphylococci, streptococci, leptothrix, etc., in the wound surface. The writer holds that tonsillotomy should not be performed in a general hospital, or during epidemics of scarlet fever or diphtheria.

When hemorrhage occurs it is usually soon after operation, rarely secondary. Moure reports one that occurred one week after operation. (The abstractor reported two cases several years ago, one in a boy of 5 years, the other in a man of 20 years, each occurring on the fifth day.)

The causes to which hemorrhage are due are given as the following: Injury to the tonsillar artery, atheromatous changes in the vessels, hemophilia, injury to the internal carotid if the latter pursues an abnormal course. When the above conditions are suspected, Seifert advises the use of the galvano-cautery

snare, and suggests that only three quarters of the tonsil should be removed. Complete rest, sucking ice and gentle gargling are recommended after operation.

Case of Epithelioma, Involving Tonsil, Faucial Pillar and Tongue, Treatment and Apparent Cure.

S. H. Oren (*Jour. Amer. Med. Assoc.*, August, 1901). The growth was microscopically diagnosed as epithelioma. Hypodermic injections of pure alcohol were made in several places outside the periphery of the ulcer, and in and above the anterior faucial pillar. Inflammatory reaction resulted, leaving a hard, circumscribed mass This indurated area was then dissected out, and the base curetted and cauterized. One year later there had been no return of the disease.

Case of Primary Epithelioma of the Uvula.

Appenheimer (*Medical Record*, August, 1901) reports the case as occurring in a man aged 81 years. It commenced in the tip of the uvula, rapidly involving the whole of the organ. It grew as large as a walnut. It was bluish red, not ulcerated, and firm to the touch. The cervical glands were slightly enlarged but not tender. Slight pain was complained of, radiating to the ears. A small piece removed and examined microscopically presented the characteristics of epithelioma. Operation was considered inadvisable.

The Treatment of Laryngeal Papillomata in Children.

Hunter Mackenzie (*Jour. of Laryn. Rhin. and Otol.*, September, 1901) enters fully into the surgical treatment of this disease; and from his wide experience weighs the various methods in a judicial balance Speaking of thyrotomy he says a more unsatisfactory method of treatment for laryngeal papillomata in children could scarcely be devised. The risks of the operation are: permanent alteration and injury to the voice, chronic stenosis, and possible death as a result. Besides these, and perhaps more important, is the fact that the operation of thyrotomy with removal or destruction of the papillomata, is almost invariably followed by recurrence of the growths. As examples he quotes the following: Lenden operated seventeen times within two years on one child. Eventually stenosis resulted, necessitating the permanent insertion of a tracheotomy tube. Abbé operated four times on one child, and eventually had to resort to tracheotomy. Permewan reported the case of a boy of 11 years, on whom he performed thyrotomy twice, removing the growths and cauterizing the basis. They again recurred, and before they were considered

dangerous enough to require another operation, the boy was found dead in his bed. Downie reports a two year old child upon whom thyrotomy was performed six times in one year.

Of endo-laryngeal operations for young children suffering from papillomata, Mackenzie speaks almost as scathingly, although he acknowledges that the immediate and remote risks are not quite so great as when thyrotomy is performed. The most serious objection is the difficulty of performing intra-laryngeal operations at so early an age; and the impossibility of doing them in a radical manner. Almost invariably operation is followed by recurrence.

One man is reported as having gone through 220 intra-laryngeal operations for the removal of papillomata between the ages of 7 and 30 years. Finally he invested in the necessary instruments and learned to perform the operation himself. Mark Howell operated fourteen times intralaryngeally, under chloroform, upon a boy aged 3½ years before he could pronounce the larynx clear of the growths; and Bond operated nearly fifty times upon a girl between the ages of 10 and 18 years.

Tracheotomy, and the prolonged wearing of the tube, the writer believes to be the ideal way of combatting this disease. The larynx is left severely alone, and the tube is kept *in situ* for periods varying from six to fifteen months. Seven of his own cases are reported. Of these four completely recovered, and the others were all benefited. Reference is also made to the reports of other writers, who, from personal experience, speak very favorably of the method of treatment.

After operation the cough is diminished. Complete rest is given to the larynx, both phonatory and respiratory, and by avoiding irritation nature works a spontaneous cure.

Traumatic Dislocation of left Arycartilage.

Henry L. Wagner, of San Francisco, (*Laryngoscope*, August, 1901) gives the history of a case of this unusual accident. He believes that it is the second on record. It occurred in a man 72 years old, and was caused by a blow, which produced unconsciousness. On recovery he was voiceless. Breathing was difficult, and there was intense pain. After subsidence of swelling, some days later, the left arycartilage was seen to be dislocated in front of its normal position, and fixed between the respiration and phonation position. Massage treatment was tried for some weeks and attended by slight improvement. At this stage the patient ceased his visits, and the further result is unknown.

Foreign Body Lodged for Four Months in the Trachea of a Thirteen Months old Child.

H. F. Brownlee (*Med. Record*, July, 1901) gives the history of the case. The child at first was supposed to be suffering from croup. At last dyspnea became marked and tracheotomy was performed under chloroform anesthesia. The foreign body proved to be a thin flake of coal, the size being $\frac{1}{4} \times \frac{1}{2}$ inch. Inflammation at the point of obstruction had caused the increased stenosis. Rapid recovery followed the removal of the foreign body.

Vaccination by Osteopaths Not Recognized.

The School Board at Ashley, Pa., has refused to accept certificates of vaccination performed by osteopaths. Several hundred children are affected by this, and before they can get into school will be required to have a second operation in order to get a certificate from a registered physician.—*New York Medical Journal.*

Treatment of Leukemia.

La Médecine Moderne, September 4, 1901, recommends the administration of Fowler's solution in the following manner in leukemia: Three drops are given three times a day before meals, and this dose increased a drop with each day. When 10 drops are being taken, a drop of laudanum is added to each dose; when 15 drops are being taken, 2 drops of laudanum are added. Every two or three days a teaspoonful of Carlsbad salt is given before breakfast. By the addition of laudanum and the laxative salt, toxic effects are avoided. If toxic symptoms should appear, however, the dose of arsenic is gradually decreased. In place of 45 drops of Fowler's solution as the maximum, this amount is reduced to 40 drops the first day, 35 drops the second, 30 the third, and so on, progressively lowering the dose by 5 drops each day until 20 drops are being taken, this representing the minimum dose. This amount is given for several days until the toxic symptoms disappear, when it is again increased. This treatment is continued for many months without interruption. The avoidance of wine and the use of milk as a beverage favors tolerance of the drug. As a result of this treatment, it is stated, the appetite improves, strength returns, the ganglionic enlargements in the groin and axillas disappear, the spleen decreases in size, the number of white blood corpuscles diminishes, and the red corpuscles assume their normal appearance. Complete return to health is said to have been observed.—*American Medicine.*

Editorials.

CONTRACT PRACTICE.

We consider that contract practice, as we now understand it, is the greatest curse which has fallen on our profession in modern times. We think it is no disgrace, but simply a misfortune, when any physician enters upon such work. Take Toronto for instance. Such men as the late Drs. George Wright, Laughlin McFarlane and John E. Kennedy had a certain amount of contract practice in their earlier years of professional work. Many others still living, of undoubted respectability in every respect, were at one time, or are now, engaged in such work. The evils connected with this sort of practice are fully recognized in all parts of this country, but the remedy for the same appears to be hard to find.

Bad as things are in this respect in Canada, it seems that they are infinitely worse in Great Britain. It is a revelation to many of us to study this question in the *British Medical Journal* of November 2. In that issue we find an original communication and a leading editorial on the subject. From both we infer that, while there is much that is objectionable in connection with contract practice, it must be considered a necessary evil, and physicians must try to obtain the best possible terms.

Dr. Larking, of Folkestone, the writer of the communication before referred to, gives his personal experience as follows: "I practised for nine years in a country town and district of about 9,000 inhabitants. I commenced *de novo*, and at first had no patients at all. Then one came and then another (mostly people who owed money to other doctors in the place). I think I took in cash about 15*s.* in two months. Then, in an evil hour, I was led astray and seduced into taking clubs. I was so sick of doing nothing and so impatient to make a practice, that I prostituted my professional knowledge, and agreed to attend for a yearly fee of 4*s.* each. Having once consented to take clubs, it was a case of *facilis descensus averni*, and at the end of a few years I had a large club practice as well as a private one. I had plenty of work, night as well as day, and yet

pecuniarily I got no forwarder. I found I had enough work for two men and earned only enough to keep one."

One physician in the West of England who received 5*s.* per head a year earned 7½*d.* per attendance, and for this he had also to supply medicines, surgical dressings, spirits, etc. According to the editorial in the *British Medical Journal* a contract practice at 4*s.* a head per annum works out about 6*d.* for each attendance. Of course at 2*s.* 6*d.* per head the income becomes proportionately less. We can quite understand the truth of the following: "The man who has a large contract practice cannot earn an adequate income without doing an amount of routine work which makes it impossible for him to do his duty by his patients, or to add to the stock of medical knowledge." What kind of medicines do these two-and-sixpenny men give? Mr. Labouchere tells us that "the two great remedies in the hands of our profession are Faith and Purgation." Dr. Larking, in commenting, says: "With an urbane and confident manner, many club patients are conquered and their faith strengthened—the Epsom salts do the rest."

GIFTS TO EDUCATION IN THE UNITED STATES.

Two remarkable gifts were made in December in the United States. One was Mrs. Stanford's gift of $30,000,000 to the Leland Stanford University in California, probably the largest on record. According to the *Literary Digest*, the *New York Evening Post* says: This makes that university the richest institution of learning in the United States, and probably in the world. The other was Mr. Carnegie's gift of $10,000,000 to a new institution which he wishes to found, to be called The University of the United States, to be located in Washington. It is not intended that this shall compete with any other existing institutions, as it is to be purely a post-graduate university for the pursuit of original investigation. It is probably not generally known that Washington has, as the *Boston Transcript* says, splendid educational resources, but they are not properly systematized. "To search for knowledge there is like trying to find pearls in a junkshop. With about $8,000,000 annually available for the promotion of scientific research, there is evidently an uneconomical employment of the money,

It is not wasted. Doubtless the best use possible, under present conditions, is made of it. But the conditions are haphazard and clumsy." Ten millions is a large sum, and its judicious expenditure ought to do much towards introducing something like system in the Washington methods.

There seems to be a general consensus of feeling in the United States that a research university is needed above all other things from an educational point of view. Much research work has already been done. Johns Hopkins did a great deal in this direction for fifteen years, but diminished endowment through the failure of the Baltimore and Ohio railroad, and increasing demands of the undergraduate department, have greatly curtailed the resources for research. It is interesting to note in connection with this subject, as pointed out by the *Chicago Tribune*, that during the year 1901 one hundred and forty-nine institutions of learning have received gifts amounting in the aggregate to $81,415,220.

FIFTY YEARS OF MEDICINE.

A very interesting banquet was given in New York, in honor of Dr. T. Gaillard Thomas, on his seventieth birthday, November 21st, 1901. We find a great deal that is entertaining in his address on that evening, as published in the *New York Medical Journal*. He told his friends that as he looked backward down the dim vista of fifty years, he could see the disembarkation of a young physician of twenty-one from a coasting schooner from South Carolina, without one acquaintance in New York, and with a purse no more plethoric than which usually falls to the lot of the son of a clergyman of the Episcopal Church. The medical world of to-day recognizes that young physician—Dr. Thomas—as one of the greatest gynecological surgeons of this or any age.

He also referred to the science of medicine as founded by Hippocratus about 2,300 years ago, and said that during the last fifty years there had been done for the advancement and growth of medicine more than was done in the 2,250 years preceding. We quote his own words, as follows:

Think for a moment of the wonders which we have seen

effected in and for medicine in that time! We have seen the "cellular pathology" of that most eminent of living physicians, Rudolph Virchow, proved true beyond question and made the basis of a grand and imposing superstructure. We have seen pain annihilated by anesthesia, so that the human body could lend itself without sensation to the perfection of the surgeon's art; we have seen the vision of the physician so magnified in power as to penetrate the opaque walls of the body; and we have seen surgery, thus aided, lifted up from its lowly estate as a mechanic art and placed almost upon the level of an exact science. We have seen the primordial elements of disease, that bacterial host, invisible to the men of old, brought face to face with us by the miracle-working microscope: and by preventing their agency in the production of sepsis we have minimized the death-rate of surgical operations and almost stamped out puerperal fever. Working upon the same lines, we have succeeded in rendering impossible forever those appalling epidemics of the plague, yellow fever, and cholera—those pestilences which for our fathers "walked by darkness" in their gruesome work of decimating the nations of the earth. We have seen the entire field of gynecological surgery, the world over, revolutionized by the eminent labors of Marion Sims, our late associate; and we have seen practical medicine elevated and freed from previous doubt and uncertainty by the wonderful influence of clinical thermometry.

We have detected the true pathology of those obscure cases of so-called idiopathic peritonitis, which from the very dawn of time until our day have filled year by year, throughout the world, not thousands, but millions of graves, and we have experienced an honest pride in seeing a surgical remedy for appendicitis, their true cause, placed upon an enduring basis by McBurney, a son of New York.

TORONTO GRADUATE NURSES' REGISTRY.

The attention of the profession is drawn to the advertisement of the Toronto Graduate Nurses' Registry.

In times past efforts have been made to establish such a Register, but not until the present has a practical method been

proposed. We are satisfied that at last we have a Nurses' Registry upon a firm working basis, which will meet with the support of both nurses and physicians. The support of the graduate nurses in this city is assured already and this cannot fail to command the support of the medical profession.

The names and addresses of all members are carefully entered upon the Register, and any special nurse may be had on application if she is disengaged. If engaged, there is a long list of nurses, all well trained and competent, from which a good one may be obtained.

Unanimity on the part of the nurses is now most essential. If they will but unite with the common object of making the Registry a success, they will benefit very materially by it in many ways. Recent graduates will secure an introduction to private nursing, and the older nurses will be able to conduct the business part of their work more systematically. The volume of work will be much increased both in the city and the country, but more especially in the latter. Is it too much to hope that at some time not far distant the several training schools may have a central examining and licensing body, which will place them all upon a common level and result in securing very superior work in their profession ?

ALUMNI OF THE TORONTO GENERAL HOSPITAL have elected the following officers: Hon. President, Dr. J. T. Fotheringham; Hon. Vice-President, Dr. Goldie; President, Dr. F. A. Cleland; Vice-President, Dr. A. Chisholm; Secretary-Treasurer, Dr. J. H. Brent; Committee, Drs. O'Brien and Currie.

TETANUS FOLLOWING VACCINATION.—The recent fatalities from tetanus following vaccination at Camden, Atlantic City, Bristol, Brooklyn, Cleveland and St. John, N.B., have naturally caused a certain amount of alarm. We have been requested to state that in no instance did any such fatality follow the employment of vaccine virus furnished by Parke, Davis & Co., of Detroit, and Walkerville, Ontario, or by the Walford Co., of Philadelphia. We think we are justified in saying editorially that we thoroughly believe the statements of the representatives of the houses named. The subject is, however, of such vast importance in the interests of the profession and the public that we have asked a competent pathologist and bacteriologist to investigate the matter and prepare a careful and unbiased report, which we hope to publish in our next issue.

Obituary.

W. D. C. LAW, M.D.

Dr. Law, for many years a practitioner in Beeton, Ontario, a graduate of McGill of 1868, died at the General Hospital, Winnipeg, November 17th, aged 58 years.

DR. J. M'GUIRE.

Dr. J. McGuire died in Kansas City, November 2nd, aged 40. He was the son of a well-known resident of Trenton, Ontario. After graduating in medicine he left his native town and settled in Detroit. Six months ago he went to Kansas City. Death resulted from morphine poisoning.

DUNCAN M'LEOD, M.D.

Dr. Duncan McLeod, one of the best known physicians of Detroit, died December 29th, aged 53. Dr. McLeod was born in Cape Breton, but spent most of his boyhood days in Hamilton and neighborhood. He received his medical education in Trinity College, Toronto, graduating in 1873, and at once settled in Detroit, where he practiced up to the time of his last illness.

SIR WILLIAM M'CORMAC.

It is supposed by his friends that the death of Sir William MacCormac, December 4th, in his 66th year, was the result of fatigue and exposure in South Africa. After his return to England he suffered from dysenteric symptoms, with lumbar pain, abdominal pain, and abdominal tenderness. He went from London to Bath, December 2nd, with the hope that the more genial climate and the baths ought to benefit him. He had a bath and douche on the following day, feeling better for them. He slept better than usual on the following night, and awoke at 5.30 o'clock on the morning of December 4th, feeling comfortable and cheerful. At 7.30 a.m., he was sitting up taking his coffee, when suddenly, with an expression of pain, he put his hand to his heart, fell back on the pillow, and died almost immediately.

DR. HUGH M. BAIN.

Dr. Hugh M. Bain, of Calgary, N.W.T., at one time a resident of Prince Albert, died October 2nd, aged 49.

GEORGE T. ORTON, M.D., M.R.C.S., ENG.

Dr. Orton, of Winnipeg, died at his residence, November 14th, aged 64. He received his medical education in Great Britain, graduating M.D., St. Andrew's University, in 1860, and becoming a member of the Royal College of England in 1862. He practised for many years in Fergus, and for many years was prominent in politics, being well known as an ardent Conservative. He represented Centre Wellington in the Dominion Parliament for many years.

MR. WALTER S. LEE.

Through the untimely death of Mr. Walter S. Lee, January 4th, the Toronto General has lost its best friend. He became a trustee in 1877, and succeeded the late Judge Patterson as Chairman of the Board in 1889. After that date the Hospital had some dark days, especially during the depression following the boom. To Mr. Lee, who worked faithfully and persistently, although in his own quiet and unostentatious way, is due the chief credit for bringing the institution safely through those troublous times.

Personals.

Dr. A. P. Kelly (Trin. '98) is now practising in Orillia.

Dr. W. Harley Smith has been appointed Italian Consul for Toronto.

Dr. R. B. Nevitt, of Toronto, has removed from Jarvis Street to Bloor West.

Dr. W. A. Cerswell (Tor. '01) has gone to London, England, for post-graduate work.

Dr. A. H. Hough, of Wiarton, has been appointed an associate coroner for Bruce County.

Dr. Jennie Gray delivered an address at the Working Boys' Home, December 20th, on "Narcotics."

Dr. J. Orlando Orr was appointed Lecturer on Bacteriology for the Technical School of Toronto, December 19th.

Dr. E. Herbert Adams delivered an address on New Ontario before the Ross Liberal Club, in Toronto, December 19th.

Dr. C. D. Parfitt (Trin., '94) has been appointed to a position on the staff of the Gravenhurst Sanatorium for consumptives.

Dr. G. E. McCartney (Tor. '01) has been appointed House Surgeon to the New York City Hospital for a term of two years.

Dr. George S. Beck, of Port Arthur, is taking a well-earned holiday. He is now spending a portion of his vacation in Toronto.

Dr. J. C. Gilchrist, of Dumfries, Scotland, a recent graduate of Edinburgh University, spent New Year's Day with relatives in Toronto.

Professor J. G. Adami, of Montreal, read a paper on "Classification of Tumors" before the Toronto Pathological Society, January 4th.

Dr. George A. Sutherland (Tor. '98), of Embro, has recovered from his serious attack of typhoid fever, with perforation of the bowel, for which an abdominal section was performed.

Hon. Dr. Montague has returned to Canada after having spent nearly a year in Australia and New Zealand, where he was working in the interests of the Independent Order of Foresters.

Dr. W. H. Groves (Tor. '89) was recently appointed surgeon to the *Sekondi*, of the African Steamship Company, plying between Liverpool and the west coast of Africa. For some time previous he had been engaged at post-graduate work in Europe.

Correspondence.

POST-GRADUATE WORK IN TORONTO.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR,—The importance of my proposition is beyond question that the requirements of the medical profession, of this great Province in particular, and in a wider sense of the Dominion west of Montreal, call for an efficient medical polyclinic at Toronto. The large urban and directly contributory neighboring population, and the urban hospitals and other public charities, afford the necessary clinical material for the purpose. The post-graduate courses being conducted in summer, after the close of the undergraduate courses in the medical colleges, there would be no interference between post-graduate and undergraduate interests and requirements. The capital city has other desirable advantages for a polyclinic centre, which being obvious, I will not here particularize.

In corroboration of the assertion in my recent correspondence, that no visible practical attempt has been made to furnish provision for polyclinic or post-graduate study in medicine at Toronto, I adduce the following evidence :

1. At the close of an article over his own signature in the July number of your periodical, Dr. Adam H. Wright, a leading professor in the Toronto Medical College, an unimpeachable authority, uses the following language : "We have been talking for some years about post-graduate courses. We have plenty of teaching ability and a fair amount of clinical material at our disposal. How would it do to stop talking and go to work!" This remark is capable of but one meaning. Although they had for use satisfactory teaching ability and clinical material, Dr. Wright and his colleagues for years talked about post-graduate courses of instruction, but had actually done nothing. *Vox et præterea nihil.*

2. The entire absence of information in the published annual announcements of the Toronto Medical Colleges, concerning post-graduate courses in their curriculum, when and where to be given, and what features comprising. Such information, in fact, as would and should be afforded of actual *bona fide* post-graduate courses, and which appears in the annual announcements of medical institutions elsewhere, that provide genuine post-graduate courses of training.

3. Personal interviews with recent Toronto medical graduates,

who all testify their ignorance of any post-graduate medical courses in Toronto, and if there were any they would know the fact.

4. Members of the staff of the Toronto and St. Michael's hospitals have given me similar information.

5. Public notoriety.

My second item of evidence is supplied by the annual announcements for the last ten years, in my possession, of the Toronto Medical Colleges, and of various separate polyclinic medical institutions, and medical colleges, which give post graduate courses, situated in the United States. The post-graduate attendance lists contain an immense number of Canadian medical practitioners and graduates, three-fourths of them from Ontario, attending post-graduate courses in those foreign institutions. The annual announcements of the Toronto Medical Colleges of course are entirely destitute of such lists. I have no means of knowing the number of Canadian medical men visiting Europe for post-graduate culture, but it must be considerable.

Had Toronto been a polyclinic medical centre of high repute, as it ought, far the major portion of this outflow of Canadian doctors old and young, to foreign post-graduate institutions, would have been an inflow to Toronto, augmented by large numbers desiring to take post-graduate courses, but unable to attend far distant foreign polyclinics. All the medical men I have met strongly endorse my views about the importance of making Toronto a leading polyclinic medical centre without delay.

LUCIUS S. OILLE.

St. Catharines, January 6th, 1902.

PARKE, DAVIS & COMPANY'S VACCINE VIRUS.

Editor Buffalo Medical Journal.

SIR,—We respectfully ask you to apprise your readers on the faith of our positive assurance, that not one of the recent tetanus fatalities following vaccination at Camden, Atlantic City, Bristol, Brooklyn, Cleveland and St. John, N.B., succeeded the employment of our vaccine virus. In not a single, solitary one of these cases was our vaccine used. We incriminate no one's vaccine, but we propose to assert the truth about our own. If we can prevent it, no physician or pharmacist shall labor under the false impression that a fatality has ever followed, either by coincidence or by cause and effect, the application of vaccine virus or serum bearing our name.

PARKE, DAVIS & CO.

Detroit, December 5th, 1901.

Book Reviews.

Modern Obstetrics: General and Operative. By W. A. NEWMAN DORLAND, A.M., M.D., Assistant Demonstrator of Obstetrics, University of Pennsylvania; Associate in Gynecology, Philadelphia Polyclinic. Second edition, rewritten and greatly enlarged. Handsome octavo, 797 pages, with 201 illustrations. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $4.00 net. Canadian agents: J. A. Carveth & Co., Toronto, Ont.

The first edition of this book was well received, especially in the United States. In the revised editions it has been very greatly enlarged, so that it now forms a large and complete text-book of obstetrics. A number of new sections have been added, including chapters on the surgical treatment of puerperal sepsis, and the role of the liver in the production of puerperal eclampsia. Especial attention is given to the more recent pathology of obstetric conditions, as well as to the physiology and hygiene of pregnancy and labor; a more accurate elaboration of the mechanism of labor has been adopted. By new illustrations the text has been elucidated, and the science of modern obstetrics is presented in an instructive and eminently acceptable form. The book is especially well suited for the needs of students and young practitioners.

A Text-Book of Obstetrics. By BARTON COOKE HIRST, M.D., Professor of Obstetrics in the University of Pennsylvania. Third edition, thoroughly revised and enlarged. Royal octavo, 873 pages, with 704 illustrations, many of them in colors. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $5.00 net. Canadian agents: J. A. Carveth & Co., Toronto, Ont.

In this edition the book has been thoroughly revised. New matter has been added to almost every chapter, notably those treating of diagnosis of pregnancy, the pathology of pregnancy, the pathology of labor, and obstetric operations. More than fifty new illustrations, including three colored plates, have been introduced. The literature of the subject has been carefully reviewed, and the most important references since the last edition are given. In reviewing the former editions, we have spoken in the highest terms of this valuable work. Its great popularity, especially in the United States and England, is, we believe, well deserved. In all respects the book is admirable, and a credit alike to the author and the publishers.

Transactions of the American Electro-Therapeutic Association. Ninth and Tenth Annual Meetings, 1899-1900. Cloth, $2.50. Philadelphia: F. A. Davis Company, publishers.

The treatment of disease by electricity in one or other of its various forms has been so largely heretofore in the hands of

charlatans, that the general profession is rather prone to look askance at any claims made for its use even by physicians. Possibly this feeling is being, to a certain extent, fostered by the very enthusiasm of those who have rescued it from the quacks, and who themselves promise great things from the use of an element as yet but little understood. It is time that great and useful discoveries as to its applicability have lately been made, and that it should be given a fair and careful trial in medicine. A work such as this gives an insight into the work being done and the great difficulties which have to be overcome. Being a society's transactions, it shows that the members have faith in their methods and are willing to submit them to the medical public for criticism. The book should be looked into by all who wish to have a broad knowledge of medical topics.

A Treatise on the Acute, Infectious Exanthemata.—Including variola, rubeola, scarlatina, rubella, varicella and vaccinia, with especial reference to diagnosis and treatment. By WILLIAM THOMAS CORLETT, M.D., L.R.C.P. (Lond)., Professor of Dermatology and Syphilology in Western Reserve University; physician for diseases of the skin to Lakeside Hospital; consulting dermatologist to Charity Hospital, St. Alexis Hospital, and the City Hospital, Cleveland; member of the American Dermatological Association and the Dermatological Society of Great Britain and Ireland. Illustrated by twelve colored plates, twenty-eight half-tone plates from life, and two engravings. Pages viii-392. Size, 6¼ by 9¼ inches. Sold only by subscription. Price, extra cloth, $4.00 net, delivered. Philadelphia: F. A. Davis Company, publishers, 1914-16 Cherry Street.

This book, with its many fine plates, ought to be a great help to the student and young practitioner not very familiar with the exanthemata. Those familiar with the clinical pictures of those diseases will not find so much of value except that it is in handy form for reference, and treats of these disease forms very fully. It ought to be read by those not thoroughly well acquainted with its subjects, and kept in mind by those who know them well, remembering that it is practical, and written by one who has had a large experience with the diseases of which he writes. Especially is this true of smallpox, and the descriptions of the various forms of this prevalent disease are well worth reading.

Johnnie Courteau. By WILLIAM HENRY DRUMMOND. Illustrated by Frederick Simpson. G. P. Putnam's Sons: New York and London.

If Robert Burns is the recognized exponent of the common people of Scotland, then William Henry Drummond is preeminently the gifted and genial interpreter of our French-Canadian life. In "Johnnie Courteau" we have a collection of ballads of which any country might feel justly proud. In every line there glows the true poetic fire. In this volume we

have thirty-four gems of the Muse. Every page sparkles with genius like fire-flies in an Indian grove. The delineation of "The Country Doctor" is simply superb, and may take rank with that charming creation of Ian Maclaren's "Dr. McClure." William Henry Drummond sings to the heart, and the men and women are a great multitude who will be made happier and better because of the songs he sings.

A Text-Book of Diseases of Women. By CHARLES B. PENROSE, M.D., Ph.D., formerly Professor of Gynecology in the University of Pennsylvania. Fourth edition, revised. Octavo volume of 539 pages, handsomely illustrated. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $3.75 net. Canadian Agents: J. A. Carveth & Co., Toronto, Ont.

Regularly every year a new edition of this excellent text-book is called for, and although it is distinctly a text-book, it appears to be in as great favor with physicians as with students. Indeed this book has taken its place as the ideal work for the general practitioner. The author presents the best teaching of modern gynecology, untrammelled by antiquated ideas and methods. In most instances only one plan of treatment is described. This is a great advantage, since it prevents confusion on the part of the reader, and also gives space for carefully detailed instruction in the methods recommended. In every case the most modern and progressive technique is adopted, and the main points are made clear by excellent illustrations. The new edition has been carefully revised, much new matter has been added, and a number of new original illustrations have been introduced. In its revised form this volume continues to be an admirable exposition of the present status of gynecologic practice in this country. We can cordially commend this work.

American Edition of Nothnagel's Encyclopedia.—Typhoid and Typhus Fevers. By D. 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. Cloth, $5.00 net; sheep or half morocco, $6.00 net. Canadian Agents: J. A. Carveth & Co., Parliament Street, Toronto, Ont.

The original German edition of this volume is universally recognized as the standard authority on the subjects of which it treats. The American edition, however, even surpasses the German, for, besides containing all the material of the original, extensive additions have been made to almost every chapter, thus incorporating into the work the very latest views on the subjects under discussion. The chapter on bacteriology has been thoroughly revised and much new material added, giving prominent consideration to the distribution of the typhoid

bacilli, especially in the urine, the rose-spots, and the blood. To the chapter on pathology many minor additions have been made, incorporating the important work of Mallory. The literature on the localized lesions due to the bacillus has been carefully reviewed and made to conform to the most recent advances in that part of the subject. Thayer's exhaustive study of the state of the blood has been utilized, and the surgical aspects of typhoid fever have been fully revised with the aid of Keen's monograph. Much valuable material has been added to the chapter on diagnosis by bacteriologic methods, particularly with reference to the recent work in blood-cultures and on the detection of bacilli in the urine. The chapter on perforation and peritonitis has been practically rewritten, as has also the section on the hepatic complications of typhoid. Thus it will be seen that the American edition of this valuable work, while still possessing all the commendable qualities of the original German, is greatly enhanced in its field of usefulness by being brought strictly abreast of the latest literature on the subjects, and by representative specialists.

Clinical Examination of the Urine and Urinary Diagnosis. A Clinical Guide for the Use of Practitioners and Students of Medicine and Surgery. J. BERGEN OGDEN, M.D., Instructor in Chemistry, Harvard University Medical School, etc. Illustrated. Price, $3.00 net. Philadelphia: W. B. Saunders & Co. Toronto: J. A. Carveth & Co., Canadian agents.

The author's aim in this work is to present in a concise form the chemistry of the urine; the most approved working methods, both qualitative and quantitative; and the diagnosis of diseases and disturbances of the kidneys and urinary passages. A very important feature of the book is the fact that Dr. Ogden goes beyond mere urinary chemistry and treats in detail the important subject of urinary diagnosis, and the application of information furnished by careful chemical and microscopical examination. One of our best teachers of chemistry and clinical medicine in Toronto has expressed the opinion that this is the best work of the kind published from the student's standpoint.

A Book of Detachable Diet Lists. For Albuminuria, Anemia, Diarrhea, Dyspepsia, Fevers, Gout, Obesity, Tuberculosis and a Sick-room Dietary. Compiled by JEROME B. THOMAS, JR., B.A., M.D., Instructor in Materia Medica, Long Island College Hospital, etc. Second Edition. Revised. Philadelphia: W. B. Saunders. Toronto: J. A. Carveth & Co., Canadian agents.

This is an exceedingly useful book for the general practitioner. The various diet lists for the different diseases mentioned are made out with great care and judgment, each list containing a generous variety to select from. We have much pleasure in recommending this to our readers.

Selections.

Excerpts from the Remarks made by Dr. Albert C. Barnes, of Philadelphia, at the second annual meeting of the American Therapeutic Society, held at Washington, D.C., May 8th, 1901.

The paper of Dr. Reyburn just read merely reiterates the well-known fact that petroleum, when administered internally, is not absorbed from the gastro-intestinal tract, but, as is equally well known, a remedy may have the most pronounced physiologic effects purely on account of its mechanical properties. Dr. Robinson, of Philadelphia, states in the *Medical News* of July 14th, 1900: "In over fifty selected cases where nutrition, digestion and body weight were impaired and the purest oil administered in one or two dram doses, four times a day for periods of from three to six months, there was in every instance increase in weight and improvement in health, strength and feeling of well-being. The gain in weight was five and a quarter to twenty-three and a half pounds. There was no other change in living conditions or medication which might have caused these improvements." These clinical effects have been noted and recorded by a number of other observers. The manner in which petroleum accomplishes these results is shown by the laboratory experiments described in detail by the speaker. It was found that the addition of petroleum to albumen digested by an artificial gastric juice under exactly the same conditions as prevail in the human system, very materially hastened and facilitated the process of digestion; it was more rapid and complete than in the same experiment conducted without petroleum. Furthermore, it was shown experimentally that the mechanical influence of petroleum upon the churning, peristaltic movements of the upper portions of the small intestines favorably influenced the processes of absorption. In view of these experiments it can be safely concluded that the manner in which petroleum beneficially effects nutrition is by facilitating, expediting and completing the processes of digestion and assimilation of food. Another experiment described by the speaker was that conducted upon a man with marked malnutrition, in which the changes in metabolism were accurately studied for a period of three weeks by feeding the patient upon a normal diet, and then determining the daily elimination of nitrogen in the urine and feces. It was found that under the influence of petroleum the retention of nitrogenous matter in the system was increased. As is well known, the only method of determining the influence of any agent upon nutrition is by determining the daily body

elimination of nitrogen in the urine and feces; if a patient's retention of nitrogen is increased, the most important element of the tissues is conserved, and nutrition is correspondingly improved. Futhermore, the facts that petroleum passes through the intestines in its original form, and that it is a solvent of many remedies administered for their antiseptic and astringent influence upon the intestines, indicate a useful field for petroleum as a vehicle. Robinson states (*ibid.*): "I have extensively given from five to ten grains of salol in two drams of this oil, four times a day, and reclaimed the oil from the feces and found it to contain some salol and its components, phenol and salicylic acid. This proves the carrying of a chemical antiseptic and antiferment through the entire canal." This work has been corroborated by numerous other observers. The speaker stated in conclusion that the bulk of experimental and clinical evidence tends to show that petroleum is entitled to a wider field of application in medicine.

Hematuria Following the Use of Urotropin.

Goldsmid (*Australasian Med. Gaz.*, Sept. 20th, 1901) reports two cases of hematuria following the use of urotropin. The first was a man 53 years of age, who, after taking viiss grs. *t.i.d.* of this drug for four days, noticed a sense of discomfort in the urinary tract. At the same time his urine became bloody. Urotropin was then withdrawn for a few days until these symptoms passed away, being resumed in v-gr. doses *t.i.d.* without further trouble. The second case suffered in the same way from ix-gr. doses *t.i.d.* He was a man 41 years of age and had been taking smaller doses of the drug for some time.—*International Medical Magazine.*

Blood in Surgical Diagnosis.

After an extended study of conditions of the blood, Cabot, Blake and Hubbard (*Annals of Surgery*, September, 1901) conclude that at the end of complete anesthesia there is commonly a slight leucocytosis; that at the end of an operation there is much leucocytosis in one-half the cases, and almost always a distinct increase over the number of leucocytes found at the end of complete anesthesia; that the blood at the end of operations for malignant growths is not necessarily much impoverished, in favorable cases usually recuperating rapidly; that hourly variations in the white-cell count may happen in conditions other than in the preperforative stage of typhoid fever, and may be present in health also; and that violent physical exertion produces conditions in the blood that pass the normal and may be identical with those found in a state of disease.—*Therapeutic Gazette.*

Materia Medica and Therapeutics.

PHTHISIS AND ITS TREATMENT.

PHTHISIS is pre-eminently a wasting disease, and by exalting failing nutrition, cod liver oil being little more than a given food, a great advance was made in therapeutics. It has been found, however, that the oil does not in many cases meet the indications; for not only is nourishment needed, but the digestive power is so reduced that but little use is made of the food taken. Hence a demand both for nutritious material and also for something which will aid food suitable for assimilation. The clinical starting-point in the history of the greater number of cases of phthisis is malnutrition, and when that is guarded against much is accomplished.

After a full trial of the different oils and extracts of malt preparations in both hospital and private practice, I find Maltine most applicable to the largest number of patients, and superior to any remedy of its class. Theoretically we would expect this preparation, which has become PRACTICALLY OFFICINAL, to be of great value in chronic conditions of waste and malnutrition, especially as exemplified in phthisis. Being rich in *diastase*, *albuminoids* and *phosphates* according to careful analysis, it aids in digesting farinaceous food, while in itself it is a brain, nerve and muscle producer.

In practice this hypothesis is sustained. A female patient in St. Luke's Hospital, aged 35, with phthisis, signs of deposit in left upper lobe, losing flesh for six months, poor appetite and night sweats, was put upon Maltine. Within a few weeks her weight was increased to 121 pounds, she ate well, no night sweats, and the evidences of local disease were much less marked.

Another case of phthisis: A gentleman from Alabama, with all the physical signs of phthisis, rapidly losing health and strength. His was the remarkable gain of 10 lbs. *from six weeks' use of Maltine.*

Seven pounds' increase in as many weeks is the record of a third patient, a lady of 41 years, who had no other medication than the Maltine. In these and other cases the increase in strength and mental vigor was in proportion to the gain in weight.

These instances are sufficient for illustration, and are *duplicated many times in the experience of physicians everywhere.* There is a universal reluctance always to testify to results from medicinal preparations, but when, as in this case, the composition is fully known, and the profession invited to investigate the manner of preparing it, there is no reason why the remedy should not receive general approbation, provided it be worthy.—*Quarterly Epitome of Practical Medicine and Surgery.*

Nervous Diarrhea.

Pariser distinguishes five forms of nervous diarrhea, due to (1) central nervous influences; (2) toxic causes, as from teniæ, nicotine, morphia; (3) reflexes from the pelvic organs, stomach, nose or skin; (4) neurasthenia; (5) combined catarrh and neurosis. The differential diagnosis is easy when the symptoms point to neurasthenia, while one of the most valuable signs is persistence of the diarrhea after adoption of a simple non-irritating dietary. The great abdominal nervous plexuses are often hyperesthetic; mucous is absent from the stools, save sometimes in the fifth group; other objective signs are lacking. The treatment resolves itself into finding first the cause, then removing.—*Edinburgh Medical Journal.*

On the Use of Alcohol in Phthisis.

Edward Preble, in the *Journal of Tuberculosis,* writes well concerning this subject. The use of alcohol in phthisis was at one time thought to be a specific for phthisis. To-day physiological action of alcohol is well known. It checks nitrogenous waste, promotes appetite, in small doses accelerates digestion, facilitates the pulling on of fat, and slightly reduces temperature. It stimulates the heart and nervous system and favorably influences the night-sweats and insomnia. Alcohol he says, should therefore be a valuable remedy in phthisis, if all possibility of abuse is guarded against. All depends upon quality and dose. Now, as formerly, tolerance is an essential point, and the use of the drug should be forbidden to all in whom its action goes, so to speak, against the grain: and this prohibition includes all children. Patients may exhibit intolerance to malt liquors and yet derive benefit from spirits; even the season of the year plays a part in relative tolerance; for malt liquors seem to be more acceptable to some individuals in the hot months. It is generally agreed that alcoholics are best taken while eating, and if spirits are required between meals, they should be given in the form of egg-nog and milk-punch. As a general proposition, all spirits and strong wines should be given diluted. Under certain circumstances alcohol is contra-indicated even in the absence of intolerance. Its use is generally believed to be inappropriate after hemoptysis, or perhaps a case in which repeated hemoptysis is a feature. In the gastritis which not infrequently accompanies phthisis, alcoholics are necessarily out of place. In cases of phthisis in which cough is unusually distressing, the use of alcohol may or may not be contra-indicated. Williams, the English expert, finds that the various alcoholics exert a different influence upon cough, and that good claret may be borne in these cases when other forms of stimulants produce irritation. Upon this point experience alone must be our guide.—*Charlotte Medical Journal.*

Typhoid Fever.

Typhoid fever is said to be more prevalent in the United States at present than at any time since health departments began to make records. From every section come reports of an unusual increase in the number of persons suffering from the dread disease. In Chicago the record shows that the typhoid mortality for the past three months is four times what it was during the corresponding quarter last year. In New York the hospitals are crowded with typhoid patients, although the prevalence of the disease there may be due to the general tearing up of the streets. In Boston, Baltimore, Cincinnati, Minneapolis, New Orleans, Philadelphia, Pittsburg, St. Louis and Washington, more than the usual autumnal increase is reported.—*Med. Standard.*

Treatment of an Irreducible Dislocation of the Interior Maxilla.

Kramer (*Centralblatt für Chirurgie*), reports the case of a girl that presented herself for treatment five weeks after the accident. The dislocation being irreducible, operative interference was decided upon for its relief. The author made a horizontal incision on the under rim somewhat forward from the middle of the zygomatic arch, then upward, the last incision being only through the skin, partly loosening the masseter muscle from its attachment. There was then a thorough separation of the much stretched fibres of the outer lateral ligament and the external pterygoid muscle. On exposing the capsule of the joint, it was found to be uninjured. The dislocation was reduced, and the wound was closed without drainage. The patient made an uninterrupted recovery and regained the full use of the joint.—*Therapeutic Gazette.*

Case of Tubercular Ulcer of the Stomach.

Edwin Fischer (*Phil. Med. Jour.*), in a paper read before the Pittsburg Academy of Medicine, reports a case of tubercular ulcer of the stomach. The only other reported cases are those of Petrouschky, who diagnosed, treated, and cured his patients by the new tuberculin. In Fischer's case there were only slight evidences of tuberculosis in other organs, so that they may be regarded as secondary and not important in relation to the ulcer in the stomach. The patient was thin, both kidneys were movable, gastroptosis was present, acidity was .2% HCl, and there was marked pain under the left hypochondrium, both on pressure and after eating. This case resisted treatment by the usual means employed in gastric ulcer; but yielded a clear diagnosis and made a good recovery under new tuberculin. The important point is to make an early diagnosis so that antitubercular treatment may be instituted and the patient saved.—*International Medical Magazine.*