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MEDICINE AND SURGERY.

Vol. XIII. HALIFAX, NOVA SCOTIA, JANUARY, 1901. No. 1

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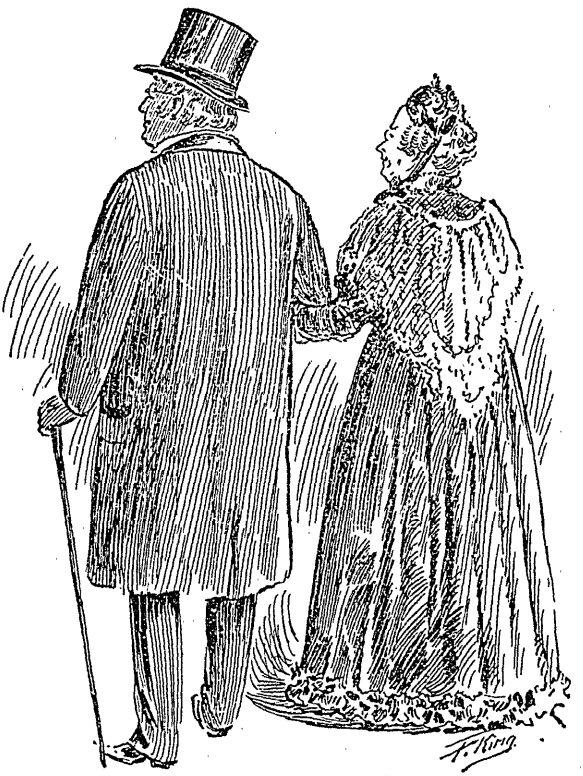

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THE

MARITIME MEDICAL NEWS,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIII. HALIFAX, N. S., JANUARY, 1901. No. 1

Original Communications.

TREATMENT OF FRACTURES.*

By MAJOR H. S. PEEKE, R. A. M. C., HALIFAX, N. S.

During the last ten years the means we have at our disposal for the treatment of simple fractures have not materially changed, unless we except "skiagraphy," the introduction of which has been so valuable in aiding the diagnosis of doubtful cases and clearing up any uncertainty as to the position occupied by the broken fragments in complex injuries. The methods of application of these means, however, has undergone some change during the last five years, and the progress has tended to rational methods which I think contrast favorably with the hard and fast prolonged splinting of former days.

In my student days at St. George's Hospital, I remember that a fracture was "set" and put up in splints to remain for a stereotyped time, varying from about three to six weeks, according to the bone or bones affected, the limb not being touched, except perhaps to adjust or re-apply a loosened or too tight bandage or change a pad.

Plaster of Paris and dextrine splints were very popular, and these were applied not to be taken down till such time elapsed as would lead the surgeon to hope that firm union in a good position had taken place. As the joint above and below the fracture had been rendered immobile during the progress of union, we were not surprised to find on removal of the splints stiffness of these joints due to adhesions, or

*Read at meeting N. S. Branch British Medical Association, Dec. 5th, 1900.

atrophy of the muscles and matting together of the parts in the proximity of the fracture. The breaking down of these adhesions, frequently requiring an anæsthetic, rendered the after treatment very tedious and trying both to the patient and the surgeon. And not infrequently the patient would leave hospital with a stiff joint, rather than undergo the painful passive motion necessary to free the joint. At that time every London hospital had its own particular method in splinting fractures; but the general line of treatment was much the same.

The chief indications for treatment in simple fractures are:

1. To reduce the fracture and place the fragments in apposition so as to restore as far as possible the bone to its natural shape.

2. To maintain this position of the fragments till there is firm union.

3. To promote the restoration of the normal functions of the part and attend to the general health of the patient.

The various methods of carrying this out may be summed up as follows:

1. Some immovable splint such as plaster of Paris, silicate of potash, dextrine, or the like.

2. Removable splints where the facture can be easily examined; and massage and active or passive motion employed. (Both these, if necessary, may be combined with traction.)

3. Direct fixation by operative measures, such as by incision and fixation of the fragments by wire, screws, pegs, etc.

4. Treatment without splints.

I have purposely mentioned the treatment by immovable splints first, not because I think it is the best method, but because it is still the mode of treatment most generally adopted—and I do not intend to discuss what is familiar to you all. It is of the second mode of treatment by removable splints, assisted by massage, active and passive movement, of which Mr. Bennett of St. George's Hospital has been the chief pioneer, that I wish to speak, and I think perhaps that it may be of interest in a discussion on this subject to explain the mode of treatment in a general way that he advocates. Take for example a fracture of the tibia in the middle third. The fracture is set. The limb is secured on a back splint, with a slightly oblique foot piece, by bandages at the ankle

and knee. Side splints fixed by webbings complete the fixation of the fracture. Smooth rubbing may now be commenced at any time, the sooner the better, after the fracture has been set. The straps or webbings fixing the side splints are unfastened and the splints are allowed to fall away from the limb. The knee is then steadied by one hand of the manipulator whilst smooth, gentle rubbing from the foot upwards is effected by the other hand, which is made to grasp as much of the circumference of the limb as possible. The time occupied in doing this is from five to ten minutes. The objects are the relief of muscular spasm and rapid absorption of effused blood, &c. After this the splints are replaced. This massage is employed every day. At the end of the *third day*, again, after practising this smooth massage for ten minutes, passive movement of the muscles and tendons at the back of the ankle and in the calf should commence. In order to effect this you begin very gently by moving the toes only, the foot still being bandaged. The hand is placed under the toes and dorsal flexion 'en bloc' is made. Every time the toes are bent in that way the flexor tendons are pulled upon and a little movement is produced. The little movement thus produced in the calf accomplishes the beginning of what is called internal massage. This not only stimulates the circulation but it makes sufficient movement to prevent immediate adhesions from forming about the fracture. This is continued till the *fifth day*. If all goes well passive movement of the ankle may be commenced from the *fifth to the seventh day*. For this purpose the limb is allowed to lie quite comfortably on the back splint. The side splints having been removed and the bandage around the ankle taken off, the bandage around the knee remains undisturbed. The foot is grasped with one hand and freely moved at the ankle-joint, the fracture at the same time being steadied with the opposite hand. After a few days the patient may be allowed to make voluntary movements of the ankle as it lies on the splint, the fracture being steadied by the surgeon's hand. Having arrived at this stage, all fear of any adhesion about the ankle-joint or the parts behind the fracture ceases. In these passive movements three to five minutes at each sitting is sufficient; this is preceded by a quarter of an hour's smooth rubbing, by which the patient is generally made most comfortable. These processes are

repeated day by day, extending at the end of the first fortnight to as much as half an hour for each sitting. *At the end of a fortnight, a little more or less,* according to the state of union, attention must be given to the joint above the fractured point. The joint below the fractured point is naturally the most important, because it is that which is most interfered with if adhesions form. At the end, then, of *a fortnight or less,* the knee must be subjected to passive motion. In bending the knee great care must be exercised, because the fracture being only a fortnight old, or a little more, is not in a condition of anything like firm union. The bending of the knee may be carried out in two ways. It may be done (1) by simply taking the leg with one palm under the limb just above the heel and the other grasping it under the thigh, then lifting the knee from the splint. By degrees the knee may be raised daily more and more till at the end of the three weeks it is bent to a right angle; or (2) to put on a pair of short splints, either straight or Cline's side splints, retained in position with webbings, and then bend the knee and ankle, by grasping the foot with the right hand, and with the left palm rest the back of the knee joint, gently raising the knee. This brings the treatment up to about the end of the third week after the receipt of the injury, and by this time in the majority of cases treated in this way the fracture is nearly sound—that is sound enough for the patient to be left without a splint, or if the patient be a private one and prefers to be sitting up on a couch, he may do so after being provided with a case of poro-plastic or leather to be worn around the calf over the seat of fracture as a kind of protection. At the end of three weeks complete ordinary muscle massage may be thoroughly carried out in order to develop the muscles throughout the limb.

Mr. Bennett specially lays stress on the value of this treatment in intracapsular fracture of the neck of the femur, when it cannot be commenced too early. As bony union will not occur, the indication is to get as useful a limb as can be. No splints should be used. They tend to the production of bed sores, render the patient most uncomfortable and do no good. Commence smooth rubbing at once and employ passive movement in a couple of days, reserving rotation movements for the last, the main object being to prevent muscle waste.

In Potts' fracture and Colles' fracture he advises passive movement in two to three days at the latest and smooth rubbing from the commencement. In shoulder joint cases, he advises firstly to and fro motion (antero-posterior). At the end of three or four days gentle abduction, at the end of a fortnight circumduction and rotation, which latter must not be attempted before this. He simply uses a protective shoulder cap of poro-plastic or leather retained in position by straps, the arm resting in a sling. No axillary pad or splints.

In the treatment of fracture of the patella and fracture of the olecranon two cardinal points must be borne in mind. (1) The avoidance under all circumstances of any chance of the upper fragment of the patella or olecranon becoming adherent to the subjacent bone. Such adhesion may be prevented by massage and lateral manipulation combined with gentle flexion and extension. (2) All manipulation and passive movement should be preceded by smooth rubbing. The advantages of this treatment are summed up as follows:

1. The ease with which the patient is made comfortable by arresting muscular spasm and so relieving pain.

2. The effecting of rapid absorption of effused blood.

3. The prevention of stiffness by obviating the formation of adhesions.

4. The prevention of muscle wasting and the preservation of the normal nutrition of the limb by aiding the circulation of the blood.

5. The shortening of the time under which the patient is prevented from resuming the ordinary use of the limb.

Two great objections to this plan are, firstly, the difficulty which must arise in carrying out this treatment as, unless a competent masseur is available, the time required is frequently more than the practitioner can spare, and it is a treatment requiring great care in its application, and therefore requires a competent person to manage it, and secondly it must of necessity be expensive unless employed in a charitable institution, but this expense is more imaginary than real, I think as, if the patient is able to resume his duties much earlier with a sound limb this expense is minimized to a great extent.

Mr. Bennett has collected recently some valuable statistics and facts from 300 hospital surgeons in London, the Provinces, Ireland and

Scotland, which were published in the *British Medical Journal* for Oct. 6th, and some of the facts deducted were as follows:

That the percentage of surgeons who use passive movements with or without massage is about the same in London and the Provinces. But London practitioners use it considerably earlier in their cases, speaking generally, than is the custom in the Provinces. The practice in Scotland appears to correspond with London. From further investigations it transpires that the quickest recoveries follow in cases which movements active or passive are earliest used.

In London 60 per cent. of surgeons use passive motion with or without massage for cases in which the joints are involved, and of these 35 per cent. use it from the first.

Lucas Championère says that in the first week massage hastens the disappearance of the swelling, and if used during the whole convalescence lessens the subsequent stiffness and atrophy.

We now come to the treatment by *direct fixation*. The operative treatment of simple fracture according to the majority of opinions is limited and should be confined to (*a*) cases which are otherwise unmanageable; (*b*) special cases, such, for example, as certain spiral and oblique fractures, mainly of the tibia; (*c*) certain fractures near joints in adults, notably of the humerus at the elbow and fractures of the patella and olecranon. With regard to the cases of simple fractures suitable for immédiate operative interference, Mr. Burghard, of King's College, assumes it to be a primary law that it is the surgeon's duty to cut clean and fix together the fractured ends in all cases in which it is impossible either to reduce the fragments or to keep them properly in position after reduction. This would include fractures of the olecranon and patella; *most* of the fractures into the elbow and knee joints, and some of the oblique fractures of the long bones. The need of operating upon these latter fractures, however, he believes to be very small, as they could almost all be reduced and kept reduced with proper care under anæsthesia.

Mr. Golding Bird puts the question—"What is the test of the value of any treatment in fracture?" The answer is a double one. The less the time a patient takes before he gets about the better the treatment, and if that can be brought about by operating in a case of simple fracture, we are usually justified in adopting that course. He

says that there are *two* great gains that result from operation, *one* is the more certain adaptation and fixation of the fragments obtained, and the *other* an effect similar to that produced by massage, in as much as, by free incision you are able to remove all extravasated blood, and hence the reason might be employed as a strong argument by those who have advocated operation in simple fracture as preferable to treatment by splints.

As regards transverse fracture of the patella and olecranon with separation, Mr. Jonathan Hutchinson, Jr, has operated by the open method of wiring (using silver wire the ends of which were hammered down beneath the periosteum so as not to require subsequent removal) in a considerable number of cases and says there is no other method by which the surgeon is able to clear the joint of all blood clots. (2) Lift up the ragged edges of aponeurosis which dip down in the gap. (3) Obtain perfect apposition of the fragments. (4) Allow the patient to actively flex and extend the joint within a few weeks of the accident and then to prevent wasting of the extensor muscles and to dispense entirely with any sort of splint within two months.

He says the cases must be carefully selected, elaborate disinfection of the skin carried out and the operation deferred until inflammatory reaction following the injury had subsided.

I have endeavored this evening to set before you in a general way some of the methods now in vogue for the treatment of fractures. In doing so, I have relied solely on the statements of those surgeons most fitted to give their opinions from a large experience of this class of injury. I may perhaps have shown a bias in favour of early movement and massage; but it is chiefly based on the experience of others as I have not had sufficient opportunity recently of putting it into practice to any extent.

ADENOID VEGETATIONS OF THE NASO-PHARYNX*

By W. G. Putnam, B. A., M. B., C. M., Yarmouth, N. S.

These are defined by Bosworth as a true hypertrophy of the normal lymphoid structures found in the pharyngeal vault.

Etiology. It is essentially a disease of childhood, developing in infancy, sometimes congenital. It tends to disappear at puberty. Some claim that the so-called "lymphatic" constitution is the cause of the disease. Others hold that it is the result of inflammatory changes in the lining membrane of the pharyngeal vault, due to repeated colds. Heredity undoubtedly plays an important part, for we often see several children in one family affected. Often also we can get a history of one of the parents having been a mouth-breather in childhood. It is sometimes associated with hypertrophic rhinitis, rarely with atrophic rhinitis, and very often with more or less enlargement of the faucial tonsils.

Pathology. The growths consist mainly of lymphoid tissue covered by columnar epithelium, which follows the various convolutions, extending into the depressions between them. There is but little fibrous tissue except in the cases where the growths have persisted after puberty. The microscope shows usual structure of lymph tissue—a poorly defined reticulum with many lymph corpuscles enclosed in the meshes.

Symptoms. The most prominent symptoms are the excessive discharge of thick, ropy mucus or muco-pus, and inability to breathe through the nose especially at night. There is often a marked change in the voice which loses its nasal quality, so that "m" and "n" become "eb" and "ed."

The ear symptoms and complications are very important. Dench states that more than half of the pathological conditions met with in the tympanum are directly due to this disease. Few subjects of adenoids escape them completely.

The ear conditions met with are chronic catarrhal otitis media, and chronic purulent otitis media, in all degrees of severity. Both are

*Read at meeting of Medical Society of Nova Scotia, Amherst, July 4th, 1900.

probably due to the mechanical blocking of the eustachian orifice by the growths, whereby the ventilation of the middle ear is interfered with. The air there gets rarified, resulting in retraction of the drum head, and hyperæmia of the mucous membrane both of the eustachian tube and the middle ear, hence impaired hearing. This continuing leads to ankylosis of the ossicles, and atrophy of the tympanic membrane, a true chronic catarrhal otitis media The hyperæmia may go on to inflammation and suppuration.

Attacks of earache are common. Such an attack may last only a few hours, or may persist for several days, and finally be relieved by perforation of the drum. This perforation may be very minute and rapidly heal, or it may be large and persistent. Practically all cases of purulent discharge from the ear in children, not due to zymotic disease, are the result of adenoids, and will not heal until the adenoids are removed.

Another prominent symptom is the peculiar facial expression—a dull, semi-idiotic appearance due to flattening and broadening of the root and bridge of the nose, combined with an always open mouth. If the child be really dull and inattentive, it is probably due to the fact that the hearing is impaired. Many other symptoms are claimed by various writers as due to adenoids. I may mention persistent cough, headache, croupy attacks, asthma, pigeon breast and general arrest of development. In one of my own cases, attacks of asthma have been reduced much less frequent by the removal of adenoids.

Diagnosis.—This is based on symptoms, appearances and the result of direct examination. Some claim that the last is quite unnecessary, since all cases of nasal obstruction in children with no nasal condition to account for it, are due to adenoids. They say that having found the nares free from obstruction, all that is necessary to establish the diagnosis of adenoids is to use a fine spray in one nostril. If the cloud of spray from the other nostril is not free, then adenoids are present. The direct examination can be made either by the rhinoscopic mirror or by the finger. In older patients I use the mirror, while in younger children the finger is better. One stands behind the patient and presses the cheek between the teeth with the left hand, to make sure the exploring finger will not be bitten. The right forefinger is then pressed into the pharyngeal vault and rapidly explores it. No matter how gently the examination may be made,

there will be a trace of blood on the finger when withdrawn, if adenoids are present.

Prognosis. This is always favourable after treatment. If left alone, there is no tendency to get well until puberty, and even then a post-nasal catarrh is likely to result. If ear complications have already developed, they will certainly improve after treatment of adenoids, and may be cured. If necrotic changes have taken place in the middle ear, the prognosis of course is not so good, but even then there is a good chance. Chronic catarrhal otitis will certainly improve very much.

Treatment, General. Tonics may be indicated, but usually are not. My favourites are cod-liver oil and syrup ferri iodide, if any are needed.

Local. The only satisfactory local treatment is complete removal, under a general anæsthetic as a rule. Slight cases may be improved by the use of astringent sprays, but such cases are not often brought under notice, being put down by the parents to a slight cold in the head.

My own method of operating is as follows: The patient is prepared for the anæsthetic in the usual way. A hard pillow is placed under the neck so as to allow the head to hang down somewhat. The anæsthetic is given until general relaxation occurs, when the mouth-gag is inserted. I then put my left forefinger in the pharynx as a guide and leave it there until the patient is turned on the side, or operation is completed. I use the Knight's forceps, which cut behind, above and slightly in front, so that there is little danger of including the septum nasi or uvula, and use a combined cutting and twisting motion. Usually three grasps of the forceps are necessary to clean out the whole vault. Then the Gottstein curette is used and a few full sweeps of it clean out the balance of the growths. I generally use the forceps again at the point to remove any hanging shreds left by the curette. A final sweep of the finger around the vault tells whether or not everything has been removed. Then the patient is turned over on his face to allow the blood to escape. This manœuvre may have been necessary before should the bleeding be excessive. Usually, however, the operation can be completed without moving the finger from the pharynx, and no more anæsthetic administered. Bleeding is usually free for a minute or so, and then quickly ceases. In very young children it is not advisable to give an anæsthetic.

Two or three sweeps of the curette will practically clear out the growths in them, while the child is firmly held by an assistant. In young adults, also, we can often operate without general anæsthesia, using cocaine locally to partially kill the pain.

After treatment.—An astringent spray is all that is necessary. I generally use acid tannic, grains ten, to solution Dobell, one ounce, through the nose and up the pharynx as well. If there is a recurrence of the growths, it is almost certain that some part has been left behind and another operation will be necessary. I have had one such experience, but my others have all done well.

Clinical Report.

FOREIGN BODY IN THE LARYNX.

By Laurence B. W. Braine, M. D. Port Morien, C. B.

Allow me to report a very interesting case occurring in tne practice of Dr. E. E. Bissett, Port Morien, C. B.

A child of 14 months was seized at night about five weeks ago, with symptoms of laryngismus stridulus, during the paroxysm becoming black in the face. This ceased in fifteen minutes, and has not returned, but since that time the child has been troubled with great "rattling" in the throat and cough has been loose and very hoarse. Respirations have been much impeded.

The mother has been treating the child herself, by giving emetics at various times of alum and molasses under the impression that the child was suffering from "croup".

On December 30th, 1900, the child was first seen by a medical man, and the mother stated the child was a "a great deal better" than it had been on the previous evening. During the evening she had introduced her finger to the back of the throat to produce emesis. In the vomited matter there was found a piece of coal three-eighths of an inch in length and a quarter of an inch broad. The symptoms were at once relieved, and the "rattling" (which could be heard downstairs) disappeared from the throat. The child breathed freely. On auscultation, a few moist rales could be heard. During the period since symptoms first were noticed the child haswasted somewhat.

WYETH'S

Elixir Uterine Sedative Specific.

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Each fluid ounce of this Elixir contains forty grains Viburnum Opulus (Cramp Bark), thirty grains Hydrastis Canadensis (Golden Seal), twenty grains Piscidia Erythrina (Jamaica Dogwood), ten grains Anemone Pulsatilla (Pulsatilla).

DIRECTIONS.—The Elixir being free from irritant qualities may be given before or after meals. It has, indeed, the properties of a stomachic tonic, and will promote, rather than impair, appetite and digestion. The dose for ordinary purposes is a dessertspoonful three times a day. When the symptoms are acute, or pain is present, it may be taken every three or four hours. In cases of dysmenorrhœa, neuralgic or congestive, the administration should begin a few days before the onset of the expected period. In irritable states of the uterus, in threatened abortion, in menorrhagia, etc., it should be given frequently conjoined with rest and other suitable measures. For the various reflex nervous affections, due to uterine irritation, in which it is indicated, it should be persistently administered three times a day. When the pains are severe or symptoms acute the above dose, a dessertspoonful, may be increased to a tablespoonful at the discretion of the patient, or advice of the attending physicians.

Samples for experimental purposes sent free to any practicing Physician on application.

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The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

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Selected Articles.

NOTES FROM PRACTICE IN THE ARGENTINE REPUBLIC.

SUPRA-PUBIC LITHOTOMY WITH SUTURE OF BLADDER—NO DRAINAGE.

By F. G. Corbin, McGill '90, Mendoza, Argentine Republic, (formerly of Bedford, N. S.)

Very little, to my knowledge at least, has been written on the above subject. I may be mistaken, but beyond a foot note in Jacobson, I never remember seeing, much less hearing, a word about it. Let me go back and tell you why I tried it.

For the last four or five years I have been operating a good deal, and found that I could open the dura mater and sew it up without drainage; the stomach, the intestines and the gall-bladder have all been treated the same way without apparently increasing the danger. Again, on three occasions I have torn the bladder, first in a hysterectomy I did it myself; then two years ago Dr. G., who was acting as my assistant in a case of pelvic abscess, in trying to pass a pair of forceps up between the bladder and the anterior surface of the uterus in order to get vaginal instead of abdominal drainage, tore the bladder, while in a third case, a hysterectomy, the bladder was badly torn the blame resting between myself and my assistant Dr. D. In all these cases I sutured the bladder immediately and in the two hysterectomies left no drainage, and nothing untoward happened. This last case happened a week before I by chance was doing a suprapubic lithotomy on a child of six years. Dr. D. assisted me. I proposed suturing the bladder as I had done with perfect success the week previous, and the operation was completed in this way. Since then, nine months ago, I have done the same in all cases of stone in the bladder without pyuria, I have met with. Nothing in surgery could surpass the results; in every one of my cases the return to health and happiness has been without any bother and above all without loss of time. All surgeons who have practiced suprapubic, median or lateral lithotomy know how long some of their patients take to get their fistulæ healed up.

When drainage is used be it glass, rubber, or gauze, you never by any possibility get the rapid brilliant success to be attained by suturing the bladder; besides, I do not believe the danger to the patient is increased if done by men accustomed to abdominal work. Naturally, if before one begins, one cannot feel sure of sewing the bladder in a way to leave it watertight and without stitches on its inner surface, it is better to drain, because, although the urine in perfect health is aseptic, on entering the bladder one cannot be sure it will be in that particular case and at that particular time; moreover, it might get septic after leaving the bladder, and would certainly in any case irritate the neighboring tissues, should it leave its natural deposit. But, given an ordinary case of stone without pus in the urine (do not trouble about a bacteriological examination; if you cannot see the pus it is all right), and a competent surgeon, I claim that the bladder not only might be sutured but ought to be.

The patient will be up in a week and well in a fortnight. Should he then be a month, two months, or longer still, with a disgusting fistula on which to spend money in dressings and lose his time and patience, not to speak of the unpleasant odour and irritation of the skin which are accompaniments of all ordinary fistulæ? By suturing the bladder on removal of the stone all this may be done away with.

My own cases are not yet sufficiently numerous to allow me to speak so confidently, but I have great faith in this operation, which I suppose is more or less new; and my results have been so perfect and pleasing that, personally, I will continue practicing it, and, until I find out some ulterior drawbacks, if there are any, will continue to recommend it.

As to the technique of the operation, it is simple, in the extreme, much more so than when drainage is resorted to. We have all read about that serous membrane known as the peritoneum. Don't think of it if you are intending to suture the bladder in a suprapubic lithotomy. In my former suprapubics, and now when I wish to drain, I always take great care not to open the peritoneum. Look for it, trace it down over the front of the bladder, and incise the organ below its reflexion. Sometimes a bother, to say the least, and nearly always leaving very little room after the bladder is empty, to work with comfort. Besides, the bladder has to be well dilated and most authorities advise a rectal bag, or something of that class, to aid in getting the much dreaded peritoneum a little more out of the way.

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	Teaspoon.	
As a Gargle in Sore Throat, Colds, etc.	½ to ⅓	TO ONE QUART OF WATER.
To Heal Wounds and Sores and to stop Bleeding use solution with lint and oiled silk	1	
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As a Radical Cure for Mange (in Dogs, Sheep, etc.). A few Drops suffice: The hair will grow again	Parts 1	in 20
For Horses, as a Preventive and Cure for Mange the coat of animal should be well saturated with solution of	Parts 1	in 60
Mop the Stables daily with a similar solution. Will keep animals in perfect safety from Infection.		
For Broken Knees, Quittor, Grease, Cracked Heels, etc., rub well with	Parts 1	in 30
For Worms in Horses give internally, on empty stomach, a quart solution of	Parts 1	in 30
Throat-worms in Lambs, Diphtheria in Fowls, all internal Parasites eradicated by giving solution of	Parts 1	in 30

If the above Directions are not perfectly clear, please request the Druggist to explain the same.

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Creolin-Pearson is an antiseptic and disinfectant of the first rank. According to the bacteriological investigations of von Esmarch, it acts decidedly more powerfully than carbolic acid on pus-micrococci, on typhus-bacilli, and on cholera bacilli. A 1 : 1000 solution kills the cholera bacilli in 10 minutes ; a 5 : 1000 solution in 1 minute ; whereas it takes a 1 : 1000 solution of carbolic acid 4 days to do the same. The typhus bacilli are distinctly checked in their formation by a 1 : 1000 solution of Creolin-Pearson, and are powerfully affected in 24 hours ; a 1 : 1000 solution of carbolic acid exerts no restricting influence on their formation even after 22 *days.* Pus-bacilli are distinctly hindered in their growth in 1 hour, and are killed in 4 days ; carbolic acid fails completely to produce any efiect in 4 days.

CONVENIENCE AND SAFETY

Creolin-Pearson is easy to carry : 1 to 1⅝ fl. oz. suffice to prepare from 7 to 11 pints of good disinfecting fluid. It readily mixes with water and distributes itself uniformly. It does not stain the clothes, nor injure the hands or instruments. Creolin-Pearson presents an obvious and decided advantage over carbolic acid in its comparative non-toxicity.

In my last three cases I have purposely opened the bladder through the peritoneum and for the reason about to be explained, I think it is better to do this. After suturing the bladder itself, that same peritoneum comes in very, very handy for a new line of sutures, which leaves no doubt in your mind of the perfect tightness of the bladder. I use a continuous suture of fine silk, and fasten the peritoneum to the sutured wound of the bladder. We all know how quickly the peritoneum throws out its plastic material and seals up, or over, anything to which it may be attached.

Thus, not only is it surer but it does away with rectal bags, etc., while the operation is easier on account of more room, a great point certainly. "More room!" How often in abdominal operations I have wished for that, so much so that in operations on the kidney I have been tempted over and over again to go at it by an abdominal instead of a lumbar incision.

Another point I would like to point out. Don't make too small a cut in the bladder. Make the incision long enough to get the stone out without bruising the edges. A clean cut heals much better and is more easily sewed, while a cut two inches long heals in exactly the same time as one an inch long. Some surgeons forget this, and you see them working away through a two inch incision with difficulty instead of working with ease, comfort and speed through a four-inch one. Besides the margins of the small wound are more apt to be bruised than those of the large one.

After the operation, I leave in a soft catheter for four days, then draw of the urine every three hours for four days more. For the cystitis, which surely exists to a more or less extent, I use twice daily a gentle washout with four per cent. boracic acid solution in sterilized tepid water. Be careful not to overstretch the bladder wall at this time.

Do not close the abdominal wound if you are not sure of your bladder suture. A bit of gauze drain for a day or two may save you trouble later and the patient his life. I have never tested my sutures by water pressure and think it better not to do so, as the pressure can certainly do no good and might do harm. Do your suturing well and sleep without worrying. I must acknowledge I was a little dubious over my first case and got up earlier than usual to go and see him.

Those who have followed me thus far will say, perhaps, that all cases suitable for suprapubic lithotomy with suture of the bladder and no drainage, are also suitable for lithotrity. I will not, how can I, either affirm or deny this? I have only one experience of crushing for stone in the bladder. Perhaps I did not do it well, probably I did not get all the fragments out; anyhow, the stone turned into stones, which I removed seven months later by median lithotomy. Since then, 1894, I have never even thought of my lithotrite. It may be good, it may be excellent, but I prefer the knife, without wishing to condemn a recognized surgical instrument of undoubted value in good hands.

As to the danger to the patient in one or the other way of operating. To my mind the surgeon used to abdominal work will have found an ideal operation without danger whereas the surgeon accustomed to the lithotrite would make perhaps a mistake in changing Practice makes perpect. I hope I am correct in my appreciation of the two methods. I would be very pleased to see more, or hear somebody more competent than myself, on the above subject.—*Montreal Medical Journal.*

A CASE OF PERFORATING GASTRIC ULCER.

By A. B. Atherton, M. D., Fredericton, N. B.

In the MEDICAL RECORD of January 5th, 1895, I reported a case of perforating gastric ulcer successfully operated on, and now I have the pleasure of recording my second operation for the same disease, which was attended with a like result.

As is well known, it is essential in this complication of gastric ulcer that a diagnosis should be made very early, and prompt surgical treatment be instituted, in order that the patient may have a fair chance for recovery, and for this reason the surgeon who does some general practice and has the good fortune to be called at once to such a case has the advantage over the more purely consulting surgeon, who is more apt to be called in somewhat too late to give the best result from operation. In both my cases I operated within twenty-four hours from the commencement of the acute symptoms, the exact time being in the first fifteen and in the one now reported only ten hours.

At 1 A.M., on March 26th, 1899, I was hastily summoned to see M. D.——, aged sixty-two years, on account of a severe pain in the belly, which had suddenly come on about an hour before. On inquiry I learned that he had had dyspepsia for fifteen years. He had to be very careful about the food he ate, because of pain and sometimes vomiting. He had never vomited blood. His mother died from "cramps" at fifty, after an illness of twenty-four hours. There was nothing to indicate any hereditary tendency to gastric disease unless this was.

He had been travelling by rail and water for a few days, and his stomach had not felt well. He had not eaten anything for twenty-four hours except a little porridge the previous morning.

I found him sitting on the side of his bed, leaning over forward to relieve the agonizing pain in his abdomen. He could not lie down. He had not vomited. His abdomen was very tender and rigid, especially at its upper part. The left rectus seemed rather harder than the

right. The belly was somewhat tympanitic, but there was no manifest distention, and liver dullness was present. P., 70; T., normal.

I at once gave a half-grain of morphine subcutaneously. A short time afterward he vomited over a quart of dirty, dark fluid with some oatmeal in it. No blood was noticed. The morphine required to be repeated in half an hour, and a third dose was given at 3.30 A. M. After this he became fairly easy, but preferred still a sitting posture.

I visited him again at 6.30 A. M. He had taken in the meantime by the mouth a fourth half-grain dose of the morphine, and had slept half an hour. He was now found lying down in bed. The belly seemed much the same as at my first visit. The pulse and temperature likewise were as before.

At 8 A. M., he was removed in a hack to the General Hospital, and was operated on at 10 A. M., the usual preparation being made to insure antisepsis.

The anæsthetic was given by Dr. McLearn, and assistance rendered by Mr. Roy Van Wart, medical student.

A median incision about four and one-half inches long was made above the navel. When the peritoneum was opened a puff of gas escaped, and some bubbles were also seen. Then some turbid serum flowed out from the right side of the upper incision, and some mucus and lymph were seen there. An opening the size of a lead pencil was found on the anterior surface of the stomach, near the pylorus, with nearly black mucous membrane p uting out of it. The hole was closed by two rows of Lembert's silk sutures. Considerable induration was felt around the opening. Sponges were used to clean out parts beneath the liver and the right lumbar region. Some strips of iodoform gauze were placed here for drainage, their ends being brought out of the upper end of the wound. The rest of it was closed by fish-gut sutures. Iodoform and bichloride gauze dressings were applied.

12.30 P. M.: He feels much better and has slept considerably since the operation. He is rather lethargic. The pupils are much contracted. P., 68; T., 96.5°.

March 27th, 9 A. M.: The dressings were changed last night and at the visit; the temperature ran up to 100° in the night; it was 99.5° this morning. He had gr. one-sixth morphine last evening and rested fairly well.

March 28th, 9 A. M.: Temperature normal. One piece of iodoform gauze was removed from the abdominal cavity. No vomiting has occurred since the operation.

March 29th: The rest of the gauze was removed from the abdomen. Some fish-gut sutures, which had been left loose at the site of the strips of gauze, were now tightened. P., 70; T., normal. The bowels were moved well yesterday by enema.

April 16th: All is doing well. The sutures were all removed. The wound is about healed.

April 15th: He has had heartburn at times, for which soda and bismuth have been given. Also care was used in diet. The pain in the epigastrium was quite severe to-day and he vomited a pint or more of dark liquid, with considerable blood in it. Morphine gr. one-sixth given hypodermically relieved him. He is to have only milk and lime-water, and curds.

April 20th: He is doing well, and may get out of bed. He asks for and may have the whites of two or three eggs per day, as he says they always agree with him.

April 25th: He is discharged from the hospital, and left for his home in Grand Manor a few days afterward.

On March 3, 1900, I received a letter from the patient's wife informing me that he had just died. She said he seemed to get on quite well until about Christmas when he began to be troubled again with his stomach, and vomited a good deal of bloody mucus for a week. Then he improved for a time, but later on had "pleurisy and a trouble with his lungs and never regained his strength."—*Medical Record.*

LINGUAL TONSIL SCISSORS.

By J. H. Morrison, M. D, St. John, N. B.

I know of no more awkward predicament into which the throat-surgeon can get himself than, during an attempt to remove a large hypertrophied gland at the base of the tongue with any of the ordinary snares, to find that after he has engaged the hypertrophied mass in the wire loop, no amount of traction is sufficient to make the wire cut through the tough, fibrous pedicle or base of the tumor. The snare is fast fixed *in situ*, and he can neither complete the excision nor remove the instrument; the patient becomes terrified, gags, chokes, coughs, and often vomits the contents of his stomach into the operator's lap, while every motion of himself or of the operator aggravates his discomfort and increases his alarm.

With the Bosworth snare it is quite impossible to disengage the contracted loop without detaching the proximate ends of the wire from the finger rings, cutting off the twisted portion, and forcibly pulling the instrument away, leaving the wire still fast to the gland. Then one or perhaps two fingers must be inserted into the patient's throat and the wire unhitched from the gland—a difficult and awkward proceeding. If the operator prefers to take up the slack wire and cut the loop in the mouth with a pair of wire-cutters, the cut ends of the loop fly upward and stick into the soft-palate, tonsils, or even up into the naso-pharynx, every motion of the patient's tongue causing him the greatest distress and discomfort. Then the operator must insert his fingers and remove the cut loop, and admit a failure. The chances are that he will never again get a snare into that patient's mouth.

Even with the end-loop snare, in which the loop of wire may be quickly pushed out of the cannula, the greatest difficulty is experienced in removing it from the half-severed pedicle or base.

Generally the fibrous base cannot be cut through by traction made with the fingers; and the nut, wheel, screw, and ratchet attachments are quite useless.

To meet such an emergency which sooner or later comes to every throat surgeon, I have devised the lingual tonsil scissors. When it is

found that the gland cannot be cut through by finger traction upon the snare, the throat mirror is discarded, the scissors are inserted, the points guided by the forefinger of the left hand, and the gland is snipped off with the wire still engaging it. The patient considers it an essential part of the operation, and the whole difficulty is over in a moment. The forefinger should be pushed quickly along the dorsum of the tongue under the cannula until the wire and gland are reached, and the scissors passed, under the finger, cannot fail to reach the exact desired spot. As the parts have been locally anæsthetized, the quiet but rapid introduction of the finger gives the patient no discomfort or concern. With a cool, collected patient, who will continue to pull forward the tip of the tongue, the snare may be passed to the left hand, the tip of the cannula somewhat elevated, bringing the base of the tongue into view, when the contracted pedicle may be quickly severed without the necessity of passing the finger into the mouth.

The instrument is in reality a combination of the Asche septum forceps and the common curved uvula scissors. Beyond the pivot the curve is somewhat less than that of the snare cannula and loop. The shanks are separated and rounded to avoid the possibility of engaging and wounding the dorsum of the tongue. This is an essential point in the construction of the instrument, for the patient is apt to let go his tongue and pull it back into his mouth, where, being arched, it would be sure to get between the cutting blades if they extended back to the pivot. The cutting edges are half an inch long and concave, so that the pedicle cannot escape when they are closed upon it. The tips are blunt and slightly rounded inward toward the cutting line to avoid the possibility of wounding the epiglottis, which might be thrown up against them should the patient gag or cough during their introduction. The handles are long, so that the operator's right hand is quite free and entirely outside of the patient's mouth.

In favorable cases in which the glands are large they may be excised with the scissors without having recourse to the snare at all. In these cases the scissors are, of course, used in conjunction with the throat mirror.—*Medical Record.*

THE

MARITIME MEDICAL NEWS,

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Editorial.

THE CENTURY THAT IS PAST.

It seems right and proper that our first issue in the new century should make some reference to the progress which was made in our profession during the years of the century just closed. And yet the task is one from which we may well shrink, for it is by no means easy to attempt even a very brief survey of the advance of a hundred years within the limits which usage puts upon the lengths of an editorial article. In every branch progress has been so great that but scant justice would be done were we to devote our whole space to but one branch.

Anatomy, but imperfectly taught at the beginning of the last century, is now one of the largest subjects of the medical curriculum, and, aided by the improvements wrought in the microscope, now embraces the minutest details of the structure of the neurone, and of the blood cell, and of every tissue. Physiology has expanded to include an extensive and definite knowledge of the control of brain cells over the various functions of the body, has determined, with reasonable accuracy, the problems of digestion, has thrown some appreciable light upon the question of nutrition, and has in various ways opened certain vistas into hitherto impenetrable mysteries of the life processes. The development of chemistry, especially of organic chemistry, and increased knowledge of physiological physics, have contributed largely to this result. And the birth and growth of the new science of comparative anatomy and embryology (altho' we should perhaps hardly claim the birth of either for the nineteenth

century) have had a profound influence in modifying our views of development, of heredity, and of vital processes generally. First mooted by Wolff in 1759, again suggested, and with more by way of substantiation, by Lamarck in 1809, it was not until the lapse of a further period of fifty years that Darwin brought forward, with all his wealth of argument, that theory of evolution with which we must also associate the names of Wallace, Huxley, and Hæckel in particular, and which has come to have so large a place in our conception of life's problem.

In pathology, too, the strides have been enormous, and this subject has grown to immense proportions. It must be confessed, nevertheless, that the end of the nineteenth century leaves us with our information upon disease-processes, altho' immense in volume, somewat ill-assorted and teasingly indefinite. The recent attempt at correlation of the sciences in the study of morbid processes may, however, have the effect of removing some of the obscurity with which many of these are now enshrouded.

Fin-de-sicle in development, altho' of full five decades antiquity, is the science of bacteriology—essentially a product of the nineteenth century. And what boundless gain has followed the promulgation of knowledge concerning the minute plant-forms to some of which such malefic influences have been attributed! With our information about the pathogenic bacteria as the base, we have built up our elaborate system of preventative medicine and aseptic surgery, and have been able to lessen to an incalculable degree the amount of sickness and suffering and death, while we have also turned our knowledge of many of the non-pathogenic bacteria to account in various arts conducive to the healthfulness and comfort of man.

In pharmacy, pharmacology and therapeutics, advance has been so rapid of late that the effort to keep abreast seems almost hopeless. Greatest among the discoveries of the century, however, must be mentioned the use of the anæsthetics. Following chemical and physiological experiment, the addition of new drugs to our armamentarium has become so frequent an occurrence as to hardly attract attention. Apart from the host of recently introduced derivatives of coal tar, etc., we must not omit reference to the determination of the value of iodides in the advanced stage of syphilis, quinine in malaria, salicylates in rheumatism, iron in anæmia, and the various anti-serums in various bacterial infections.

In the practice of medicine and surgery, much of our advance is dependent upon the progress made in the other branches of the curriculum. Modern surgery, of which we boast so much, is the outcome of knowledge of bacteria on the one hand and bactericides on the other, with the further influence of the introduction of anæsthetics. Medicine, too, has been much helped by the development of physiology, chemistry and bacteriology.

Reference should be made to the introduction of several instruments which have become necessities to us. The stethoscope, the clinical thermometer, the compound microscope, the spectroscope, the sphygmograph—these are all creations of this century just ended. And electricity, so useful as a diagnostic agent and sometimes also as a therapeutic agent, has become applicable only of late years. Even our means of determining the presence of albumin in the urine is a nineteenth century achievement.

But space will not permit reference to others of the many additions to our knowledge gained during the period. The century was indeed rich in discovery. Especially towards its close, the number of earnest scholars after knowledge, devoted to research work became very large, and we cannot doubt but that as a result of their labours, the early years of the new century will yield an abundant harvest. Perhaps the medical advance of the nineteenth century might be summed up in two words: anæsthetics, antiseptics. But who can foretell what the twentieth century will bring forth?

WYETH'S Granular Effervescing

Each Dessertspoonful contains 30 grains of the salt.

SODIUM PHOSPHATE

A Remedy for Constipation, Obesity, Rickets, Jaundice, Etc., Etc.

Sodium Phosphate is Unexcelled:

Sodium Phosphate has long been the favorite purgative, inasmuch as it acts gently but surely, has little or no taste, and is easily taken by children and delicate persons. In the present form—the effervescent—it is a delightful remedy, constituting a refreshing sparkling draught of bland action.

1. As an Hepatic Stimulant with beneficial effect on the appetite.

1. Sodium Phosphate is a mild but certain hepatic stimulant, and relaxes the bowels both by promoting an excretion of bile and by acting directly upon the mucous membrane of the intestines. It does not cause "griping," nor does it derange the stomach or excite nausea; unlike many other purgatives, it has a beneficial effect upon the appetite and digestion, stimulating the flow of gastic juice and increasing assimilation.

2. As a Treatment for Diabetes.

2. Diabetes is treated with decided advantage by means of the Sodium Phosphate. Not only are its cholagogue properties beneficial in this malady, but also its well-known power of arresting the secretion of sugar in the liver.

3. As a "Nervetone" in cases characterized by Debility, Spermatorrhœa, etc.

3. Phosphorus is a fundamental constituent of nervous matter, the substance of brain, spinal cord and nerves. Hence, the usage of the present compound in diseases characterised by a deficiency of "tone" of the nervous system in Debility, Spermatorrhœa, Impotence, Locomotor Ataxia, Neurasthenia, etc., is strongly to be recommended. In Asthma and the debility of the advanced stages of Phthisis it is serviceable. In such cases it acts as a restorative and respiratory stimulant.

4. As a Purgative in cases of Exanthematous Fevers.

4. In grave, exanthematous fevers, where a purgative, to be safe, must be simple and efficient, the Sodium Phosphate can be relied on. In such cases its cooling, saline qualities render it grateful and refreshing to the patient.

5. As a cure for Biliousness, Constipation, Jaundice, Diarrhœa, Dysentery, etc., especially in children.

5. Sodium Phosphate, causing a marked outflow of bile, whose consistency it renders thinner, is an incomparable remedy for Biliousness constipation, and, above all, for Jaundice, especially in children, on account of its absence of taste, and its efficient but unobjectionable properties. Diarrhœa and Dysentery in children are effectively controlled very often by the action of this salt in cleansing the mucous membrane of the lower bowel, and evacuating in a complete and unirritating manner the rectum and large intestine.

DOSE.—For children, to relieve diarrhœa, constipation, etc., a small dose only is necessary, ½ to 1 teaspoonful according to age and effect desired. As a purgative in adults, one or two dessertspoonfuls. As an alterative in gout, obesity, hepatic derangement, etc., one dessertspoonful morning and night. As an excellent substitute for Carlsbad water (which depends largely for its beneficial effect upon the presence of this salt) may be obtained by adding a dose to a tumbler of water and taking it gradually on getting up in the morning. ☞The glass cap on our Effervescing Salt bottle, when filled, is equivalent to one dessertspoonful, and also embodies a time device adjustable to any hour at which the next dose is to be taken.

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Society Meetings.

ST. JOHN MEDICAL SOCIETY.

Dr. J. Robertson McIntosh, President, in the Chair.

Nov. 28th.—A discussion on "Furuncle and Carbuncle" was introduced by Dr. James Christie. These diseases, he said, were dealt with in the books in a very perfunctory way, for instance in the latest edition of Ashurst's Surgery, seven lines were given to furuncle, thirty-three lines to carbuncle Boils probably were known as soon as luxuries began to be used by man. The early treatment was purging with salts; this still was as good as any method. The pathology of the disease is considered to be an inflammatory action of the skin and cellular tissue, which unless absorbed, goes on to suppuration. The staphylococcus aureus and other bacteria are found to be present. The particulars of a recent case were given:—Boils were distributed all over the body, at first small in size, then quite large; a dermatitis with intense itching co-existed. Comedones were innumerable, and the boils appeared to originate in the hair follicles.

It was a question whether furuncle and carbuncle were identical or separate diseases. The patient referred to had a carbuncle of peculiar origin—three incisions were made into it and pure carbolic acid applied, followed by great relief. Furuncles were associated with hair follicles. The speaker had little faith in applications to abort boils. Incision was best made after suppuration had taken place. This does ot hold with carbuncle, where early incision was advisable. Ichthyol cannot be depended upon to abort carbuncles. The injection of carbolic acid was the most recent method of attempting to cut short an attack.

The President said, in the case of the ear, boils tend to be multiple and bilateral. Boils appear to be contagious or auto-inoculable especially in debilitated subjects. Pus is present and can generally be reached. A suppurating Meibomian cyst is frequently followed by a succession of others. He suggested the use of vegetable solvents such as papain in boils and carbuncles.

Dr. Mott advised the epilation of affected hairs and application of carbolic acid to the furuncle. A solution of silver nitrate was also useful painted round a boil. Concerning carbuncles, when sinuses had formed, incise freely and apply carbolic acid. Later, dissect out the decayed tissue. Peroxide of hydrogen is useful in promoting the healing process. Proto-nuclein packed into the cleaned out tissue has been advocated.

Dr. Crawford was surprised that furuncles do not occur frequently in the aural meatus in chronic middle ear suppuration, where the channel is constantly bathed in pus. The activity of germs may vary at different stages of disease and hence explain the reason. He did not believe in carbolic acid as effective in aborting boils.

Dr. G. A. B. Addy said it was generally accepted that staphylococcus aureus gave rise to boils and carbuncles. The two diseases were a question of degree, carbuncles being more in the sul cutaneous tissue. The infection enters through the skin follicles and is auto-inoculable as is frequently seen from boils being generally confined to one location. Contamination is often carried by fingers or instruments which explains its supposed symmetry in boils of the ears. Carbolic acid is the principal abortive measure for furuncle. Poultices should be avoided as they spread pus and increase the crop.

Dr. Melvin thought that there was a pretty close clinical resemblance between carbuncle and malignant pustule, although the anthrax bacillus had not been discovered in the former. The clinical differences were so pronounced, in the case of furuncles and carbuncles, that it should not be taken absolutely for certain that they were identical in etiology.

Dr. Skinner considered that boils were caused or favoured by irritation, hence so often seen in the neck. Both calcium sulphide internally and carbolic acid locally were frequently tried; their aborting powers however, were very doubtful.

Dr. Olding uses carbolic acid and ergot along with oxide of zinc and starch made up with rose ointment. This limits inflammation and softens the tissues.

Dec. 5.—PATHOLOGICAL SPECIMENS.—A number of such specimens were presented to the Society by the family of the late Dr. John Berryman

The President read a paper entitled "Corneal Troubles," which will appear in the NEWS.

In the discussion which followed Dr. J. H. Morrison considered foreign bodies in the cornea the plague of the oculist. Penetrating bodies are still more dangerous, but may be removed by a powerful magnet. Only mild germicides may be used on the eye, this is a great handicap for the oculist. All ulcers when grave should be curetted. Strong caustics must be used with caution. Migratory ulcers call especially for curettage and application of caustics. It was likely that some more vigorous germ than staphylococcus aureus was present in some cases.

Dr. Crawford said the severer forms of corneal disease where infection occurs were seen by the oculist. In 75 to 80% of these cases, disaster results to the eye, opacity being left; indeed enucleation, in view of sympathetic trouble, is the best treatment in some cases.

Dr. Wetmore considered any nasal disorder that might be present should receive careful attention.

Dr. G. A. B. Addy thought all ulcers were infected from the beginning, staphylococcus aureus being the organism generally present.

Dr. Mekes related a case of herpes zoster involving the cornea; the disease persisted during several months.

Dr. T. D. Walker spoke of characteristics common to all ulcers, and asked if skin grafting had been attempted in the case of the cornea.

Dr. Jas. Christie found valuable, abundance of fresh air and good hygiene. Light was not found to be hurtful; cocaine and atropine give much relief.

In reply the President referred to transplantation of cornea from rabbits as being a failure and so with grafting, but the conjunctiva is sometimes drawn down over the ulcer with some fair results. Cocaine should be used cautiously where abrasions exist, on account of the danger of infection.

New Instrument.—Dr. J. H. Morrison exhibited his linquil tonsil scissors, an account of which will be found in the NEWS.

After adjournment, the members of the society were entertained by the President, in a very pleasant way, to a dinner which passed off with great success.

Dec. 19th, 1900.—Dr. G. C. Jones, President, in the chair. Meeting was held at 8.30 p. m., at the Halifax Hotel.

Dr. Kirkpatrick reported two cases, one of paralysis of the left external rectus muscles and the other paresis of the right internal rectus. He then exhibited a case of tubercular ulcerative laryngitis and explained the diagnosis from syphilitic and malignant ulceration. In tubercular there is no redness around the ulcer while the vocal cords and arytenoid cartilages are favorite sites. He showed also another patient of a young man, who when 13 or 14 years of age showed signs of cataract. There were only signs of ripening in part of the cataract in left eye. Iridectomy was performed and much improvement in vision resulted.

Dr. Goodwin referred to a case of gonorrhœal conjunctivitis which he sent to the hospital some time before.

Dr. Kirkpatrick replied that he had never before seen such a case so amenable to treatment. Applications of cold and bichloride solutions 1 to 10000, were used and no changes in the cornea took place. After four or five days nitrate of silver was substituted. When two days in the hospital the other eye became affected, but not so severe as the first. Treatment extended over three weeks.

Dr. Goodwin said he had never seen such a good result. Bichloride washes had been used before going into the hospital.

Dr. Mathers asked Dr. Kirkpatrick if he thought needling would suit in the case of cataract shown.

Dr. Kirkpatrick replied that he had it in mind, but had not decided to do it.

Dr. Ross was then called upon for his paper on the "Treament of Orchitis."

Dr. Ross said that the title of his remarks would be more strictly in reference to epididymitis rather than orchitis. Regarding prophylaxis as much rest as possible in acute gonorrhœa was important. Whenever testis becomes tender, patient should go to bed. A good fitting suspensory bandage is a precaution in all cases of severe gonorrhœa. Leeches, antimony, tartar emetic, calomel and salines are good remedies in the acute stages. Leeches are valuable when infla-

mation is at its height and stasis has occurred, and should not be used when rapid swelling is taking place. When acute hydrocele predominates the pain may be relieved by puncture of the tunica vaginalis while aspiration by the hypodermic needle is often efficacious. Ice is sometimes recommended, but is generally uncomfortable. Moist heat is more comfortable. Applications of guaiacol and nitrate of silver are sometimes recommended in the acute stages, but they often produce severe pain as has been noticed in some cases.

The most useful local treatment is heat in combination with narcotic drugs, such as tobacco and linseed poultices and if desired, laudanum sprinkled freely on the surface. When acute symptoms have subsided, pressure by strapping is of service. Have had no experience with electricity in such cases, but it is spoken of as very valuable. The negative pole of a faradic battery is used, combined with massage, to reduce swelling after acute symptoms have subsided. Internally opium relieves pain and reduces inflammation. If fever is high aconite or veratrum viride may be given, and also bromides and other sedatives may be useful. Balsams for the treatment of gonorrhœa should be stopped, and of course all injections. Pulsatilla has been highly recommended for relieving pain and tenderness by Piffard and Lydston. Ten minims of the tincture are given every two or three hours. Mercury and iodide in later stages to produce resolution are useful. Lydston says these remedies combined with electricity, even in long standing cases give hope of success.

Dr. Goodwin said that salines or glycerine suppositories to deplete the lower bowel are useful. The testicles should be well elevated to prevent increased congestion. After strapping, a good-fitting suspensory is important. In the acute stage lotions of aconite or belladona and glycerine are sometimes useful.

Dr. Trenaman stated that in the olden days the patient was at once put to bed, leeches applied to the scrotum and tartar emetic and magnesium sulphate given in small repeated doses. Afterwards warm applications and then strapping. In orchitis following mumps the same measures were successful in most cases.

Dr. M. A. B. Smith thought ice should never be employed, as he had seen it increase the pain. Heat is very beneficial; he generally used lead and opium lotion. He thought early injections in gonorrhœa the cause of epididymitis in most cases.

Dr. Murphy believed ice relieved the pain considerably; if used early it would limit the swelling, though would not use it after the second or third day. Testicle should be protected with flannel when using ice. Some years ago used tobacco poultices with good effect.

Dr. Walsh said no two text-books agree. Cannot say whether abstraction of serum did good in the cases he tried it. Leeches he found very good. Ice is beneficial and grateful in the first twenty-four hours in special cases. He is in the habit of putting the testicle on a shelf. Free purgation with salines early is useful; Rochelle salts with aconite when pulse is full and bounding.

Dr. G. M. Campbell found ichthyol and belladonna most useful, spread on thickly, and instead of any ordinary suspensory, a jock-strap.

Dr. Morton referred to atrophy of testicle following mumps.

Dr. Walsh said he never felt that the vas deferens had been obliterated in epididymitis. In one case where both testicles were effected atrophy followed in one. The man had since married and reared children.

The President referred to the benefit of strapping.

Dr. Ross, in closing, said that strapping should be done when inflamation had subsided and testicle could be handled without producing much discomfort. Had found tapping the fluid beneficial in alleviating pain. Agreed with Dr. Campbell as to the value of the jock-strap for suspending the testicle.

Dr. Goodwin brought before the meeting the custom of sending certain medical journals to physicians when not ordered, and afterwards a bill being sent for the same. He thought the custom very reprehensible, and with permission at a future meeting would bring forward a resoltion about the matter.

The President said the same thing had happened to him. He believed Hon. Dr. Parker had had a law passed in this province which would not necessitate paying for a journal when not ordered.

Drs. Kirkpatrick, Curry, Trenaman and Walsh said they had similar experiences.

The President thought it proper for Dr. Goodwin to introduce a resolution in reference to the matter.

PATHOLOGICAL SPECIMENS.—Dr. G. M. Campbell showed several interesting microscopic slides—one taken from cancer of the tongue, and another from sarcoma of the nostril.

WYETH'S SULUTION

IRON & MANGANESE PEPTONATE

(NEUTRAL.)

Liq. Mangano—Ferri Peptonatus—Wyeth's.

Iron and Manganese as offered in the shape of numerous inorganic preparations are, at the best, only sparingly absorbed after a long and tedious process.

When combined with Peptone in a neutral organic compound, the result is complete assimilation and absorption, thus deriving the full benefit of the ingredients as tonics and reconstituents, and rendering the remedy invaluable in

Anæmia, Chlorosis, Scrofula and Debility

The improvement accomplished by the administration of the solution is permanent, as shown by the increase in amount of Hæmoglobin in the blood : i.e. 3 to 8 per cent.

As regards the digestibility and rapid assimilation of the preparation, its aromatic properties and the presence of peptone in it renders it acceptable to the most susceptible stomach.

DOSE.—For an adult, one tablespoonful well diluted with water, milk or sweet wine, three or four times a day ; dose for a child is one to two teaspoonfuls, and for an infant 15 to 60 drops.

Offered in 12 ounce bottles (original package) and in bulk at the following list prices.

Per Demijohn, $6.25 ; Per five pint, $4.50; Per doz. 12 oz $11.00.

WRITE FOR LITERATURE.

DAVIS & LAWRENCE CO., LTD.,

Manufacturing Chemists,

MONTREAL, CANADA. **General Agents for Canada.**

To the Medical Profession:

ABBEY'S EFFERVESCENT SALT is without doubt the most elegant, palatable, and efficient saline laxative and antacid within your reach.

It possesses every requisite that such a salt should have; the slight granulation enables the patient to obtain the fullest benefit of the slower development of the carbonic acid gas; its action upon the bowels is gentle, but positive, and its valuable antacid properties render its use particularly beneficial in many cases where a harsher aperient might prove deleterious.

The use of Abbey's Effervescent Salt is growing daily, and is now regarded as a standard preparation, put up in the most high-class manner, and sold through druggists only.

The preparation is manufactured in the most perfectly appointed laboratory in America, under the supervision of expert chemists, and is in every way guaranteed to meet the many requirements for which its properties render it useful.

Dr. Walsh referred to the advertisements of "Dr." Bennett. He thought it about time the Provincial Medical Board should do something. This man now signs his name M. D. He thought a resolution should be passed bringing their attention to the matter.

Dr. Murphy referred to two cases which, though in poor circumstances, had paid $25 each, Bennett having guaranteed a cure; one was a case of tuberculosis, and the other gangrene of the hand.

Dr. Walsh moved that a copy of the *Morning Chronicle* containing Bennett's advertisement be sent to the Provincial Medical Board, drawing their attention to it, and asking if J. Gordon Bennett is a qualified practitioner, and if not, why is he allowed to advertise as such. Dr. Murphy seconded the motion, which was put and carried.

Dr. Goodwin referred to certifying deaths by midwives, in cases of children, and would like to know the law on the matter.

Dr. Trenaman said midwives could do so for still-born children.

Dr. Trenaman then referred to the continuous serious illness of Dr Farrell. He would suggest that a letter of expression from the branch regretting his continued i" ness be sent to him, as it would show that the branch missed his presence. He would suggest also, that a similar letter be sent to Dr. Chisholm.

Dr. Walsh seconded the motion, and suggested a reference to the hope of a speedy return to health The President concurred in the vote.

Motion was put and carried.

Obituary.

DR. JAMES MACLEOD.—It is with deep regret that we chronicle the death of our esteemed friend and associate editor, Dr. James Macleod, who died at his home in Charlottetown, P. E. I., on Saturday evening the 22nd of December, 1900, about 7.30 p.m. About eight months previous to his death he was attacked by a serious ailment from which his friends hoped he would recover, little dreaming that the disease was of a fatal nature, but towards the end, as time advanced, he kept gradually getting worse and finally passed quietly and peacefully away.

Dr. Macleod was born at Uigg on the 13th of June 1845; was educated in the Uigg school and at the Normal school and Prince of Wales college receiving his medical education at McGill, graduating at that institution in 1873. In the spring of that year he became associated in the practice of his profession with Mr. John T. Jenkins, M. R. C. S. Eng., of Charlottetown. Shortly afterwards he removed to Summerside and entered into partnership with the late Dr. Robert MacKelvie, where he remained two years. Returning to Charlottetown he again became associated with Mr. Jenkins, but later on opened an office on his own account. The *Guardian*, published at Charlottetown, in its issue of Dec. 24th, 1900, speaks as follows:—"His practice extending rapidly in town and country. The exposure of long drives in the country in which he was often liable to storms and inclement weather produced the too common effect of rheumatism from which he suffered so severely last winter that he was compelled to almost give up his practice. About Good Friday he became more seriously ill and was compelled to keep within doors. In August last he removed to his summer home in Keppock and for a time apparently made some progress toward recovery. But the hope proved delusive and his near friends became convinced that his end was near at hand. Dr. Macleod was married to Margaret Alma, daughter of Mr. John Henry Gates of this city, who with two children are left to mourn a loss that is irreparable."

Dr. Macleod was President of the Medical Council of Prince Edward Island from 1890 to 1899, and a member of the council up to the time of his death. He was President of the Maritime Medical Association in 1893 when it met in Charlottetown, and delivered a most excellent address. He was associate editor of the MARITIME MEDICAL NEWS and his articles were always a welcome contribution to our pages. He was a man of more than ordinary ability, clear sighted, keen, of courteous and pleasant manners, of extensive knowledge, good intellectual power, slow and deliberate speech, and he was possessed of other qualities which enabled him to win and hold the friendship of those whose friendship he valued. His death will be lamented by all who knew him. He was a supporter of all honest measures to advance the interests of Charlottetown and his native province, and was foremost in advocating the system of water works and sewerage for the city of Charlottetown. He was equally forcible in denouncing all dishonest practices and shams. He was a skillful surgeon, whose

council and advice were constantly sought, and he was greatly esteemed by his professional brethern. His funeral was one of the largest ever witnessed in Charlottetown. Being a prominent member of the masonic fraternity, he was buried with masonic honours, and all classes, including the medical profession as mourners, turned out *en masse* to pay their last tribute of respect and esteem to the memory of a valued and dearly beloved friend, a faithful companion and a staunch defender of professional rights and honour.

"The air was full of farewells—and
Mournings for the dead."

DR. EDWARD FARRELL.—After a brave fight for several weeks against a complication of maladies, the progress of which was watched with the keenness of a personal interest by nearly every citizen of Halifax, Dr. Edward Farrell entered into his rest in the early morning of the first day of the new century. It

is doubtful if the loss of any other Haligonian could have aroused so general and such sincere regret as was manifested from every quarter of the city, and by all sorts and conditions of men, when the sad news of his death was made known. Dr. Farrell's large practice, his interest in public affairs, and his genial kindly manner, had made for him a circle of friends much larger than it is the fortune of most men to possess, and he was known to almost everyone in the city. And so it was that the inevitable subject of conversation between friends on New Year's Day, after the preliminary New Year's greeting, was the loss sustained in our late confrere's death.

Born in 1842, he received his literary education in St. Mary's College, and after a medical course in the College of Physicians and Surgeons of New York he graduated from that institution with honors in 1864. After graduation, he served as house surgeon first in Bellevue Hospital and later in the Charity Hospital, New York, and then he began the practice of his profession in Halifax, where he quickly established a reputation as a surgeon of more than ordinary ability. He associated himself actively with everything pertaining to the medical life of the city, and was one of the most earnest and devoted of those who fathered and fostered the Halifax Medical College. At the time of his death he was President and Professor of Surgery of this College, and also Dean of the Faculty of Medicine of Dalhousie University. He was Surgeon to the Victoria General Hospital, a member of the Provincial Medical Board of Nova Scotia, and member of the Provincial Board of Health of Nova Scotia, and had at one time or another been President of the Nova Scotia Branch of the British Medical Association, of the Medical Society of Nova Scotia, and of the Maritime Medical Association. He was a vice-president of the Section in Surgery at the Montreal Meeting of the British Medical Association in 1897. Some years ago he was commissioned by the Government of Nova Scotia to attend the International Congress of Hygiene, meeting in London, England, and in the summer of 1899 he attended the International Congress on Tuberculosis, at Berlin, as the delegate of the Dominion Government. His excellent report to the government upon this last mission received very wide circulation, and was commented upon by the NEWS at the time of its publication. The last act of Dr. Farrell, before he was compelled to take his bed, was to go to Ellershouse Hills to inspect a site which

had been suggested as one suitable for the proposed Provincial Sanatorium for Consumptives.

But Dr. Farrell's activities were not limited to purely professional work. Despite the demands of a very extensive practice and of his college and hospital work, he was able to find time to interest himself actively in many other matters pertaining to the welfare of our city and county. His voice was often heard at the meetings of the Board of Trade where he always received an attentive hearing. From 1874 to 1878 he represented Halifax County in the Nova Scotia legislature, and was a member (without portfolio) of the Hill Government. Subsequently he received the nomination of the liberal party for the Dominion Parliament, but failed to be elected. He was an excellent public speaker, fluent and witty, and possessed in a rare degree the faculty of inspiring others with his own enthusiasm.

In social circles Dr. Farrell was always a favorite. His bright, genial manner, his kindly disposition and his ready wit, won for him the friendship of all he met. As President of the historic Studley Quoit Club, one of the most noted social institutions of Halifax, he proved the ideal host to all who were guests of the club, and his humourous sallies will ever remain fresh in the memories of the present generation of Studleyites.

Dr. Farrell was a consistent and honored member of the Roman Catholic church, and at his funeral service in St. Mary's Cathedral, low mass was said by one of his personal friends, His Grace Archbishop O'Brien. The funeral was a very large one, men from every walk of life attending to pay a last tribute of respect to one who had been universally loved. As was fitting, the medical profession of the city were present almost to a man, and several physicians from outside the city also walked in the cortege. The floral tributes were very numerous and very handsome.

Dr. Farrell leaves a widow, four sons and four daughters to mourn their heavy loss. The eldest son, Edward, (who, by the way, is the sixth Dr. Edward Farrell of his family), is practising medicine in Halifax; the second son, Louis, also a physician, is just about entering the Royal Army Medical Corps; and the third son is a lieutenant in the Royal Canadian Infantry. The fourth son has not yet completed his college course. Of the daughters, the eldest, Mary, is the wife of Captain Brush of the Liverpool Regiment; the other three are at home.

To those so deeply afflicted the NEWS extends most sincere and heartfelt sympathy.