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# The Canada Lancet

A Monthly Journal of Medical and  
Surgical Science, Criticism and News

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JOHN FERGUSON, M.A., M.D., Tor., L.R.C.P., Edin.

AND

WM. EWART FERGUSON, M.B.

*Editors*

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# The Canada Lancet

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## EDITORIAL

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### PREMATURE OLD AGE.

If one takes the trouble to study the mortality statistics of countries and insurance companies, several interesting facts reveal themselves. One of these is that the death rate is very materially lower among the younger ages than it was twenty and thirty years ago. This is due to a number of causes, and among these we might mention shorter hours of labor, more sanitary conditions in workshops, better food, housing and clothing, and the reduction of infectious diseases.

But as the death rate is lowered among the young, a larger number live on to more advanced ages; and this has the effect of bringing about a larger number of deaths among the latter. There is, however, a distinct tendency for the death rate about the age of 60 and after to rise considerably higher than it was some decades ago.

This has been explained as due to the more strenuous life people live, leading to many forms of degenerative diseases. This is shown by the increasing mortality among the old due to chronic heart and arterial diseases, to kidney diseases of some form, and to nervous breakdown.

The very strenuous life so many lead gives rise to high blood pressure and all its evil consequences. It tends to derange the activities of important glands like the thyroid. It induces the habits of indulging in stimulating foods and drinks to keep up the wear and tear, and so overload the system with waste products. All these processes react on the delicate human mechanism, and some part begins to give way. Truly the get-rich-quick custom of modern times is yielding more serious results than those arising from the doubtful investments that are a feature of the same state of affairs.

How is all this to be avoided? First of all, some attention should be paid to this in all our stages of education—common school, high school, and college. It should be made clear to all that the human body should not be over-taxed. It should be shown that over-taxing the

nervous system by long hours and worry is much more dangerous than over-taxing the body by too long hours; and that both are disastrous in the highest degree.

Much attention should be paid in education to the fundamental laws of physiology, so as to avoid overloading the organs of the body with the effete and waste products of faulty metabolism. This would be an easy lesson for all to learn, and, if learned, would be observed by many.

The whole subject is one of much importance, and is bound to come in for its due share of attention, as soon as people really begin to realize its importance.

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### NATURE'S ANTISEPTICS.

The keen observer must have been struck by the fact that the lower animals do not suffer much from septic wounds. This is due to several reasons. In the first place the wounds are left open to the air and the sunlight. In the next place the blood of the lower animals evidently can more rapidly react and produce immunity. Their constitutions are stronger, due to their method of life.

In the case of man, germs find their main field of development. What must be aimed at is how best to enable him to defend himself against these invisible foes. The present war is bringing out some very important points, which bear out what many had already observed.

When a part of the body is injured or infected there is a determination of blood to that part. This brings an increased supply of nature's defenders to the part in the form of leucocytes and anti-bodies. The latter are very important. The famous John Hunter was the first to point out that fresh blood arrested putrefaction.

Sir Almroth Wright, who usually brings to bear on all problems a scientific mind, has suggested that the best form of antiseptic for the wounds of the soldiers would be the serum from their own blood. With this end in view he applies to the wounds non-irritating saline solutions of stronger saturation than the blood, which has the effect of causing a free exudate of fresh serum. The result has justified the reasoning, and has exceeded the most sanguine expectation. Here science comes in to point the way to new and better methods. To such men as Sir Almroth Wright the words of Homer are peculiarly applicable:

The physician skilled our wounds to heal  
Is more than armies to the nation's weal.



## THE FIRST WOMAN DOCTOR.

Elizabeth Blackwell was one of those women who made a name for themselves by doing something of an abiding character. As Halleck, the poet says:

One of the few immortal names  
That were not born to die.

She was born in Bristol in 1821. When she thought of entering upon the study of medicine there were so many difficulties in the way that she was advised to dress as a man and in this way gain entrance to college and work her way through.

When young she had a distinct aversion to medicine and things pertaining to the human body. Later on this feeling began to disappear, and she became dominated with an antipathy to marriage. She then took up the study of medicine to fill up her time and occupy her active mind. She then began to think that the larger life of being useful to her sex was the highest calling to which she could devote her energies.

She came into contact with Dr. Samuel H Dickson, of Charleston, S.C., who loaned her books on medical subjects, and otherwise assisted her to enter college. In 1847 she made her first real attempt to become a student of medicine in the medical colleges of Philadelphia. In that city Dr. Elder and his wife gave her every assistance they could. She called on Dr. Jackson, Dr. Darrach, Dr. Warrington and others of the teachers in the medical colleges of Philadelphia of that period, but to no purpose.

She was advised to go to Paris, don men's attire, and work her way through college. Dr. Warrington, or Philadelphia, at last succeeded in having her admitted to the college in Geneva. In due course of time she received her degree. When it was conferred upon her she said: "Sir, I thank you; it shall be the effort of my life, with the help of the Most High, to shed honor on my diploma." Immediately she was given a most unique greeting by all the students, and they were all males.

But Miss Blackwell was a woman with an ideal. She made up her mind to be a doctor. When she found the greatest difficulty in securing admission to a college, one of the professors to whom she applied said that she had better go to Paris; but it was such a horrible place he feared the consequences. Her reply was a most remarkable one: "If the path of duty led me to hell, I would go there; and I did not think that by being with devils I should become a devil myself." It was this sort of idealism that made her the power she was, and gave her the great influence she came to possess. To her the higher education of women is deeply indebted.

## RECIPROCITY IN MEDICAL PRACTICE.

"It is an ill wind that favors nobody," said Shakespeare in one of his plays. For one thing, out of the great war comes this good result. The desire became strong for Canadians to have the right to enter the service of the British army, as doctors and surgeons. But there were legal obstacles in the way.

Much to its credit the Ontario Medical Association acted promptly and wisely and agreed to the principle of reciprocity with Britain. This position was transmitted to Britain, and the authorities there made the necessary changes to make the decision of the Ontario Medical Council effective. There is now reciprocity in medical qualifications between Ontario and Great Britain.

Thus it comes about that a long-drawn-out discussion has been brought to a happy conclusion. *The Canada Lancet* felicitates all who took part in aiding the cause—for it has ever stood firm for this view.

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THE MEDICAL COUNCIL OF CANADA.

The third annual meeting of the Medical Council of Canada is just to hand. It gives abundant evidence of progress, and this more than proves the wisdom of having brought the National Medical Council into existence. For many years we urged this course. It took many years of urging and education, but, thanks to the persistency of Dr. J. G. Roddick, we have the Medical Council of Canada.

The officers for this year are: Sir T. G. Roddick, honorary president; Dr. R. J. Gibson, Sault Ste. Marie, president; Dr. John Stewart, Halifax, vice-president; Dr. R. W. Powell, Ottawa, registrar, and F. H. Chrysler, K.C., legal adviser. The council consists of thirty members, representing the medical colleges, the various Provinces, the Dominion Government, and the homeopathic practitioners.

The president in his address refers in fitting terms to the knighthood that had been conferred on Dr. Roddick. Never was such honor more worthily won. Another feature in the president's address that is entitled to more than casual mention is the reference to uniform medical legislation for all the Provinces. There is nothing that would do more to completely unify the medical profession than would such a step; and there is no reason why it should not be brought about. It is much easier of attainment than was the securing of the Canada Medical Act. Another point of interest mentioned was that dealing with medical reciprocity with Britain. The president mentioned that the nine Provinces

had now signified their willingness to grant reciprocity as provided for under the General Laurie Act. This makes reciprocity universal so far as this country is concerned.

The registrar reported that 86 had written for the diploma of the council. Of this number 49 were successful, 22 failed, and 15 were referred back on one or two subjects. Of these 79 were English-speaking, and 7 French. The registrar calls attention to the small number of men seeking registration through the proviso of the ten-year clause. Up to the close of the council year, 31st March, only 133 had registered their names under this section of the Act. We thoroughly agree with Dr. R. W. Powell that more should register, and think that some steps should be taken to bring this matter before the attention of the profession. The fee for examination and subsequent registration is one hundred dollars, and we do not regard this as too high; but we do regard this as too high a fee to charge for registration alone in the case of those who have been ten years in practice prior to the establishment of the Canadian Medical Council. No doubt this has much to do with why so few of this class have registered. We would press this matter upon the notice of the Dominion Medical Council. Materially lowering the fee would have the effect of inducing many to register, making the right to practise in any Province more general, and the profession more national in character.

While on this topic we notice with satisfaction that the Province of Saskatchewan has discontinued holding examinations. This will compel all from that Province to take the Dominion Council examination.

One word of criticism. We hope the term "exams" will not in future be used for "examinations."

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### AUTOLYCUS OUTDONE!

The following item appeared a few days ago in the Toronto newspapers:

"At the meeting of the Toronto Association of Osteopathic Physicians last night, Dr. Millard, president, reviewed a number of letters, received from the Army Corps officers, in which graduate osteopaths were refused admission, when offering their services to join the medical staff to treat sprains, rheumatic shoulders and wrists, and lumbago. Resolutions were passed to the effect that through the Toronto papers the public should know why the osteopathic physicians were not sending their quota."

This has a grim phase of humor about it. Just think of surgeons

and physicians of the Army Medical Corps requiring the aid of osteopaths "to treat sprains, rheumatic shoulders and wrists, and lumbago!" This would do credit to German arrogance or self conceit. It would be the limit of the descent from the sane to the ridiculous to remove the care of such cases from the care of highly-trained men forming the Army Medical Corps to that of osteopaths whose training has been so imperfect and limited in scope. This is surely an example of Autolyceus outdone.

But the humor of it all is that it makes good advertising matter. They pose as capable of taking a place with the doctors at the front, and they ask the papers to publish this.

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### THE COMMOTIONAL BRAIN SYNDROME.

Physicians and surgeons have often met with a remarkable group of symptoms that follow injuries to the head, causing at the time commotion or shaking-up of the brain. On this subject the following from the *British Medical Journal* of 31st July is timely and deals with cases arising during the present war:

"Numerous cases of cerebral traumatism comparable in many ways to 'commotio cerebri' have occurred during the war. In these there is no external injury to the brain, but the cerebral functions are very seriously upset in various manners. Quite recently forty-eight patients exhibiting the 'commotional syndrome' have been studied at Montpellier by Mairet, Piéron, and Bouzansky. These authors divide its nervous signs and symptoms into six groups, as follows: First, sensation is almost commonly affected, usually in the direction of diminution or abolition of function—blindness, deafness, loss of taste and smell, partial or complete anæsthesia, have all been noted; usually the distribution of the disturbance is asymmetrical. Various degrees of hypoæsthesia, hypoalgesia, loss of sensitiveness to pressure, heat, or cold, limited to zones or areas of the body, or affecting (as is most common) only one side of the body, perhaps with the loss of the superficial reflexes, are all more frequently seen than the hyperæsthesias, which involve as a rule the existence of areas painful on pressure. Secondly, these authors describe on the motor side increased reflex excitability of the tendons and muscles, oftenest unilateral, in rare cases going on to the production of hysterical or epileptiform attacks; less often paresis or paralysis of groups of muscles, with or without contracture, has been recorded. Thirdly, vasomotor disturbances have been very general in these patients; chilliness and cyanosis that may be unilateral, dermatography, and cardiac irregularity are mentioned under this heading, and it is added that

headache is almost constantly present, perhaps with nausea or vertigo. Fourthly come perturbations of the affective functions; altruism and family affection are lost, egoism comes boldly to the fore in the shape of causeless irritability or rage, causeless fear, or even terror. Fifthly are placed associative troubles or disturbances of the intellectual faculties; retrograde amnesia, or loss of memory for the events preceding the shock, is very common—the patient may forget his own name, his home, the faces of his friends—speech may be lost or halting, intellectual inertia to the point of stupor may be found. Alternatively, indeed more usually, the patient's imagination is unduly active, making him the victim of dreams, nightmares, hallucinations, sleep-walking, even delirium, in which bygone battle scenes are re-enacted. Sixthly and lastly, the authors describe disturbances of the perceptive functions: the patient retains no recollection of the shock itself or of the events following it for a shorter or longer period, and is left with a permanent lacuna in his memories. In addition, he is often unable to concentrate his mind on any subject, such as reading, or is very readily fatigued thereby. From this analysis of the possible symptoms it is clear that the phenomena presented by the victims of the commotional syndrome can be very various, so that the patients may readily be classified under the heading of some predominant trouble, such as blindness, aphemia, or the like. But the large number of cases studied by the authors of this paper seems to justify their proposal to group all instances of nervous shock together under a single heading, and their term 'the commotional syndrome' appears to be as suitable as another."

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#### AMERICAN RED CROSS.

American Red Cross doctors and nurses will be withdrawn from the battlefields of Europe on October 1 because of a lack of funds to keep them there longer, according to a statement made last week at Washington by Miss Mabel T. Boardman, chairman of the Red Cross Relief Commission. It is possible that the two units in Belgium, where the greatest need exists, will be continued, but the other fourteen detachments will be recalled on the date mentioned, when the American fund of \$1,560,000 will be exhausted. In the work of cleaning up Serbia the Red Cross has used 358,783 pounds of sulphur, 700,000 bichloride tablets, 7,000 gallons of kerosene oil, 5,600 pounds of formaldehyde, 12,200 doses of cholera vaccine, 500 whitewash brushes, 70 bathtubs, 50 step-ladders, and 11 automobile trucks.

## ORIGINAL CONTRIBUTIONS

## TREATMENT OF THE FEVER HEART.\*

BY H. B. ANDERSON, M.D., L.R.C.P. (Lond.), M.R.C.S. (Eng.)

THE treatment of the fever heart is a problem, if one may use a paradox, at once so simple and so complex, that I have had difficulty in delimiting the ground to be covered in discussing it.

Fever as a clinical condition is symptomatic of the toxæmia associated with many different forms of local or generalized microbial infection. The effect of these upon the heart varies with the nature of the infection, its intensity, duration, individual resistance and many other associated conditions. It is well known that the infective bacteria of many diseases—as pneumonia, typhoid, influenza, gonorrhœa, septicæmia, etc., may invade the heart, though in other diseases—as diphtheria—the injury to the myocardium is due to the toxæmia alone.

The treatment of the fever heart is *simple*, because often it is satisfactorily included in the proper routine management of the case, without any medication directed specially toward the heart. Thus rest, mental as well as physical, fresh air, proper regulation of the quality and quantity of food and drink, baths, relief of pain, efficient elimination, specific medication, such as antitoxin in diphtheria or quinine in malaria, the drainage of septic cavities or the removal of foci of infection—all measures directed against the underlying infection, are important, directly or indirectly, in safeguarding the heart. Frequently nothing more is required.

It is important here to bear in mind the modern conception of fever as a conservative reaction designed to increase the resistance of the individual to the infection. Ordinarily it is only when fever assumes the type of a hyper-pyrexia that in itself it becomes the object of treatment. Then the use of baths, the application of the ice bag to the precordium and like measures are our safest and most efficient remedies.

It is unnecessary at this time to caution against the use of the various coal tar preparations, as acetanilid, antipyrin, phenacetin and other depressant febrifuges, which formerly were so commonly used, with disastrous effects upon the heart and circulation.

The too common use by the laity of antikamnia, bromo-quinine and various headache powders containing coal-tar products, to relieve the

\*Read at Ontario Medical Association. Peterborough, May 25 to 27, 1915.

pains of influenza (or other developing fevers) is responsible, I am sure, for some of the cases of cardiac failure and sudden death occurring in this disease.

The treatment of the heart in fever is *complex*, because etiologicaly considered, it involves a knowledge of the specific action of the various infections upon the heart and circulation. In diphtheria, typhoid fever and other fevers the most competent authorities as yet are unable to give us the precise information that would enable us to apportion at all definitely the relative importance to attach to the heart and vasomotor mechanism for the resulting circulatory embarrassment. In other words, we lack the exact knowledge of the pathology of the condition which would enable us to direct our therapeutic aims against a definite objective point. We have, therefore, to rely to a large extent upon clinical experience, and resort to symptomatic treatment for the circulatory trouble, whether due to the effects of the toxins upon the heart itself, the vasomotor centres or the vessels. In fact, recent investigations tend to show that in the circulatory failure of the acute infections, vasoparesis from poisoning of the nerve centres is perhaps of greater moment than primary cardiac depression. The two conditions, however, usually occur together and "the functions of the heart and vessels reciprocally effect each other to a marked degree."

It is manifestly impossible to discuss in detail the changes in the heart, with their variations in character and degree, in different infections. These may include cloudy swelling, fatty and hyaline degeneration of the muscle cells, congestion and thrombosis of the vessels, hemorrhages into the connective tissue, leucocytic infiltration, connective tissue proliferation, inflammation of the endocardium and epicardium, with extension of the inflammatory process along the supporting connective tissue between the muscle fibres. These changes are important chiefly to the degree in which they weaken the efficiency of the heart muscle in maintaining circulation. It is very important for us to bear in mind that owing to the tremendous degree of reserve power possessed by the cardiac muscle, extensive pathological changes may be present without symptoms or signs of circulatory embarrassment to indicate them, at least before evidences of muscle insufficiency manifest themselves.

The mental attitude of the physician towards the dangers in the fever heart should be similar to that in regard to hemorrhage or perforation in typhoid fever—a clinical alertness based on a knowledge of pathology, which recognizes serious possibilities and takes measures to guard against them, even in the absence of all symptoms.

For this reason I believe that a knowledge of the pathological

changes liable to occur in the heart in different infections is often a safer guide than signs or symptoms, especially for prophylactic treatment and the management following convalescence.

If we stop to consider the possible extent and degree of these changes, and especially the time that will be required for regeneration and repair in so highly organized a tissue as heart muscle, it will impress us with the necessity for sparing the organ as much as possible for a long period after the disappearance of the fever and other active evidence of the infection.

A careful observation of the heart, however, will enable us to detect important danger-signals, such as feebleness of impulse, weakening of the muscle quality of the first sound, the dropping of beats, the pulsus alternans, development of soft systolic murmurs in the mitral and tricuspid areas, or at times signs of even more serious import, as displacement of the apical impulse or the inception of auricular fibrillation. These signs point to interference with the functions of conductivity, tonicity and contractility of the heart muscle.

The treatment of the fever heart naturally falls under two headings:

- (1) During the course of the fever, when it cannot be separated clinically from the associated central vasomotor and peripheral vascular involvement.
- (2) During the following convalescence, when myocardial phenomena are of most importance.

As I have already stated, during the acute stages of the fever, the treatment of the heart is often included in the proper routine management of the disease, and does not call for special medication.

Rest and comfort of the patient are of great importance. And here may I emphasize the influence of the cheerfulness, hope, encouragement and confidence inspired by the judicious physician and nurse, in inducing and maintaining the mental quiet which every experienced clinician recognizes to be so important a factor in the management of cardiac cases.

The depressing effect on the heart and circulation of pain, restlessness and insomnia, are at times not sufficiently appreciated. In these conditions the administration of morphia, or some prefer pantopon, bromides or other sedatives to induce rest and sleep, may be of the utmost value indirectly in relieving the heart.

Similarly the relief of digestive disturbance, and especially distention of the abdomen, should be borne in mind. A mercurial, followed by a saline, by depleting the portal circulation, may indirectly relieve the right side of the heart.



In vigorous patients, with evidence of overloading of the right side of the heart, especially early in pneumonia, venesection is a therapeutic measure which has perhaps fallen too much into disuse.

The ingestion of excessive quantities of fluid, necessitating increased work on the part of the heart to force it through the circulation, is a matter which is too often lost sight of in our endeavors to flush out the system.

The use of baths and the ice bag to the præcordium to quiet the circulation, reduce the fever, slow the pulse and improve the vascular tone, are all valuable means of assisting the heart.

In circulatory failure due to vasoparesis, with overfilling of the splanchnic area and depleting of the general circulation, the subcutaneous or intravenous administration of normal saline solution is of value, though to a less degree than in that resulting from hemorrhage.

The inhalation of oxygen I have found of value in maintaining cardiac action in some cases of failing circulation, especially where cyanosis is present.

It is impossible from the nature of its function to give the heart physiological rest, but whatever measures tend to lessen the frequency of the pulse without impairing the circulation are in the right direction.

The heart and vasomotor centres may be favorably influenced reflexly by sensory stimuli from the surface of the body, so that baths, friction, mustard plasters to the præcordium, and such measures have a rational justification for their use as circulatory stimulants.

Every clinician will recognize how often the history of a case of myocardial insufficiency may be traced back to an attack of fever—pneumonia, typhoid, influenza, rheumatism, septicæmia, etc., occurring a longer or shorter period before, even though no definite evidences of heart complication showed themselves at the time. Da Costa, many years ago, called attention to this in his contributions on "Heart Strain in Soldiers." One cannot emphasize too strongly the necessity for avoiding any unusual or severe exertion until there has been time for myocardial regeneration after fevers. Failure to observe this precaution is a common cause of angina, or other forms of irreparable damage to the heart.

The importance of chronic foci of infection in the tonsils, about the teeth, ears, accessory nasal sinuses, etc., as the sources whence pathogenic bacteria may enter the circulation and attack valves or endocardium, especially if previously diseased, should never be lost sight of. Recent investigations of the etiology of subacute and chronic bacterial endocarditis strongly emphasize this point.

Drugs in general have a more limited field of usefulness in the

fever heart than in chronic cardiac diseases. Mackenzie says: "That apart from the probably specific action of salicylate in rheumatic cases the employment of cardiac or other drugs is of little avail. The heart is already in possession of a poison far more powerful than the drugs at our command, and these in medicinal doses are without effect. The man who puts his faith in drugs exclusively neglects too often the most useful methods."

I believe that the value of the salicylates in protecting the heart in rheumatism is very questionable, and may be a source of danger, if by relieving the pains which necessitate the patient's keeping at rest, he is allowed up sooner than would otherwise be possible.

I do not propose to enter into a discussion of the difference of opinion among pharmacologists as to the action upon the heart, medullary centres and vessels of the various drugs recommended for their beneficial influence, nor of the fallacies involved in applying the knowledge of their action on the healthy organs of experimental animals to the diseased organs of man. The question of their value, after all, is a practical one, to be ultimately determined by critical investigation and accurate clinical observations in hospital wards and private practice. In this direction much work yet remains to be done.

I have never seen any benefit from drugs of the digitalis group in the cardiac weakness of fevers. They do not, ordinarily, slow the pulse, they may interfere with digestion, or produce vomiting, and in cases of intermittency of the pulse from involvement of the auriculo-ventricular bundle, may induce heart block.

There is also a growing pessimism in regard to the value of strychnia, though it undoubtedly is a stimulant to the medullary centres and possibly exerts a favorable influence on the tone of the heart muscle.

Camphor, acting principally upon the nerve centres, has been a more recent favorite. I have used it extensively and have thought it of some use, though its effect is not striking.

Caffeine is a stimulant to the medullary and cerebral centres, and so increases the feeling of well-being, but in large and repeated doses may tend to induce sleeplessness.

I have never seen any benefit from the hypodermic administration of ether, which formerly was so extensively used in circulatory failure.

Adrenalin, intravenously or subcutaneously, may be used in cases with low blood pressures, though its influence is transient.

Despite the results of pharmacological investigations and the opin-

ions of many excellent authorities, I believe alcohol is of real value in some cases of circulatory failure, though by no means the essential to treatment it was once considered.

To summarize I would say:

- (1) That chief reliance should be placed upon general treatment—mental and physical rest, the relief of pain, insomnia, digestive disturbance; baths, diet, the ice bag to the pericardium, etc.
- (2) Cardiac drugs occupy a secondary role in treatment.
- (3) Coal-tar and other depressant antipyretics are dangerous and should be used, if at all, with great caution.
- (4) A careful study should be made of the pathological changes liable to occur in the heart in the various fevers, as a guide to the care and time required for regeneration and repair of the damaged heart muscle.
- (5) It is necessary to avoid over-exertion or strain during convalescence—for months or even a year after a severe infection.
- (6) It is important to guard against subsequent infections, such as tonsillitis, influenza, etc., in patients whose hearts have previously been damaged. Even short febrile attacks should be considered seriously and carefully treated.

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## THE METHOD OF DEALING WITH TUBERCULOSIS IN THE PUBLIC SCHOOLS OF TORONTO.\*

BY ALEXANDER MACKAY, M.D.,  
Chief Medical Inspector, Board of Education, Toronto.

**M**EDICAL inspection was begun in the Toronto public schools by the Board of Education in 1910. Miss Lina L. Rogers was appointed superintendent of nurses. In the same year two medical inspectors and four nurses were appointed. The work of the medical inspectors and nurses disclosed such serious conditions of health that arrangements were undertaken by the board to organize a system that would embrace all the school children of the city. In February, 1911, Dr. W. E. Struthers was appointed chief medical officer, and in March eight assistant medical inspectors, one dental inspector, and thirteen nurses were added to the staff. One year later, February, 1912, six additional nurses, and in March, ten additional medical inspectors were added; in March, 1913, three more medical inspectors and twelve nurses were appointed to complete the medical and nursing staff. Dental rooms were equipped in four schools, and four dental chairs were installed. In

\* Read at meeting of Ontario Medical Association, Peterborough, May 25th to 27th, 1915.

April, 1913, two dental surgeons were appointed, and later two more were added. We have at present 13 dental clinics established in schools in those sections of the city where we feel the need is most urgent. We are now able to secure the complete treatment of the mouths of approximately 600 to 700 children per month.

The present total staff consists of a chief medical officer who gives his whole time to the department, twenty medical inspectors on part time, one of whom is a special examiner for tuberculosis, one chief dental officer and thirteen dental surgeons on part time, one superintendent of nurses and thirty-five nurses on whole time.

The city is now divided into districts with a medical inspector and two nurses in charge of each district. The medical inspector and the nurses of each district are expected to obtain an accurate knowledge of the prevalence of disease, sanitary conditions, home environment, and the number of indigent families in the district. The investigation and control of positive and suspect cases of tuberculosis among school children is being carried on with the assistance of the whole staff by one of the assistant medical inspectors specially qualified to undertake this work. The work is being developed in proportion to its importance and magnitude. All known cases are recorded and every exposed and suspect case is examined. The medical inspectors and nurses assist the special examiner by referring to him all exposure and suspect cases with a report of home conditions.

Extract from instructions to the staff regarding positive and suspect cases of tuberculosis:

"Cases naturally divide themselves into two classes. First, those without a history of exposure, and second, those with a history of exposure, that is, direct contact.

"All suspect cases *without a history of exposure* must first be examined by the school medical inspector, who, if he deem it necessary, will have a report sent in requesting an examination by the special examiner. Special consideration is to be given cases where an examination is requested by the parent.

"All suspect cases *with a history of exposure* should be reported, and a notification will be sent stating the manner in which the case is to be followed up and examined.

"Reports, of *all new* cases of suspect tuberculosis, and *all old* cases not as yet recorded with stickers, should be sent in with your daily records, on the form provided. In the event of not having a form, give all the information which is thereon asked for: Name of school, family name, address, names of all the children of all ages in the family, present whereabouts and condition, history of contact or exposure, agencies interested, and your signature.

“Cases which are reported from the office of the chief medical officer and having a history of exposure are to be examined as soon as possible by the special examiner or at a chest clinic at one of the hospitals or dispensaries mentioned in the notification.

“Cases which are examined by the special examiner or at a chest clinic will have the results of the examination reported to the medical staff of the school as soon as possible. If the child is advised to discontinue attendance at school, the report will state this, and when advised to return to school after absence the child will be given a note to this effect.

“Cases reported by the special examiner, and no others, are to be recorded by the school medical inspector on the children’s reference and physical record card, with colored stickers. These stickers are used according to a code supplied.

“Under the heading on the report, “Agencies Interested,” the following are the four principal ones: the parent or guardian, school, family physician, and any recognized professional agency, in the order in which they are to be considered.

“A record of every child examined to determine if tuberculosis infection is present is kept in the office of the chief medical officer. In so far as possible the record of each family will be completed under the following heads:

- Date of the special examination.
- Names of all the children in the family.
- Ages of all the children.
- Family address.
- Name of the school or schools that the children attend.
- Brief history of the exposure: family, house, occupational, time, duration, degree.
- Result of the tuberculin test.
- Number of the X-ray when taken.
- Pathological lesions.
- Diagnosis, and by whom it was made.
- A note as to whether the case has been registered or reported to the Board of Health.
- A note stating by whom the child was referred for examination.
- A note of the child’s present physical condition, and of the home and social conditions.
- A note of the recommendations re school and treatment.
- A note of the termination of attendance or treatment.

“The work of the department is carried on in conjunction with the work of the family physician, dentist, the chest clinics at the hospitals and dispensaries, the various missions, the social service organizations, and the Board of Health. From these sources reports are received and acknowledged. The work is being developed and expanded in harmony with the existing organizations in order to reach the largest number of children possible, and as soon as there is reasonable ground for investigation to bring the timely aid which will ultimately be a great factor in lessening the prevalence of tuberculosis among school children—conservatively estimated at 25 per cent.—and also as a direct consequence among adults.

Information may be obtained at any time by the members of the staff from these records.

“When the ‘Agency Interested’ is a physician the following form letter is sent to him and no further steps are taken in the case until a reply is received:

Toronto, .....

Dr. ....

Dear Doctor,—I have received a report that you are interested in the ..... family, ..... Street. The report states that the children attending school have been exposed to an infection with tubercle bacilli. We are desirous of gaining some definite knowledge regarding this infection, the control of which is one of the aims of medical inspection of public schools. We ask for your co-operation in one of three ways:

1st.—That you send a certificate giving your examination findings, and state whether the case shows sufficient signs and symptoms to make a clinical diagnosis of

....., age .....

....., age .....

2nd.—Or that you will express your willingness to have the children examined at school by the school special examiner, Dr. F. S. Minns, who will send you a report of his examination.

3rd.—Or that you will express your willingness that arrangements be made by the school nurse for an examination at a chest clinic at one of the hospitals.

Trusting to hear from you soon in regard to this matter, I remain,

Yours sincerely,

ALEX. MACKAY,

Chief Medical Officer.

This special work has been carried on for a year and a half. During this time a large number of letters have been written to the doctors. The response in almost every case has been prompt and in all cases a ready will has been shown to assist in the work in every way. Every

doctor has experienced the difficulty of getting permission to examine all exposure and suspect cases which he meets with in his private practice and he has been found to welcome the aid which will enable him to render service to those under his care.

Contagious diseases reported to the Board of Health from all sources are daily reported by the Board of Health to the chief medical officer. These cases are then reported by telephone and mail on special forms to the principal and to the medical inspector of the school in the district in which the cases live. Cases of tuberculosis reported from the Board of Health, however, are for several reasons sent on to the school medical inspector only. The school nurse then discovers whether there are any school children in the house with the case. If school children are found a complete record is sent in on the form provided, and where there are no school children a report to this effect is returned. The results of all examinations and the recommendations in each case made by the special examiner are reported to the Board of Health. In the case of tuberculosis adults examined at the clinics at the Toronto General, St. Michael's, and the Western Hospitals, instructions are given to the patient that all the children exposed are to be brought to the chest clinic at the Hospital for Sick Children for examination, irrespective of presence or absence of symptoms of tuberculous infection. The results of the examinations and the recommendations made by the examiners at the hospital are reported to the medical staff of the school which the children attend. The Board of Health and the Board of Education nurses therefore receive the same information about the cases. This tends in a measure to prevent overlapping of medical, nursing, or relief work. Many new cases other than the above are continually being found by the nurses in their work in the school or while making visits to the homes, and these cases are reported to the special examiner.

The examinations made in the schools are arranged by the school nurse, who gets a written consent from the parents for the examination. The nurse also endeavors to have the parent present. This is of considerable help in obtaining an accurate history and it ensures the prompt carrying out of recommendations. A tuberculin test is made for each child examined—either a Von Pirquet or a Mantoux.

Cases examined are divided into three groups: positive, negative, and cases of doubtful evidence. Cases in the third group are kept under observation and re-examined until placed in either the positive or negative group. The positive cases are sub-divided into two groups—open and closed cases. The closed cases are all positive tuberculin reactors with clinical evidences of tuberculosis.

This branch, as are all the branches of medical inspection work, is

carried on to help each child of school age to attend the largest number of days. This is possible for a healthy child only. The natural question which arises is: "What are we doing for the child who is found with signs and symptoms of tuberculosis?" The large majority of them are found to have one or more of the following more common pathological lesions, viz., sore eyes, defective teeth, discharging ears, enlarged cervical, mediastinal or bronchial glands, or some pulmonary involvement. Varying grades of anæmia and degrees of debility with frequently recurring colds are common conditions. In many cases treatment of the non-tuberculosis conditions is the best treatment for the tuberculous. Parents are advised to take their children to the family dentist. If unable to afford to do so, the children are treated at one of the school or municipal dental clinics. For ear, nose, or throat treatment, the children are referred to the family physician, or to one of the hospitals. The correction of these defects in many cases is all that is necessary, with the addition of general measures to improve the general health. Tuberculin treatment is advised for suitable cases and is given by the family physician, or at the chest clinic at the Hospital for Sick Children. Open cases among children, pulmonary or otherwise, which are a menace to others, are excluded from all schools and are treated by the family physician, and in the case of the poor are also under the supervision of the Department of Health. In some instances they are referred to the Queen Mary Hospital at Weston, where there is accommodation for about sixty children. These children are taught by a teacher supplied by the Board of Education. A large number of closed cases are sent to the Preventorium of the Daughters of the Empire for a period of from one to four months. Their education is also carried on by a teacher provided by the Board of Education while in this institution. The admissions to this institution are granted at the chest clinic at the Hospital for Sick Children. The child sent to the Preventorium is one who, after repeated examinations, is considered safe to mingle with other children and to be re-admitted to school. During the six warmer months of the year the Heather Club Chapter of the Daughters of the Empire with the co-operation of the Hospital for Sick Children are able to care for fifty children at the Lakeside Home. During this period the Board of Education also maintain two forest schools, one in Victoria Park, the owner, Mr. H. P. Eckardt, having generously given the use of the grounds and buildings for the past two years, and one in High Park, a corner of which is being used with the consent of the City Council. In this school we use two large tents. One as a dining-room, and the others divided part as kitchen and part as store room for blankets, pillows, and supplies.



The appropriation of the Board of Education for the maintenance of these schools is based upon an average daily attendance of 100 children at each of the schools. This appropriation provides for equipment, feeding, tuition, both academic and hygiene, car tickets for those children who are too poor to provide them.

In as much as these schools are intended for children physically subnormal and presumably more susceptible to secondary infections, great care is exercised to select only such cases in which infectious pathological conditions are quiescent. Frequently it is found necessary to cope with bad environment, poverty and ignorance, and here the agencies of pure air, selected diets, and education are the remedies par excellence. After Easter holidays the medical inspector of each district is instructed to send to the chief medical officer the names of all the children in his district who are physically subnormal and who he believes would be benefited by attendance at the forest school.

The children are selected in the following order:

1. Those who are positive T.B. (closed cases).
2. Those who have been exposed to T.B.
3. Those who are subnormal from other causes—*anæmia*, malnutrition, etc., who might be called *suspect cases*.

Every child is reported upon a form giving name, address, age, school, grade, height, weight, chest, mentality, physical defects, personal history, family history, home conditions.

From this list submitted the chief medical officer selects about 250 of the most deserving cases in the order above named. (We find that a registered attendance of 250 children gives us a daily average attendance of about 200.) Any child selected who is suffering from adenoids, enlarged tonsils, defective teeth, etc., must have these defects corrected upon entering the school, in order that there may be no impediment to his receiving the greatest amount of benefit. The staff of each school consists of a principal, who is in charge, and two assistants, a nurse, who looks after the feeding and personal hygiene of the children. Besides these there is a cook and two kitchen help. These schools are open about six months of the year. From the middle of May until about Nov. 1st, or as long as weather conditions will permit. During fair weather the children spend about 10 hours in the open. They arrive about 8.15 a.m. and leave for home about 6.15 p.m. The following is the daily routine: Breakfast, 8.30; school, 9.00—10.30; then a glass of milk and a play period; school, 10.45—11.30; then another play period and a wash-up for dinner at 12. From 1.00 to 3.00 they sleep in the open. Then a glass of milk, and school 3.15—4.15; then a play period and a wash-up for supper at 5.00. Afterwards a play period

until time to leave for home. Besides the school work taken up by the teacher the nurse instructs the children in the use of the tooth-brush and the care of the teeth, gives talks on cleanliness and care of the body, ventilation, wholesome food, manners and deportment, gives breathing exercises and nature talks as they ramble in the woods. Every day a certain number are given a tub bath. The children are weighed once a week and weight recorded.

1914.

Cost of maintaining a child per month at Victoria Park ..... \$8.75  
 Cost of maintaining a child per month at High Park ..... 8.49

#### HIGH PARK SCHOOL.

The average gain in weight of 63 children was  $4\frac{1}{4}$  lbs., the gain varying from  $\frac{1}{2}$  to 12 lbs.

#### VICTORIA PARK SCHOOL.

The average gain in weight of 100 children was 3 lbs., the gain varying from  $\frac{1}{4}$  to  $18\frac{1}{2}$  lbs.

The child gaining only  $\frac{1}{4}$  pound left school early in July and would not return.

The following is the history of the child gaining  $18\frac{1}{2}$  lbs: When Florence Watson, aged 12, entered Victoria Park school she weighed  $71\frac{1}{2}$  lbs., and had the following defects:

Enlarged glands,  
 Defective hearing,  
 Marked anaemia,  
 Defective teeth,  
 Positive T.B.

In August she had her teeth extracted and filled at the municipal dental clinic. When she left the school she weighed 90 lbs., which was a gain of  $18\frac{1}{2}$  lbs. There was a marked improvement generally. Gain increased materially after treatment of teeth.

#### A REPORT OF THE RESULTS OF THE EXAMINATIONS MADE AT THE CHEST CLINIC AT THE HOSPITAL FOR SICK CHILDREN AND IN THE PUBLIC SCHOOLS OF TORONTO FOR THE YEAR ENDING APRIL, 1915.

*Compiled by Dr. F. S. Minns.*

Number of children examined at the hospital ..... 592  
 Number of children of school age ..... 422  
 Number directly referred from the schools ..... 90

This is a small estimate because it leaves out the many cases that are referred by the schools to the other departments in the hospital,

viz., eye, ear, nose and throat, medical, and surgical, which are recorded as referred by the department and not by the school.

Positive.	Negative.	Doubtful evidence cases.
174	90	158
41.23%	21.32%	37.45%
Number of children examined in the schools . . . . . 213		
Positive.	Negative.	Doubtful evidence cases.
112	41	60
57.27%	19.24%	23.49%

One explanation of the difference in the percentages given is that in the case of the examinations made in the schools the cases can be followed up more closely. This means the shifting of more cases from the doubtful evidence group. It is found difficult in many of the hospital cases to get the children to the clinic a sufficient number of times to make a definite diagnosis.

The gain in weight is very desirable and important, as it should indicate increased vitality and strength; but this is only a small part of what has been accomplished. Besides the renewed health and strength a child's ideals have been raised and a vision given of the higher calls of life.

Not only will forest schools do much to prevent debility, consumption and all wasting diseases, but will do much to restore vitality and produce a physical and mental development which means efficiency and usefulness to the city and state. While acknowledging the splendid results that accrue to subnormal children by attendance at these schools, yet we must acknowledge that there is one serious drawback to these schools becoming generally adopted by school boards, and that is the expense, \$8.50 per month per child. Then we must not forget that a certain percentage of the benefit obtained is lost when in the autumn these children return to their usual school and home conditions—the home conditions in nearly all these cases being extremely bad. How can this be remedied?

1st. Improving home conditions. The nurses employed by the Board of Health are doing splendid work in improving the unsanitary conditions of the homes from which these children come and in instructing the mothers in the principles of clean and healthy living.

2nd. By open air schools and open air classrooms in connection with out public school buildings. For some two or three years our medical inspection department has been urging the Board of Education to make in all new schools and in additions to old schools provision for one or more open air classrooms. Also to have the roofs of several schools in selected districts fitted up as open air schools. We have at

last succeeded in making a beginning. The new Orde Street school, which will open in September, is being provided with two open air classrooms and the roof is being fitted up as an open air school.

The Board of Education of Toronto have always given generous consideration to any project that will benefit the health of our school children, and I am living in hopes that in the not far distant future every classroom in our public schools will be an open air classroom, because only then and not until then will we get the highest physical and mental development in all our school children.

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### HOW SHALL WE ENFORCE A BETTER OBSERVANCE OF QUARANTINE?\*

BY C F. LAURIE, M.D., M.O.H.,  
Port Arthur, Ont.

THIS is a question to which doubtless every medical officer has given a great deal of thought. If we could only enforce quarantine, if every citizen was public-spirited enough to assist us, if every contagious case was reported by the medical attendant, we could soon stamp out all contagious diseases from our country. Unfortunately all physicians do not report all their cases as they should. Some are not sure of their diagnosis; they cannot decide if it is a severe case of tonsillitis or diphtheria, whether the case is a simple rash or a mild attack of scarlet fever. They hesitate to report the case as suspicious on account of the inconvenience to the patient's family, until the disease spreads to others, perhaps outside the family, then when too late it is reported and the Medical Officer of Health finds that he has an outbreak of disease on his hands, which may cause him a great deal of trouble, work, anxiety and expense. All of which might have been avoided if the physician had reported the first case as suspicious and had had the proper steps taken to quarantine and watch it. And after eleven years' experience in the office of Medical Officer of Health, I am very much in favor of a close, strict quarantine. We are often asked to have the patient isolated in some room in the house and to allow the rest of the family to carry on their work, with all kinds of promises that every care will be taken, etc. While I admit that it is possible to do this, if the care is really taken, I am just as sure that it will not work as you cannot trust the ordinary citizen. Then if you give one citizen this privilege and refuse another whom you are sure you cannot trust, you are up against trouble at once.

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\* Read at meeting of Ontario Medical Association, Peterborough, May 25th to 27th, 1915.

You cannot make fish of one and flesh of another. So for some time I have insisted on a close quarantine, allowing the breadwinner to go out and stay out, or else stay in until the quarantine is over.

Again, other physicians are careless, intending to report but forgetting for two or three days, during which time the disease spreads. Then there is no doubt some physicians deliberately try and help the family to conceal the case so as to avoid quarantine. The family object to the quarantine on account of the inconvenience and expense; the medical attendant is asked to keep it quiet, and perhaps given a hint that if he does not they will call some other doctor next time. It is a case of dollars and cents to him; he may wish to do his duty, but is afraid to offend. He may get a promise that the patient will be kept isolated and every care taken, all of which may be done while the patient is ill, and while the acute symptoms last, but when the patient is better and all the symptoms gone, the family may become careless and allow the patient to mingle with the public long before he or she is free from infection, and thus the disease spreads. The doctor cannot now object as he did not do his duty and dare not speak.

Then in another case a physician may not be called, the family taking care of the patient themselves. They may know, or at least suspect what is the trouble and not call medical aid for fear the case may be reported. Where the child attends school and a school nurse is employed, this is hard to carry out, as the nurse is sure to call to see why the child is not at school. In this way, in our city, we have discovered quite a number of cases which would not otherwise have been reported. I think it is one of the best investments our city has made when we appointed our school nurse last year, and to-day we have very few cases of contagious disease among children. Of course, sickness and quarantine are a decided affliction, inconvenience and expense. Last year we had an extensive outbreak of scarletina and measles. The scarletina was of the very mildest type, with but few exceptions; the symptoms all disappeared in two or three days in a large number of the cases, and if they had not been seen at the beginning we would not have been able to make a diagnosis, as the patients were not at all ill nor confined to bed. In fact, a number of children with the disease were sent home from school by the nurse, the parents claiming that they had not known the children were ill, or perhaps claiming that they thought they only had a slight cold. I am quite satisfied that some of these statements are correct, but again I feel sure that some parents were suspicious, but claimed ignorance so that they would not have to keep the patient at home and to escape quarantine. We treated a number of the patients at our Isolation Hospital, but on account of the long quarantine causing

over crowding, we could not accommodate all. Then some parents refused to allow the patients to go to the hospital, preferring to keep them at home and have the house placarded. In one case, which we quarantined in April, we took the card down early in June; it was only down about a week when a second case developed, although the house had been most carefully disinfected and cleaned. A few days before we expected to take down the second card, a third case developed; thus the family had to spend between three and four months in quarantine, which, of course, was a great hardship, especially as the householder was a laboring man. We had several outbreaks in families like the above, in which the quarantine extended over many weeks, and it is very easy to understand the very strong temptation to break quarantine, especially if the family lives on some small city lot closely surrounded by houses, making them feel almost as though they were in prison. If there are a number of small children, who are anxiously standing at the fence day after day, watching their playmates outside on the street playing ball and other games, it is very little wonder to hear that they have stolen out for a few minutes' play, but perhaps carrying disease with them. If the patients had been removed to a hospital, it would have helped very much to control the disease, but there was the natural feeling of wanting to keep the patient at home, where they could watch them, as well as the fact that the hospital was over-crowded.

I think that with very few exceptions all contagious cases should be removed to a proper hospital for treatment. Our Boards of Health should have more power and authority in building hospitals, which power now rests with the councils, whose interests are often taken up in other directions, while the Boards of Health, who naturally give more time and thought to the question of health, have to persuade the council into expending money to prepare hospitals for the treatment of disease, which is often a hard thing to do, especially when everything is healthy and quiet. Of course, when there is an outbreak, the Board of Health has very great powers to deal with it, but I think we should have the full authority to prepare isolation hospitals in which to treat disease, as without doubt it is the most satisfactory method to keep disease from spreading, by removing the patient, and then we would not have the inconvenience of quarantine. The Medical Officer of Health may feel certain that some families had disease of a contagious nature in the house, but he has to prove it before the offenders can be punished. He may be told by a neighbor, after the case has recovered, if he gives the promise that the neighbor's name is not to be used in any way; then again he may feel very sure that they are breaking quarantine, but may not be able to catch them, as it is rather expensive to keep guards on all

houses day and night during an epidemic, and the Board of Health and council may object to the heavy expenditure, the medical officer being told that he must cut down expenses. I wish to say right here that an officer has to have a good deal of independence to withstand pressure and criticism in regard to expense from both the Council and the Board of Health, but results cannot be gotten no matter how careful you try without some expense, and results are what the public want and expect. However, we do occasionally find a case which we can prove, and are able to make an example of by having them summoned before the magistrate. It is an unpleasant duty and the chances are that the patient's family and friends make it a personal matter and are your enemies forever after. You are not only going to lose their practice and support, but they are going to do all they can to injure you and if possible have you discharged, which is not hard to do. Then when it is a brother practitioner whom you have to summon to court it makes your duty all the harder to perform, and he in turn may do you a great deal of harm. His friends and the patient's friends are almost sure to stand by him and attack you. If the medical officer is in private practice it may be a very serious matter for him. It seems a fact that medical men as a class are not money-makers, the majority do not get independently rich, so that they can drop out of practice and retire. The consequence is that the medical officer drawing a very poor salary from the municipality is very apt to hesitate before he will enforce the law against some influential member of the community, who may have seriously offended against the quarantine regulations. He should do his duty, but he has to live, and perhaps has a family to support, and he knows that he may receive very little support from the public. Even the Councils who pay the medical officer show by the niggardly salaries most are paid that they are not expecting very much from the officer, and look upon the office as of little importance. Left to himself, the medical officer is very apt to take a lenient view of the offence, and if possible, pass it over. Thus disease spreads and lives are sacrificed to ignorance, greed and selfishness, and many innocent families are put to a great deal of inconvenience and expense. These, gentlemen, are a few of the facts connected with our work, which must have come into the experience of every Medical Officer of Health. However, I think the fault and remedy lie to a large extent with themselves; the fault lies in the fact that a great many officers, I believe, are afraid to do their duty, afraid, as I said, on account of the opposition they arouse, and also on account of the financial losses it may cause them. Also the fact that so many seem willing and anxious to take a position which they should realize is going to give them a lot of anxious and hard work, for the miserable salaries

which some officers now receive. It belittles the importance of the office in the minds of the public generally, when they know that a medical man is willing to take such an office for less, perhaps, than is paid to the pound-keeper. Naturally we cannot blame the public for putting a low value upon our services, if we put a low value upon them ourselves. The Act says: "We shall be paid a reasonable salary." Even in some towns, I understand, there are medical officers working for \$200, \$300, or \$400 per year. If they, along with the rest of our profession, would refuse to take the office at such a meagre salary and would insist on at least a living wage, they would be in a position to render better service and give more time to their work. I think, gentlemen, that every Medical Officer of Health should be a full-time man, drawing a salary which his position, education and the services he is rendering the public demand. I believe the public would soon appreciate the better work that might then be done, and the change for the better in health conditions which would most surely follow. Of course, I understand that the townships would not be able to pay a reasonable salary to a medical officer large enough to enable him to give up private practice, but by making the office a county one, instead of a township, and perhaps taking in some of the smaller villages, I believe that the desired result could be obtained and more satisfactory work done. In cases where the county is too large or thickly populated it might be divided. It is a scheme that could easily be worked out, and I believe would bear the best results, the officers, being independent and free, would be able to give more time to their work and have less fear in punishing offenders. In cases where there is not enough work to justify a decent salary, the officer could take care of the indigent sick.

To my mind, gentlemen, these are some of the ways by which we might get better results. First, by treating all contagious cases in proper isolation hospitals, and, secondly, by taking our health officers out of private practice and thus removing them from all temptation to overlook any violation of quarantine. It is no use expecting the public conscience to grow strong enough to keep quarantine and inconvenience themselves if they can get out of it; human nature is too selfish, we all believe our neighbors should do right and we are quite ready to condemn them when they do not, but when it comes home to ourselves a great many are very willing to avoid the trouble if they can successfully, in which case our officials should be in a position to fearlessly step in and see that the law is observed.

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## CURRENT MEDICAL LITERATURE

## THE CELLULAR FACTOR IN INFECTIONS.

David Riseman, Philadelphia (*Journal A.M.A.*, Feb 20, 1915), after stating in a general way the theories of bacterial infection, and their common application to all phenomena of infectious diseases, calls attention to the cellular factor in these cases, which he thinks may have been too much ignored. Two cases observed by him a decade and a half ago, one a case of general carcinomatosis, and the other of miliary tuberculosis, clinically so similar and etiologically so different, and the second one so similar to typhoid fever, made a profound impression on him at the time and he made it the basis of a hypothesis, which he here expands, in a paper published at the time. Leaving out the nanaer case, he confines himself to a discussion of miliary tuberculosis and typhoid fever. The most striking common feature of the two is the tremendous cell proliferation. In miliary tuberculosis, the cells are innumerable, and they grow by utilizing the elements of the blood, chiefly the big protein molecule. The cast-off products of their activity may be normal, but they may overtax the power of the system to deal with them. If normal, their harmfulness is still more evident. There is probably, however, another more important factor for evil to be taken into account. The newly formed cells soon die, undergoing a change known as caseous degeneration, and this, Riesman thinks, is probably to be explained by the newer theories of ferment action, especially by the theory of parenteral digestion. The cells of the tubercle undergo a sort of incomplete digestion, and throw into the blood substances that if not qualitatively, are at least quantitatively, abnormal. He believes that in all forms of tuberculosis a large but not fully ascertained part in the production of the symptoms must be attributed to the substances liberated by the living and dying pathologic cells. What is said of tuberculosis holds true, he maintains, as to typhoid fever. The colossal proliferation of cells produced by the typhoid bacillus has to be disposed of. The bacillus disturbs the physico-chemical equilibrium, and starts a series of reactions that go from step to step to the end of the process, a physico-chemical equilibrium of either recovery or death. What part of the symptomatology of typhoid is bacteriotoxic and what part is cellulotoxic is hard to say, and further research is needed. Pneumonia is another disease in which Riesman thinks the bacterial toxemia has been overestimated, and it seems to him not improbable that some of the general symptoms are due to the exudates independently of the bacteria. "On the basis of the theory or hypothesis here advanced a new classification of bacterial

infections suggests itself. We may make two great classes: A. The productive infectious diseases, characterized by cellular proliferation. B. The non-productive infectious diseases, not so characterized. To the first class belong tuberculosis, typhoid fever, and pneumonia. In pneumonia the cells of the exudate may not be all newly formed. They may have been called forth from the cell depots in the blood and elsewhere. They are, however, new in their pulmonary site and in the Abderhalden sense are out of place. To the non-productive bacterial diseases belong diphtheria and tetanus. A closer study of this classification reveals an extremely interesting point, namely, that the infections classed under A, that is, the productive infectious diseases, are all due to bacterial endotoxins, or, in the sense of Vaughan, to split proteins, while those in Class B, the non-productive infectious diseases, are due to the soluble toxins and not to poisons contained in the bacterial bodies. Whether this is a general biologic law, I do not know. In conclusion, I beg to express the hope that men devoting themselves to research (if they find anything suggestive in the hypotheses advanced, will test them in the only scientific way, by the experimental method.

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#### CONJUGAL SYPHILIS AND PARESIS.

Robert H. Haskell, Ann Arbor, Mich (*Journal A.M.A.*, March 13, 1915), taking the material observed at the Psychiatric Clinic of the University of Michigan, gives a study of fifty-five cases of general paresis in married individuals coming under treatment during the past three years, in which they have been able to test the presence of syphilitic infection in the other mate, and secondly, eighty-six cases in which the anamnesis concerning intimate family matters of absolute sterility, pregnancies with early abortions, total number of living-born children, with additional abortions, miscarriages, etc., could be accepted without question. They found that in forty-nine cases in which the husband was parietic, seventeen wives were infected with syphilis, and in six cases in which the patients were women, four husbands were likewise infected. Only two of the infected mates had any previous knowledge of the infection, or could tell of any suspicious sign. Only one of them had had any antisiphilitic treatment. While the number of cases is small, since they are taken as they came, over a space of three years, and agree largely with the results of other investigators along this line, Haskell thinks the following conclusions justified: "The large number of 38.18 per cent. of conjugal mates of parietic patients is shown to be infected with syphilis. In most of these mates the condition courses

unrecognized as lues latens. A pitifully small number of them ever receive treatment. The proportion of these infected mates who later develop paresis appears to be higher than those who receive their infection from non-metasyphilitic sources. The number of completely sterile marriages is in syphilitic families in which one individual later develops paresis is abnormally high, constituting 32.5 per cent. This percentage is higher when it is the female that later becomes a parietic. The number of marriages in which repeated pregnancies result only in abortions is likewise abnormally high, constituting in our series 12.7 per cent. Of our series of eighty-six marriages, 45.3 per cent. were absolutely childless. Among 167 pregnancies there were forty-two abortions, miscarriages and stillbirths. Among 123 living-born children, twenty had already died before their eleventh year. The number of living children per family is abnormally small. A large number, in some investigations reaching as high as 25 per cent., of these children are actively syphilitic. An equally large additional number show signs of degenerative conformation and psychopathic tendencies without a positive Wassermann reaction. Much of all this is preventable."

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#### LOCAL ANAESTHESIA IN PROSTATECTOMY.

Legueu (*Journ. des praticiens*, June 13th, 1914) points out that the question of anaesthesia in urinary surgery is one of great importance, and that in prostatectomy, more than any other operation, it is desirable to avoid general anaesthesia. The possibility of latent nephritis and hepatic insufficiency render accidents from the use of chloroform very probable. The former of these can be eliminated in a certain number of cases, but the hepatic contraindication is not so easily recognized. According to the author, the action of chloroform on the kidneys is, in the light of clinical experience, not serious, but it has a profound action on the liver cells, and this happening in a case of hepatic insufficiency may result in subacute intoxication and death. In these cases the renal default is secondary, the kidneys failing to eliminate poisons of hepatic origin which have passed into the circulation. Autopsy has shown signs of azotaemia in these cases and an altered condition of the liver, but the kidneys as a rule are intact. The method of spinal anaesthesia has many attractions owing to its simplicity and apparent effectiveness, but it has been shown to be dangerous with cocaine and insufficient with stovaine. It is often necessary also to give chloroform in the course of the operation. According to the author, radio-anaesthesia should be abandoned in every form. The best method is regional anaesthesia of

the nervous trunks as they emerge from the vertebral canal. The prostate receives its innervation from the third and fourth sacral nerves, and anaesthesia may be carried out according to the method of Braun, the solution used being a combination of suprarenal extract and novocain. Local anaesthesia of the prostate has also been attempted by the perineum—injection, while guided by the finger, cocaine in front of the rectum. The method does not commend itself to the author, as insufficient anaesthesia has sometimes resulted. He has sometimes done the operation under local anaesthesia by opening the bladder and following the method of Réclus, proceeding step by step. After the bladder has been opened a series of punctures are made by needles of varying length and curvature, so anaesthetizing the prerectal zone. Generally about sixteen punctures are required, representing 60 to 80 cg. of novocain. This technique has given good results, and the operation lasts about half an hour. Some limited sloughing of the skin and deeper tissues has sometimes occurred, but has not in any way interfered with the successful results obtained.—*British Medical Journal*.

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#### OPERATIVE TREATMENT OF ACUTE EPIDIDYMITIS

D. O. Smith and B. H. Frayser (*Annals of Surgery*) believe epididymotomy is a rational thing to do because it shortens the disease, relieves the severe, weakening, sickening pain at once, causes the temperature to fall and induration to disappear rapidly. The operation is as follows: After shaving the parts thoroughly they use a three per cent. alcoholic solution of iodine. External and parallel to the epididymis, they make an incision into the tunica vaginalis. This incision should be large enough to deliver the testicle. Examine the epididymis and make multiple punctures with a blunt probe in that portion which is inflamed. Gently massage the part, wash with warm salt solution and return testicle to scrotum. Close the tunica with catgut and insert a narrow iodoform gauze drain. The external wound is closed with silk worm gut, using the subcuticular stitch—the drain passing out at the lower angle. After operation a sterile gauze dressing is applied and a suspensory bandage is used to support the scrotum. On the second day the wound is inspected and the iodoform drain removed. Daily dressings are not necessary. Usually on the fourth day the patients are up and allowed the freedom of the ward. On the fifth day a two per cent. alcoholic solution of iodine is applied over the line of incision, and the sutures are removed if silkworm gut has been used. In the majority of cases, patients return to duty on the sixth day.—*N.Y. Medical Journal*.

## THE WASSERMANN REACTION.

While the Wassermann reaction is considered by many physicians an absolutely accurate test for syphilis, E. L. Keyes, Jr, New York (*Journal A.M.A.*, March 6, 1915), finds some reasons to doubt its being an altogether sufficient index, and says he does not feel justified in diagnosing syphilis by this test alone. This conclusion or lack of conclusion, he says, is unsatisfactory, but it seems to be justified by the following facts: In the first place the Wassermann reaction is performed in many ways, and all of them give accurate results in the majority of cases, but no two of them exactly agree. All of them give a certain small percentage of positive with patients who have no history and present no symptoms of syphilis: its findings vary inexplicably in certain cases from those of the luetin test and the lymphocyte count, the globulin test, and the Wassermann test of the cerebrospinal fluid. In the third case the reaction is known to be positive in certain other diseases, and with certain technics higher than with others. Whatever the technic employed, the use of alcohol by the patient may render the blood negative, and the presence of acidosis in a non-syphilitic makes the blood positive, as has been demonstrated by Richards. Only recently he had an experience with forty patients of a tuberculosis hospital in which the Wassermann reaction had been reported positive. Thirty of these showed certain positive or clinical evidence of the disease. Ten of them failed to show syphilis; the blood was then again examined, both in the same laboratory and in another. Those in the same laboratory reported them all with positive reaction, while that of the other was quite different, and the worker, who obtained only one positive out of the ten, was not willing to assert that to be reliable. Such differences must be settled, Keyes says, by the collaboration of skilled clinicians and skilled laboratory workers on a large series of normal individuals as well as syphilitics. As regards the cure of syphilis, Keyes is dubious as to the value of a negative Wassermann, and his general conclusions as to the subject are given as follows: "1. A negative Wassermann is not sufficient evidence of the cure or absence of syphilis. 2. A positive Wassermann, unsupported by clinical evidence, is not sufficient evidence of the presence of syphilis. 3. A positive Wassermann does not prohibit matrimony. 4. A fixed, positive Wassermann in the later years of the disease does not inevitably point to the prospect of grave lesions. 5. A negative Wassermann after salvarsan, in the first year of the disease, does not mean that the patient is cured, or that lesions will not reappear before the reaction again becomes positive. 6. The return of chancre, glands, eruption and positive Wassermann reaction, a few months after control of the disease by salvarsan in its first few weeks, does not prove reinfection."

## PERSONAL AND NEWS ITEMS

Professor W. W. Kean, of Philadelphia, has established a research scholarship. The income from the fund now amounts to \$1,000. The recipient must spend one year in research work, and shall write at least one paper embodying his work.

The vital statistics of Egypt show a birth rate of 76,522, and a death rate of 58,641. This gives a rate per 1,000 of 44.6 and 34.2, respectively. Typhus is the most fatal of the infectious diseases.

A large committee of prominent medical men in the United States has been formed with the object of bringing about a better state of international medical ethics and morality.

During the year ending 30th June, the United States had exported medicines and surgical instruments to the value of \$35,074,000, as against \$19,916,000 for the year ended 30th June, 1914.

A careful study of many skulls in Peru goes to prove that trephining was practised in the early centuries of the Christian era.

Dr. K. Cairns, Swift Current, Sask., has been appointed to the staff of the new Saskatchewan hospital for overseas duty.

Dr. H. W. Paddell, Swift Current, Sask., has been appointed medical officer for 10th Regiment Mounted Rifles, Canadian Expeditionary Force.

An order-in-council was passed in Britain approving of medical reciprocity with Ontario. History is being made.

Recently the General Medical Council of Britain decided to permit qualified Belgian doctors to register without examination in the foreign list, and practise in Britain if they so desired.

The Medical Council of Saskatchewan offered a military hospital of 200 beds. The offer was accepted. The cost will be about \$40,000, towards which the Medical Council donated \$8,000 from its funds.

Dr. A. G. Gorrell, of Regina, underwent an operation a short time ago, but has made a good recovery and has resumed his practice.

Dr. John B. Murphy, of Chicago, recently offered a military hospital to Britain of 1,040 beds. The offer was accepted, and the personnel of the hospital was arranged under the direction of Dr. James M. Neff, who is in command.

Drs. W. S. McCullough and J. G. Fitzgerald are doing excellent work at the training camp at Niagara in looking after its sanitary affairs.

Dr. John L. Bray has resigned the registrarship of the College of Physicians and Surgeons of Ontario. It is 52 years since he graduated

from Queen's University. He was president of the Ontario Medical Council in 1882-8, and had the degree LL.D. conferred upon him in 1905. He has been registrar since 1907. He is now in his 74th year.

Dr. Arthur Jukes Johnson, of Toronto, graduated from Trinity University 50 years ago. He was one of the guests of honor at the Old Boys' Reunion at Port Hope recently.

In the Philippine Islands, according to Dr. George Davis, cancer of the cheek is very common, caused by the custom of chewing betel leaf. This is sufficiently irritating to give rise to cancer.

Dr. Bruce Goff, of Bothwell, Scotland, died a few weeks ago at the age of 83. He was a noted worker in the ranks of the British Medical Association, and was one of its oldest and most loyal members.

One of the latest cures for tuberculosis comes from Japan. Dr. Koga claims that the peach leaf yields the needed specific.

There is sometimes a humorous side to things in the Army Medical Corps. A surgeon of great eminence was called to task for operating upon a soldier without the consent of the senior medical officer of the hospital, who was a general practitioner.

Dr. W. B. Pritchard, commanding a field ambulance corps at the Dardanelles, died recently of wounds received while on duty. His home was in Manchester.

Col. W. Hunter, M.D., of Charing Cross Hospital; Lt.-Col. G. S. Buchanan, M.D., Medical Officer, Government Board; Lt.-Col. Andrew Balfour, C.M.G., of the Wellcome Research, and Lt.-Col. Leonard Dudgeon, M.D., F.R.C.P., pathologist, St. Thomas' Hospital, have been appointed a commission to assist the Army Medical Corps at the Dardanelles in controlling epidemic diseases.

Mr. Asquith, Mr. Balfour and Lord Curzon have expressed themselves as much in favor of support for the Woman's Medical College in London. The school is a charity of the Duchess of Marlborough. An appeal is made for funds.

The women's clubs and nursing organizations which are co-operating with the National Committee for the Prevention of Blindness in the United States, have been accomplishing a great deal of good. It is estimated that 50 per cent. of all blindness is preventable. These clubs pay special attention to the prevention of blindness from ophthalmic neonatorum, the carelessness of mid-wives, faulty conditions in schools, accidents and wood alcohol.

Dr. William S. Thayer, professor of clinical medicine, Johns Hopkins, was operated on recently for appendicitis; and Dr. Thomas S. Cullen, of Johns Hopkins, was operated on for gallstones and appendicitis. Both have made good recoveries.

Dr. William H. Welch and others have gone to China to organize medical education in that country.

Dr. Fayette H. Peck, associate editor of the *Buffalo Medical Journal*, died at his home in Utica at the age of 59. He was widely known as a railway surgeon.

Richard Clement Lucas, M.B., F.R.C.S., consulting surgeon to Guy's Hospital and to Evelina Hospital for Sick Children, died six weeks ago at the age of 70. He was a distinguished surgeon.

Frederick Howard Marsh, M.A., M.C., F.R.C.S., master of Downing College, Cambridge, died 24th June, at the age of 76. He was closely identified with the Royal College of Surgeons and was an author of world-wide reputation.

M. Berillon, in reporting on the poisonous gases employed by the Germans in war, remarks that "the Germans smell nastily." Yes, they veritably "stink."

Dr. Paul Fildes has made a very extensive examination of infants in East London. By the Wassermann test he found that only one newly born infant in 1,015 gave a positive reaction, and at the end of three months only three in 660. This is quite reassuring. Of the mothers 27 per cent. were positive.

Dr. R. W. Bruce Smith, so well and favorably known as the medical inspector of the hospitals of Ontario, has been in very poor health for some time. His many friends wish for him a speedy recovery.

Dr. G. G. Nasmith has earned a marked promotion for his good work as a sanitarian at the front. He has been given charge of the sanitarian interests of the entire First Army Corps and the Indian Corps.

Dr. R. D. Rudolf, of Toronto, who was connected with a military hospital in France, and who, home for a short time, has returned to his hospital, quite restored in health.

The Harrison narcotic law in the United States has been modified so as to permit osteopaths to administer drugs in those States of the Union which permit osteopaths to register.

It is expected that most of the American doctors and surgeons in the war zone, under the Red Cross Society, will return about first of October. The Red Cross Society will continue sending supplies, however.

Dr. R. H. M. Dawbarn, of New York, clinical professor of surgery in Fordham University School of Medicine, died 18th July, at the age of 55. He was a noted surgeon and writer. He paid a great deal of attention to the study of cancer.

The Midland Hospital Guild announce a recital given in the opera



house by Miss Mae Wilkenson, assisted by Mr. Earl McGee, of Bay City, Mich. Miss Wilkenson being a general favorite, the shower of comforts for soldiers was a great success.

Dr. Walter W. Wright announces that he has located at 143 College Street, Toronto, and will confine his attention to diseases of the eye.

Mr. Douglas Flattery, of Boston, has made a donation to the Harvard College fellows, a fund that will give \$800 a year, for research work on those diseases whose cause and treatment are wholly or in part unknown.

The Rockefeller Foundation has issued a report of its work in France, Belgium, Serbia and Poland. \$1,000,000 has been expended in Belgium, and \$90,000 among the refugees in Holland. \$20,000 has been devoted to assist Belgian professors. \$125,000 has been expended in Serbia fighting typhus. \$10,000 a month is guaranteed to Poland. In France a hospital was equipped for Dr. Carrel for research work. France did not need any other assistance.

Edmund Owen, LL.D., D.Sc., F.R.C.S., died rather suddenly on July 23rd. On 13th July he was seized with an attack of apoplexy and never regained consciousness. He was born in 1847. He was a noted surgeon and a noted writer. He had a most attractive personality. He held many high offices and distinctions, such as Chevalier de la Legion, Knight of Grace of the Order of St. John of Jerusalem, etc.

A certain person in the States was fined for fraudulently using the mails to distribute information that he was a specialist on nervous diseases, and conveying the impression that certain symptoms were evidence of serious disease, when such was not the case.

Sir A. Conan Doyle, M.D., LL.D., has been advocating the use of armour for exposed positions of the body in the present war.

Sir Almroth Wright has been urging a treatment for war wounds that has attracted a good deal of attention. He applies to the wounds salt solutions of such strength as to cause a free exudate of serum on the wounded surface. This serum is both antiseptic and healing.

There is to be a new hospital at Miramichi, N.B. The foundation was laid in the latter part of July. It will accommodate 30 patients.

Dr. Charles J. Findlay, who discovered that the mosquito causes the transmission of yellow fever, died on 20th August in Havana. His body lay in state and the national Government took charge of his funeral.

Lieut. H. F. MacKendick, M.D., of Galt, was given a great send-off by the 2th Regiment on the occasion of his leaving for Britain to join the Army Medical Corps.

Dr. John R. Whitham, of Brantford, has left to join the third university (McGill) overseas contingent.

Col. Pyne and Major James paid a visit to France to inspect some of the Canadian base hospitals. Work has already begun on the Ontario Hospital at Orpington.

The machine gun campaign got a neat start at Stratford when the city council at its regular session received an offer from Drs. J. A. and Lorne Robertson, prominent local physicians, to issue a cheque for \$1,000 at the council's call to purchase a machine gun for Perth county soldiers. The offer was referred to the finance committee, with the council's thanks, and will undoubtedly be accepted.

Dr. Alexis Carrel, of the Rockefeller Institute, who recently made some important discoveries on antiseptics for use in the treatment of wounds, will receive the next promotion to the rank of officer in the Legion of Honor, according to a recent announcement.

Lieut. (Dr.) Kendall Bates, of Toronto, has left with Section B., No. 2 Field Ambulance.

The late Daniel L. Simmons, of Colborne, bequeathed to the Hospital for Sick Children, Toronto, funds for the endowment of two cots, to be known as the D. L. Simmons and Eliza Anne Simmons cots.

The late James Logan, of Toronto, left \$200 to the Sunnyside Orphanage, \$300 to St. Michael's Hospital, and a little over \$1,000 to the House of Providence.

The ladies of Hamilton collected in one day (Hospital Sunday) \$4,000 for Canadian hospitals in France. The Canadian Club of Hamilton will assist the ladies and it is hoped to raise altogether \$10,000.

Dr. Royal Lee, of Gananoque, who is taking a special course at the Holy Name Hospital, Brooklyn, N.Y., met with a serious concussion of the brain in an automobile accident while rushing to attend an emergency patient. Dr. Turner, who was with him, was killed outright, and Lee's condition is considered critical. He is a graduate of Queen's University of the 1913 class.

Dr. D. D. Ellis, of Fleming, Sask., was recently re-elected Grand Master of the Orange Order of British North America.

Lieut.-Col. Dr. A. R. Gordon has been invalided home for a time. He is greatly improved since his return to Toronto.

Dr. Edward Kidd, of Trenton, has obtained a commission in the Army Medical Corps, and left a few days ago for the front. The Daughters of the Empire presented him with a wristlet watch, and citizens gave him a military revolver, binoculars and compass.

Lieut.-Col. Dr. H. A. Bruce, of Toronto, has been detailed to do some work at the Duchess of Connaught Hospital at Cliveden.

Miss Margaret Newbold, daughter of the Rev. Charles Laurie Newbold, rector of Christ Church at Manhasset, L.I., was married there recently to Dr. Van Arsdale Blakslee, of Midland, Ont.

The Board of Control, of Toronto, has refused to exempt the doctors attached to the University Base Hospital from the payment of their income and business taxes. It was feared such a precedent might lead to more important exemptions.

The new polyvalent serum that has been used on wounded soldiers has proven very effectual in the prevention and cure of sepsis.

The hospitals which have left for the Dardanelles are No. 1 Stationary, in charge of Col. McKee; No. 2 Stationary, in charge of Col. Casgrain; No. 5 Stationary, in charge of Col. Etherington. They are all Canadian.

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## OBITUARY

### ARTHUR PALLANT.

Dr. Pallant, of Victoria, B.C., was accidentally killed by being crushed beneath his automobile. He was in his 61st year. He was born in England, where he practised for some time. Seven years ago he located in Vancouver. Later he resided in Victoria. He leaves a widow and two sons.

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### H. W. MacGOWAN.

Dr. MacGowan, of Knowlton, Quebec, died at his home there. He was born at Kingsley, Que., in 1841, and graduated from McGill in 1865. He practised at Bolton Centre, Que.; Stanstead, and latterly at Knowlton.

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### MARK BICE.

Dr. Mark Bice, of Eburne, B.C., died at his residence on 13th July, aged 71.

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### A. W. H. LINDSAY.

Dr. Lindsay was well known throughout the Maritime Provinces. For many years he had filled the office of registrar of the Medical Council of Nova Scotia. He was born at Pictou, N.S., 64 years ago. He graduated from Dalhousie University in 1875. He began his practice in Halifax and became connected with the Medical College, where he

was recognized as an able teacher. He died of an attack of heart failure on 21st July, while attending a meeting of the Nova Scotia Medical Board. He was a staunch friend of Dalhousie University and higher medical education.

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J. L. DURAL.

Major (Dr.) J. L. Dural, of St. John, Que., was seriously wounded at Ypres, and died recently from the effects of these.

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BOOK REVIEWS

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AMOSS' CHEMISTRY AND CHEMICAL URANALYSIS FOR NURSES.

By Harold L Amoss, S.B., S.M., M.D., Dr.P.H., formerly Chemist, Hygienic Laboratory, U.S. Public Health Service; Physiological Chemist, U.S. Bureau of Chemistry; Instructor in Physiological Chemistry, George Washington University Medical School; Assistant in Preventive Medicine, Harvard Medical School. 12mo., 268 pages. Cloth, I\$1.50 net. Philadelphia and New York: Lea & Febiger, Publishers, 1915.

The outstanding characteristics of this volume are its clear diction, extremely lucid explanation and definition and the consistent emphasis placed on those aspects and bearings of chemical science, a knowledge of which is certain to be of practical advantage to the nurse.

Dr. Amoss has made a careful but very concise survey of the whole subject, making clear the terminology of the science, afforded definitions of unusual lucidity and selected for more detailed consideration those points, an understanding of which must increase the capacity of the nurse for intelligent service. To this end stress is laid on the chemistry of foods, of metabolism and of digestion, and on uranalysis and allied subjects. A clear grasp of the requirements of the nurse has enabled him to avoid the two extremes of superficiality and of too minute attention to detail and the more complicated aspects of his subject. Technical terms are elucidated and laboratory procedures explained. A useful feature is a brief and most enlightening summary, at the end of each chapter, of the information the author has endeavored to impart. The nurse who devotes serious attention to this volume will have an intelligent working knowledge of general chemistry and a useful, well-grounded understanding of the science as it bears on her work.

## DEVELOPMENT OF THE HUMAN BODY.

The Development of the Human Body, A Manual of Human Embryology. By J. Playfair McMurrich, A.M., Pr.D., LL.D., Professor of Anatomy in the University of Toronto, formerly Professor of Anatomy in the University of Michigan. Fifth edition, revised and enlarged, with 287 illustrations, several of which are printed in colors. Philadelphia: P. Blakiston's Son & Company, 1012 Walnut Street. Price, \$2.50.

Professor McMurrich has long been known as one of the leading anatomists of America. This work of his has now come to be recognized as a standard authority on the development of the human body. The book is got up in an attractive form. The paper is thin and of very fine quality. This renders the book light and of very convenient size. The text and illustrations are all that could be desired. We can most cordially recommend this work.

## MEDICAL CHEMISTRY.

A Compend of Medical Chemistry, Inorganic and Organic, including Urinary Analysis. By Henry Leffmann, A.M., M.D., Professor of Chemistry in the Woman's Medical College of Pennsylvania, and in the Wagner Free Institute of Science. Sixth edition, revised. Philadelphia: P. Blakiston's Son & Company, 1912 Walnut Street. Price, \$1.00.

This book is now so well known that about all one requires to do is to mention the appearance of a new edition. The entire series of quiz compends are of a very high order of excellency. We can speak in very high terms of this small manual. No better book could be placed in the hands of the student than this one on medical chemistry.

## EXERCISE IN EDUCATION AND MEDICINE (2ND EDITION).

Exercise in Education and Medicine. Second edition. By R. Tait McKenzie, A.B., M.D., Professor of Physical Education, and Director of the Department, University of Pennsylvania. Octavo of 585 pages, with 478 illustrations. Philadelphia and London: W. B. Saunders Company, 1915. Cloth, \$4.00 net; half morocco, \$5.50 net. Canadian agents, the J. F. Hartz Company, Toronto.

Dr. Tait McKenzie has long been recognized as a noted authority on training and physical culture. This edition is most welcome, being very materially enlarged and improved over the first edition. Every phase of the subject is dealt with in a careful and scientific manner so as to reflect the greatest credit on the author. The forms of physical training adopted by different countries is set out in detail, and that best suited for the various classes, such as school children, discussed. There is no doctor in practice who would not be greatly benefited by

the perusal of this book. The volume is superbly illustrated with photographs taken of the many positions assumed in training and athletics.

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### A MANUAL OF THE PRACTICE OF MEDICINE.

By A. A. Stevens, A.M., M.D., Professor of Therapeutics and Clinical Medicine in the Woman's Medical College of Pennsylvania; Lecturer on Medicine in the University of Pennsylvania. Tenth edition, revised. 12mo. of 629 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1915. Flexible leather, \$2.50 net. Canadian agents, the J. F. Hartz Company, Toronto.

This is, without doubt, one of the very best of the many manuals on the subject of general medicine. The book is now in its tenth edition, and has every error carefully eliminated. The author in addition to his wide knowledge of practical knowledge, has the unique capacity of being able to condense well. He can tell what he has to tell in small space, and he can tell it well. His exposition loses nothing by his brevity. This is a book one really grows fond of in this busy world where there is so much to read. Here the practitioner can revise his views in a short time, and the student can lay down a solid foundation without having to wade through a vast amount of padding. Our congratulations to the author on the many merits of this book.

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### HENRY PHIPPS INSTITUTE REPORTS.

Tenth Report Dealing with Pulmonary Acoustic Phenomena. By C. M. Montgomery, M.D., and E. A. Eckhardt, Ph.D., and Eleventh Report dealing with Housing and Social Conditions in Selected Districts of Philadelphia, by Frank A. Craig, M.D.

These reports are published under the auspices of the University of Pennsylvania. The Henry Phipps Institute is for the study of, treatment and prevention of tuberculosis. The two reports before us deal with two important phases of this subject. The one takes up the question of acoustic conditions met with, and the other the bearing upon the causation of tuberculosis. These reports are very valuable, and can be very cordially recommended. The Henry Phipps Institute has rendered a great service in its efforts to clear up the causation, treatment and prevention of tuberculosis.

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### THE MEDICAL CLINICS OF CHICAGO.

The Medical Clinics of Chicago. Volume I, Number I. (July, 1915). Octavo of 208 pages, 37 illustrations. Philadelphia and London: W. B. Saunders Company, 1915. Published bi-monthly. Price per year, paper, \$8.00, cloth, \$12.00. Canadian agents, the J. F. Hartz Company, Toronto.

The publishers inform us that this publication is to appear bi-monthly and is to contain specially prepared clinical articles from the

Chicago hospitals. It is thought that a publication of this sort, containing the most recent views on all topics of medical interest, and appearing at frequent intervals, will prove of the utmost value. If the future numbers are of as high a standard of merit as the first number this expectation will be fully realized. The issue before us is very superior in every way.

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#### PUBLICATIONS FROM THE JEFFERSON MEDICAL COLLEGE AND HOSPITAL.

The report to hand is volume six of those issued by the Jefferson Medical College of Philadelphia. There are a number of very ably written articles in this volume. It is well illustrated. The papers in this volume are all original, not having been previously published.

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#### HEALTH OF THE IMPERIAL NAVY (JAPAN).

Annual Report of the Health of the Imperial Navy of Japan for 1911. By Surgeon-General S. Kimura of the Navy Department.

From this report we learn that the main daily force was 45,907. The total number of old and new cases of disease and injury entered on the list was 32,131. This gives 699.92 per 1,000. The number of cases recovered was 27,943. The number of cases where treatment was discontinued was 1,707, and the number of deaths was 194. The number of days' sickness was 838,737. There is much information given as to the nature of the diseases and injuries that prevailed. The report is very interesting.

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#### NEUROGRAPHS.

A Series of Neurological Studies, Cases and Notes. Editor, William Browning, M.D., 1313 Bedford Ave., Brooklyn, N.Y.: Albert T. Huntington. Subscription price, \$2.00 a year.

The number to hand deals with the thyruis gland and its relationship to stammering. The views set forth are extremely interesting.

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#### THE CLINICS OF JOHN B. MURPHY, M.D.

These clinics are published by-monthly. Each issue is got up in the best form possible. The paper, type, and illustrations do credit to the publishers, and the printed matter sheds lustre on the noted surgeon who is its author. This publication is interesting and useful to all, but especially so to the surgeon.

## MORTALITY IN THE WESTERN HEMISPHERE.

This pamphlet has been issued as the Panama Exposition Memorial Publication No. 3 of the Prudential Life Insurance Company of America. It contains statistics dealing with the death rate of all the countries of the American continent.

## THE INSTITUTION QUARTERLY.

This publication, which is issued quarterly, gives an account of what is being done in the various State institutions of Illinois. It contains much helpful information on the management of asylums, charities, prisons, etc.

## MISCELLANEOUS

## LICENTIATES OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

The following is a list of candidates who have passed the final examination of the College of Physicians and Surgeons of Ontario and are now licensed to practise:

Joseph William Aikenhead, Brucefield; George William Alexander Aitken, London, Ont.; William Hambly Avery, Strathroy; Daniel MacTavish Baker, Fort William; Roy Ball, Toronto; Henry Merrett Barrett, Salford; John Arthur Bean, Clinton; George Ernest Binkley, Toronto; Robert Emmet Brady, Lindsay; Charles Oscar Broad, Little Britain; Rufus John Whitby Brooke, Georgetown; Walter William Buttle, Cobden; Walter Ruggles Campbell, Toronto; Theodore Augustus Carpenter, Port Dover; William Allen Cathcart, Courtright; Charles Cecil Cornish, Ingersoll; Waring Gerald Cosbie, Toronto; James Henry Cotton, Toronto; Eldon Douglas Coutts, Toronto; John Grant Cunningham, Moose Jaw, Sask.; William Douglas Cruikshank, Hamilton; Gordon McIntyre Dale, St. Thomas; Allan Lester Delahaye, Pembroke; John Henderson Duncan, Toronto; I. De La Matter; George Percival Dunning, Riceville; Allan Boyd Earl, Athens; Wilbert Harold Eby, Cookstown; David Haymes Fauman, Rochester, N.Y.; Gordon Ferrier, Mimico; Robert Howard Fraser, Chatham; William Paul Freeman, Lucknow; Harry Garrett Furlong, Norwich; Leonard Albert Glenn, Adelaide; Edith Hamilton Gordon, Toronto; Thomas Fleck Graham, Brantford; Freeman Reginald Guest, London; Thomas Reginald Guil-



foyle, London; Dan Henry Guy, Maxwell; Charles Augustus Harris, Lakeside; Joseph Wilbert Hayes, Peterboro; Percival Hearn, Toronto; Karl Edward Hollis, Hamilton, Bermuda; William Alfred Jones, London; Thomas Francis Kelly, Orillia; Harold Ivan Kinsey, Chatham; Heikki Koljonen, Port Arthur; George A. Lamont, Guelph; Edmond Larocque, Alfred, Ont.; Frederick Levi Leacock, Easton's Corners, Ont.; Frederick Winnett Luney, London; Joseph Alexander Macdonald, Toronto; George Monfette, Montreal, Que.; Walter Carneil Morgan, Arden, Ont.; Henry B. Moyle, Waterford; Arthur James McGanity, Hamilton; George Brerar McIntyre, Paisley; John Judson McKendry, South Mountain, Ont.; William Russell McLaren, Corunna; Gordon Archibald McLarty, Toronto; David McMullen, Petrolea; Jonathan Foote McQuay, Toronto; Edgar Harold MeVicker, Toronto; Chas. Newell, Milton; William Robert Newman, Toronto; Frances De Sales O'Connor, Harrowsmith; Vincent Keating O'Gorman, Cobalt; Arthur Allan Parker, Toronto; Gerald Hamilton Jeffery Pearson, London; Robert Wesley Phillips, Toronto; Adelard Louis Poisson, Belle River; Andrew Rutherford Riddell, Toronto; Thomas Clarence Routley, Toronto; Norman Franklin Schram, London; Thomas Jones Scobie, Hazeldean; William Glenn Siddall, London; Thomas John Simpson, Waldemar; Emerson Charles Smith, Chesterville; Melville John Sproul, Martintown; William Berkeley Stork, Toronto; Archibald Steinberg, Berlin; Henry Archibald Stewart, Saskatoon, Sask.; Valentine Frederick Stock, Tavistock; William Andrew Vanderburg, Cayuga; Stanley Arthur Walker, Toronto; George McKee Watt, Brantford; Charles Edgar Wilson, St. Mary's; Ivan Dolway Wilson, London; William Nathan Winkler, Toronto; Harold Alonzo Wolverton, Nelson, B.C.

#### FOR OVERSEAS SERVICE.

The following is a list of the students who have had the license granted on account of having enlisted for overseas service:

Gerald Allisson, Picton; Robert Stanley Armour, Campbellford; Stanley Stafford Ball, Hanover; Arthur McKnight Bell, Merrickville; George Beatty Burwell, Renfrew; Leeming Anderson Carr, Hamilton; Harry Arthur Cates, Toronto; John Chassels, Toronto; Frederick Walter Clement, Deseronto; Richard Colter Coatsworth, Tooonto; John Thomas Courtice, Toronto; Thomas Harold Crews, Woodstock; Charles Roderick Blackburn Crompton, Brantford; James William Deadman, Beeton; Donald Thomas Fraser, York Mills; Frederick Russell Gillrie, Hamilton; Morley Edward Gorman, Oakville; Harold Parrish Hamilton, Uxbridge; Maurice Round Helliwell, Toronto; William Roy Hodge, London; John Ranson Howitt, Hamilton; William Lorne Hutton, Brantford; Edward Shapter Jeffrey, Toronto; Clifford M. Keillor, Wallace-

town; Frederick Russell Kirkham, Toronto; Herbert Carl Martin, Hamilton; Robert Beattie Martin, London; Athol Alexander Moon, Cotham; Robert Whiteman McQuay, Foxwarren, Man.; Samuel Alexander Overend, Caledonia; Reginald Paul, Sebringville; David Emerson Scott, Spry; Harry Roy Smith, Toronto; Thomas Harold Douglas Storms, Hamilton; Hermon Brookfield van Wyck, Chatham; Stanley Young Walsh, Peterboro; David Edmund Wishart, Toronto; Harry Wishart Whytock, Madoc.

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#### CANADIAN WOMEN'S WING TO HASLAR HOSPITAL.

On a picturesque site in the grounds of the Royal Naval Hospital, Haslar, overlooking the Solent, with the hills of the Isle of Wight forming a charming background, there is being built a magnificent new wing to the great Naval Hospital which will pass to posterity as a monument to the patriotism and loyalty of the women of Canada. At the outbreak of the war the Canadian women, anxious to demonstrate in a practical form their deep sense of devotion to the Mother Country, organized a fund to aid the nursing of the sick and wounded. A sum approaching £50,000 was raised in a very short period, and was handed over to the Imperial Government to be applied in whatever way they considered best.

There had for a long time been pressing need for ward extension at the Royal Naval Hospital, Haslar, and the Government allocated the major portion of the generous gift to the construction of a new wing to that institution, which will, when completed, be named the Canadian Women's Wing. Since the outbreak of war the resources of the hospital have been taxed severely to provide accommodation for the sick and wounded from the fleet in the North Sea, and as a result of the naval operations in the Dardanelles, and the 250 beds which will be available on the completion of the new wing will add greatly to the efficiency of the hospital.

These beds are at the present time occupied by the nursing staff, though originally intended as part of the hospital accommodation proper. On the completion of the new wing the staff will be housed therein, and the beds now utilized by them in the main hospital will revert to their original purpose, so that the net result of the generosity of the Canadian ladies will be that at least 250 more sick or wounded will be able to receive treatment at the institution. The new wing will stand isolated from the main building, and will be constructed of red brick and stone facings in harmony with the older portions of the institution.

## QUEEN'S CANADIAN HOSPITAL.

If ever a haven of rest for wounded body and shattered nerves existed surpassing beautiful Beachborough Park it can hardly be of this earth. Imagine a weary war-battered Canadian transferred from the hell-fire of the battlefront, with its filthy trenches to a peaceful Kentish scene. Picture a quaint, comfortable English manor house of the sixteenth century set in the midst of thousands of green acres where ancient oaks and clumps of leafy elms dot the verdant pastures. Yew trees, centuries old, chestnuts in flower, shady plant trees and evergreen holly grace the velvet lawns about the house or group in deep forest in the distance, while hawthorn hedges, white with blossom divide the meadows in all directions.

Dark green ivy in luxuriant masses clings to the walls of the house, interspersed with climbing roses of deepest crimson. Purple iola and sprays of forget-me-not edge the flower beds and white blossoms dangle from the vines that creep over the old brick walls that guard to fruit garden in the rear. Inside cherries on queer vine-like trees, are ripening for convalescent soldiers. Queer apple trees, twisted and trained like grape vines, give promise of pippins, and luscious strawberries were ripened by the June sunshine.

Out in the grounds, above the soft carpet-like daisy-dotted turf, birds whistle and warble melodiously from every nook and corner, as only English birds know how to do. Even darkness does not completely silence this feathered choir. For where darkness distils the fragrance of the flowers the notes of a nightingale sound sweetly soft on the night air.

Stretched on the cool, fresh linen of comfortable beds, carefully tended by Canadian nurses and doctors, petted by visitors and fed on the fat of the land wounded men are nursed back to convalescence when sunny porches await them, leisurely rambles about the illimitable grounds and motor runs through the Garden of England.

Such is the Queen's Canadian Hospital, Beachborough Park, the ancient estate of the Brockman family, rented by Sir A. Markham and donated by his generous wife as an infirmary for Canada's sick and wounded sons.

Here doctors, Charles Stewart, of Calgary, and Wallis, of Hamilton, preside, and among the nurses, Sister Mitchell, of Toronto, a niece of Dr. Allen Baines. Thither from London comes frequently the officer in charge, Colonel Donald Armour.

There were sixty patients on a recent date. In fact, the hospital is filled and the staff are awaiting completion of the larie addition which is to accommodate 100 more beds.

Distinguished visitors have been calling at the hospital of late. One was Princess Clementina, the affable sister of Albert II., the hero-king of the Belgians, not a few of whose brave soldiers have been nursed back to life within these walls—for there have been others than Canadians. Princess Alexander of Teck, whose husband is a British officer at the front, was another royal caller.

The hospital is four miles from Folkestone and two and a half miles from Shorncliffe, the camp in which the Canadians are. Beachborough Park is a delightful Elizabethan mansion, gloriously situated, and an ideal place for convalescents. The full address, which should be given in order to avoid confusion with other hospitals in the neighborhood is "The Queen's Canadian Hospital, Beachborough Park, Shorncliffe."

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#### SITE CHOSEN FOR ONTARIO HOSPITAL.

After looking over several sites for the Ontario Government Hospital, Colonel Hon. Dr. Pyne has chosen Orphington, in Kent, distant from London 15 miles, and a short distance from Dover and Folkestone.

The hospital will contain 1,040 beds. Half may be used for convalescent patients and those suffering from shock, and half for acute cases, or all for acute cases, depending on the necessity that may arise. The hospital is now under way and will be completed without delay.

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#### DR. BELAND, M.P., PRISONER.

A letter received by members of his family gives interesting, though saddening, news of Dr. H. S. Beland, M.P. for Beauce county in the House of Commons, who is now a captive in a German fortress, after having been interned from Belgium, where, in his castle at Capellan, he was treating wounded soldiers.

The doctor says that recently he has been better treated by the German authorities, and that in his cell, instead of being quartered with other prisoners, he is now allowed to stay alone.

The doctor says his people would be deeply surprised if they only saw a photo of him.

"I am getting old," he says, "thorough all this suffering and harrowing scenes, and there is a lot of grey in the dark hair of your affected friend. However, I have indications that I will be freed soon. I was told by a responsible official that steps were being taken to fix the necessary matters that will bring me back to hospital work, and now I live with the hope of this day."

## MEDICAL PREPARATIONS

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### DISEASES OF WOMEN AND THE GENERAL PRACTITIONER.

The general practitioner or family physician is the one usually first consulted in reference to menstrual irregularities and diseases of women. The tendency to refer these cases to specialists takes from the general practitioner much practice which he could successfully handle if consideration was only given to their treatment.

For over forty-five years viburnum compound (Hayden's) has proven its efficacy in dysmenorrhea, amenorrhea, menorrhagia, metrorrhagia and irregularities incident to the menopause.

This standard remedy has grown in popularity with profession simply through its merits of accomplishing that which was expected of it. It is not a narcotic or secret remedy. Its formula is a matter of common knowledge and it produces positive results where the many substitutes and imitations foisted upon the medical profession and trading upon the well-known reputation of H.V.C. are disappointing, sometimes dangerous.

Imitation might be considered a flattery, but when treating diseases of women and expecting results from a remedy prescribed, it is always safest to use the original and not a substitute.

*Argument:* The therapeutic value of viburnum compound has built up an enviable reputation for its efficiency, hence its many imitations, but they are but *imitations*, in no wise compare with the original. Why let a druggist put up something inferior upon your prescription for the original.

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### ANTIPHLOGISTINE.

Antiphlogistine is a physiological antagonist of the inflammatory process—deep-seated or superficial. It produces marked osmotic action upon the swollen tissues, thus relieving congestion because of its hygroscopic, hydrophilic properties. It is antiseptic, soothing and promptly effective.

Antiphlogistine provides the best, most agreeable and convenient known means of supplying continuous moist heat, in all inflammations. This can be maintained for 24 hours or longer, at a uniform tempera-

ture. Ordinary poultices soon become cold, clammy and uncomfortable to the patient and lose any remedial effect they may have had, before becoming cold.

Antiphlogistine acts, through the cutaneous nerves upon the inflamed area, as a powerful stimulant to the blood-vessels and lymphatics, promoting elimination of morbid products. It supplies, by natural, physiological processes, regenerative material to the parts already suffering from that condition of perverted nutrition, which is a part of the inflammatory process.

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#### A VALUABLE MECHANICAL LAXATIVE.

In view of the many varieties of liquid petrolatum with which the drug market abounds, and the questionable quality that distinguishes much of it, physicians will welcome the announcement that Parke, Davis & Co. are supplying a product, under the designation of Liquid Petrolatum Heavy, that bears a substantial guaranty of purity and efficiency.

Liquid Petrolatum Heavy, P., D. & Co., is a product of high specific gravity and great lubricating power. It is tasteless, colorless and odorless, and is guaranteed to be free from sulphur compounds, acids, alkalis and all harmful by-products.

Liquid Petrolatum Heavy is not a purgative. Neither is it a laxative in the general sense of stimulating the bowel by local irritation. Its function is that of an intestinal lubricant. It passes in toto through the alimentary tract, not a particle of it being digested or absorbed. It mingles with the food in the stomach and upper intestinal tract, with the result that the feces becoming thoroughly lubricated and pass through the lower bowel more rapidly than they otherwise would and are expelled from the colon more promptly and with greater ease. Not the least valuable feature of this liquid petrolatum is its protective effect on the stomach and intestine, it being well known that abrasions or irritations of the mucous surfaces permit bacterial infection and general toxemia.

Liquid Petrolatum Heavy may be taken with a pinch of salt or a dash of lemon juice, if the patient so desires, or it may be floated on a glass of water, wine, milk or other beverage. The dose recommended adults is one or two tablespoonfuls morning and night, before or after meals, for the first two or three days. Later the amount may be diminished. To insure against possible mistakes, physicians will do well to specify "P., D. & Co." on their prescriptions.