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Original Articles

REMARKS ON VINCENT'S ANGINA, WITH REPORTS OF CASES.

By Graham Chambers, M.B., and Herbert Wilson, M.B., Toronto.

The term "Vincent's Angina" is applied to an infectious inflammation of the throat, resulting in superficial or deep necrosis. The affection is apt to be mistaken for other morbid conditions of the throat, especially diphtheria and syphilitic ulceration.

The materies morbi of Vincent's Angina appears to be a fusiform bacillus or a spirillum. The former germ, usually called bacillus fusiformis, is probably the causative agent. In 1896 Vincent called attention to the possible relationship of these germs to ulcerative anginas. In the following year Bernheim reported thirty cases of angina and stomatitis (ulcerative), in which both the bacillus fusiformis and spirillum were found. In 1898 Vincent presented additional records; and since that date many cases have been reported by various physicians.

The clinical manifestations of the disease are fairly definite. In some cases there is very little constitutional disturbance; in others the onset is characterized by feverishness, loss of appetite, furred tongue, sore throat and a general feeling of malaise. The course of the temperature is variable. In the superficial variety the elevation varies from 100° to 103°F., falling to normal in a few days. In the deep variety the fever may continue for one or two weeks.

The clinical signs are somewhat variable. The lymph nodes in the upper part of the neck are usually swollen. The breath of the patient is generally foul. The infection may begin in the mouth or throat. The affection of the mouth is an ulcerative stomatitis, usually commencing on the gums (ulcerative gingivitis). The prim-

ary seat of the angina is, as a rule, the tonsil, and in many cases the disease does not extend beyond this organ. However, there is a tendency for it to extend to the anterior and posterior pillars, soft palate and uvula. This character is probably more marked than in the case of diphtheria. The inflammatory process, be it superficial or deep, results in necrosis. In the superficial variety the disease-area is covered with a greyish-white pellicle, thin, friable, and removed with difficulty, leaving a bleeding surface. The necrotic covering is never thick and fibrinous, which characters are frequently of value in distinguishing the disease from diphtheria. Another character which we have observed in our cases was the presence of an areola of a dull red hue, suggesting a considerable degree of stasis of blood.

The deep variety of Vincent's Angina is characterized by ulcers of various sizes and depths, usually resulting from necrotic processes. The bases of the ulcers are generally covered with necrotic tissue. The edges may be vertical like that so frequently seen in syphilitic ulcers. The common seat of the ulcer is the tonsil, but it is not uncommon to see the ulcerative process extend widely, involving pillars, soft palate, and, occasionally, the epiglottis and glottis may be involved. It is probable that the morbid affection, known as cancrum oris or noma, should be placed in the same category as Vincent's Angina. This is supported by the fact that the bacillus fusiformis is, as a rule, present in noma.

The most distinctive sign of the disease is the finding of Vincent's organisms in the necrotic tissue. If one makes a spread from some of the necrotic tissue and stains with methylene blue, aqueous gentian violet or other suitable stain, spirilla and fusiform bacilli can invariably be made out.

The bacillus fusiformis may be curved or straight, single or in chains of two or three, 6 to 12 microns in length. It is thicker at the centre than at the ends. The spirillum or spirochæta of Vincent varies considerably in length and number of spirals. It is invariably larger than the spirochæta pallida.

The course of Vincent's Angina depends upon the severity of the morbid process as well as upon treatment. A fatal result may occur as a result of extensive sloughing or of a complication such as aspiration, or lobular pneumonia. With deep ulceration healing, in case of recovery, may be delayed for weeks.

The differential diagnosis of Vincent's Angina requires care, but is not difficult. It must be distinguished, especially, from diphtheria and syphilitic ulceration of the throat. The superficial variety of Vincent's Angina may resemble diphtheria. In diphtheria, however, the false membrane is frequently thick and tough,

whereas in Vincent's Angina the necrotic covering is thin and friable. Again, bacteriological examination gives definite data. The presence of Vincent's organisms or Klebs-Loeffler bacillus will determine which morbid affection is present. I may add that the organisms of Vincent's Angina and diphtheria are never found together. The presence of the bacillus fusiformis precludes the presence of the diphtheria bacillus.

The ulcers of Vincent's Angina may resemble a syphilitic ulceration of the throat. In both the ulcers may have a punched-out appearance. However, the history of the case and the consideration of other signs are usually sufficient to differentiate the affections. It should be remembered in this connection that syphilis and Vincent's Angina may occur together.

Associated Affections.—In some cases of Vincent's Angina, ulcerative stomatitis is an associated condition. In these the necrotic process usually occurs on the gums or adjacent parts of the cheeks. The ulcerative gingivitis is variable in degree. In many cases it results in ulceration of the border of the gums, producing a condition similar in appearance to pyorrhea alveolaris. I may mention that, according to the opinion of some, the bacillus fusiformis is the common cause of pyorrhea alveolaris.

In my experience ulcerative gingivitis is a common affection in children's homes. This may afford an explanation of why there is an occasional outbreak in these homes of cancrum oris, an affection which is probably due to the fusiform bacillus of Vincent.

The treatment of Vincent's Angina is usually successful. The local treatment consists in applying some antiseptic, such as hydrogen peroxide, or a solution of iodine. The hygienic treatment is important, because the disease is very apt to occur in persons who are in poor health and live in badly ventilated houses. It should also be remembered that the disease is contagious.

Case I.—E. G., aged 25, female, domestic, was admitted to Toronto General Hospital, February, 1909, for treatment of "sore throat." Patient's health had been good. About a fortnight before coming to the hospital patient began to suffer from pains in back, bones and head and chilly sensations. Nausea was present after meals, and the appetite was very poor. She thought she was getting la grippe. Two or three days later the throat became sore. It was dry and smarting and swallowing was painful. A week after the beginning of her illness she was admitted to the hospital. Then there was considerable swelling of the sub-parotid lymph nodes. Breath of patient was foul. The left tonsil was covered with a greyish pellicle, somewhat ragged in appearance, which could be removed with little bleeding. Culture on blood serum was negative

for Klebs-Loeffler bacillus. Stained smears showed the spirilla and fusiform bacilli of Vincent.

During the next few days the disease extended to anterior pillar and velum palati. The border of the disease area was dull red. Then improvement began, and in about a week later the throat was clear.

Case II.—T. M., aged 26. December 12th, 1909, patient consulted Dr. Graham Chambers on account of sore throat, from which he suffered for five or six days. In 1906 patient contracted syphilis, for which he took treatment for over two years. An examination of throat revealed the presence of a small ulcer on the left tonsil. The edges were somewhat vertical. The base, which was about a half-inch in diameter, was covered with necrotic tissue. Smears from the necrotic tissue showed the presence of Vincent's organisms. Local applications of hydrogen peroxide and boric acid resulted in a cure in about ten days.

Case III.—Clinical notes by Dr. Herbert Willson.

On December 9th, about 4 p.m., I was called to see R. G., a boy of ten years. He had been ill for about three days. He complained of extreme pain on swallowing and severe headache. He lay in bed crying and was plainly in great distress.

Examination of the throat revealed two greyish-white patches on the left tonsil. These patches were close together, almost circular, of about one-quarter inch diameter, and had a punched-out appearance. In applying a swab, the greyish exudate was easily removed and a bleeding surface was left. The tongue was heavily coated and the breath offensive. The sub-maxillary glands were swollen. The temperature was 101½° and the pulse rate 120. The bacteriological test revealed the characteristic bacilli and spirilla of Vincent's Angina. It was decided not to give antitoxin. Peroxide of hydrogen was used to cleanse the throat. Isolation was carried out as a precaution.

On December 10th, at 10 a.m., the two patches were present, as when first observed, but there had been no spreading. The condition of the patient was about the same as on the preceding day, although he seemed less inclined to complain. His temperature was slightly lower.

On December 11th, in the afternoon, the patient was feeling considerably better. The greyish exudate had disappeared, and there remained soft, ulcerated-looking areas, easily bleeding. The pulse and temperature were normal. The glands were still swollen, and there was still discomfort on swallowing.

On December 12th the patient was much better, and in the afternoon he wanted to get up. Pulse and temperature remained

normal. There was much less swelling in the glands. The raw surfaces could still be distinguished on the tonsil.

On December 13th the boy was a great deal better. On the 15th his condition was so greatly improved that his mother allowed him to get up (although against the doctor's advice). After this, so far as I could judge, his condition was normal, and he had no further trouble.

There were two other children in the family, both younger boys. One of these had a similar attack, the symptoms first appearing on December 11th, and the trouble lasting about one week. This boy, however, was of an abnormally nervous disposition, and became hysterical when an attempt was made to examine the throat, so that a swab was not obtained. In his case the swelling of the glands on one side was extreme. There were the same complaints of headache and pain on swallowing. No antitoxin was used. At the end of eight days the boy was quite well again.

Both boys remained at home during their illness. The house and the locality were very unhygienic.

THE RELATION TO THE EYE OF DISEASES OF THE NOSE, THROAT AND EAR, THE MOUTH AND PHARYNX.

By J. Price-Brown, M.D., Toronto.

Of all the different portions of the upper air tract, connected as they are with each other by canals, fissures and openings, each one being lined by a continuation of the one mucous membrane, the division which is the most remote in its direct bearing upon the eye is the one that falls to my lot to discuss.

Although a relation of diseases of the pharynx and mouth with the eye undoubtedly exists, yet this branch of the subject has received very little attention from either general or special writers. You may search through long tomes upon "Diseases of the Nose and Throat" one after another until a dozen or two have passed through your hands, but the result will be almost nil. Now and then a short paragraph will meet your eye, more frequently a sentence or even a clause, and the bearing, even then, may not be very direct.

In looking over leading works upon ophthalmology, however, a somewhat more satisfactory result will be obtained. While the

nasal chambers, the accessory sinuses and the ear, have the credit of being the chief divisions of the upper air tract that affect the eye, whether in health or disease, yet the pharynx and the mouth are admitted to have a positive though a minor bearing upon the eye, and allusions are sometimes made to the effect which diseases of the one has upon the other.

Ball tells us that even the teeth have an influence in controlling the normal condition of the eye, caries and necrosis of the teeth having been known to be responsible for optic thrombosis.

According to Fuchs, retrobulbar cellulitis has been due to dental periostitis, and it has also occurred as a sequel to the extraction of diseased teeth.

The same writer tells us that orbital phlegmon may develop from the extension backwards of either pharyngitis or suppurative parotitis.

Posey and Spiller have much to say upon the effects of bulbar and pseudo-bulbar diseases in their mutual relationship between the throat and eye, producing both dyspnea, an affection of the throat, and abnormal lacrymation, an affection of the eye, at the same time.

True bulbar disease may ultimate in degeneration of the hypoglossal nerve and atrophy of the tongue, accompanied by drooling at the mouth. The muscle fibres become thin, while the connective tissue increases in volume. The tip of the tongue is said to suffer most.

Percy and Wright call attention to the fact that diseases of the eye often owe their origin to diseases of the pharynx, and that the effectual removal of the latter is essential to the successful treatment of the ocular disease.

Knies, too, dwells upon this phase of the subject, and gives a number of instances. One example is the curious reflex influence which electro-cautery operations upon the nose and naso-pharynx sometimes produce. This consists of a temporary concentric narrowing of the field of vision. He considers it to be a species of traumatic hysteria.

Other instances not traumatic are given. Tubercular infiltration of the left lung, accompanied by dilation of the left pupil. Pneumonia of the right lung associated with herpes of the right eye. The dyspnea of emphysema, sometimes accompanied by stasis of the retinal vessels and at others by conjunctival hemorrhages.

Schmidt affirms that he has several times seen arterial pulsation of the fundus of the eye in cases of pulmonary tuberculosis. One can scarcely understand the relationship of the one to the other, particularly in the last case. That the condition of profound

anemia, so often attendant upon tuberculosis, should permit such a result is at least surprising.

Ballenger gives the history of a case of cavernous sinus thrombosis of otitic origin in which both the orbit and the throat were involved, the case ending fatally.

That in paralysis of the throat following diphtheria the orbit is sometimes involved is well known. I have personally seen two cases in which this has occurred. In each convergent strabismus developed syncronously with the pharyngeal paresis, but in neither was the general system affected.

In one of the cases, one of the pupils was dilated, but not the other. Recovery took place in a few weeks.

In dealing with this question, the large subject of hay fever is worthy of more consideration than is usually accorded to it, for there is no disease in our whole vocabulary in which the orbit, the nasal chambers, the accessory sinuses, the pharynx and the middle ear are so uniformly and so simultaneously affected as in hay fever. It further demonstrates by this very association the intimate relationship which exists between these various organs, for in many respects, though differing widely in function, fundamentally in office they are one.

Of other diseases that have a general influence extending by continuity from the pharynx through the nasal chambers to the eyes, and one that is widely disseminated throughout the civilized world is influenza.

The same in a minor degree might be said of scarlet fever and measles and other infectious diseases, the manifestations upon the mucous membrane commencing in the throat and extending to the outlying regions, including the orbit, in regular order.

But back of all these there is often a condition of a basic character that might easily be eliminated—the hypertrophy of the normal tissues of Waldeyer's ring.

In children the lingual tonsil is rarely enlarged, while the faucial and pharyngeal tonsils frequently are. By their presence they obstruct both ventilation and drainage, and thus favor the culture of germ life, something that is always inimical to the well-being of the individual.

In some ways there is a tendency in the present age to the practice of unnecessary surgery in our own line, as well as others, but I do not think this is the case in reference to the removal of adenoids. Whenever they are present in sufficient degree to obstruct nasal breathing or compress the orifice of the eustachian tube, they should be removed. And when the faucial tonsils are large enough to induce throat symptoms or mouth breathing, which

is so frequently the case in children, they should also be reduced in size. In the latter matter, I know, I differ with some of my confreres, who advocate, even in children, complete tonsillectomy, while I agree with Delaven, McBride, Simpson and other leading men, who believe that free tonsillotomy is much better for the child.

However that may be, by rendering nasal respiration perfectly free through nase-pharyngeal operations, we remove the primary cause of many of the diseases of the upper air tract, some of which might ultimately affect the orbit. Take, for instance, Ballenger's fatal case, already quoted, of cavernous sinuses, thrombosis of otitic origin, in which the eye and throat were both involved. What caused the original otitic trouble? Does not every aurist know that the majority of severe ear cases have their origin in obstructive lesions in the nase-pharynx? The probability is that if the adenoids had been removed in early life, something over which Ballenger had no control, the otitic disease would not have occurred, the cavernous sinus would have remained normal, and the child's life would have been saved. This reasoning, of course, is only hypothetical, still in the majority of instances it would be sound. And we cannot too strongly urge the advisability of keeping the pharynx as well as the mouth, in as nearly a normal condition as possible, if we wish to avoid many of the diseases that children so frequently suffer from.

BLUNDERS FROM TEMPORIZING.*

By C. N. Cobbett, M.D. (Edin.), Edmonton, Alta.

Mr. President and Gentlemen:

When I was a student, more years ago than I like to count, it was impressed upon me that there are three special emergencies in practice with which every medical man, whether his tastes are surgical or not, must be prepared to deal promptly and efficiently.

1. Obstruction of the air passages.
2. A distended bladder.
3. Strangulated hernia.

Now in modern practice there are other emergencies perhaps not so imminent, but equally vital, in which the life of the patient depends upon quickness of decision and prompt action, and it must be within the knowledge of every impartial observer and a matter of regret to every man proud of his profession that numerous valuable

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lives are yearly sacrificed through failure to appreciate the necessity for prompt action.

There is a too common tendency to "wait and watch" whilst alleviating symptoms, temporizing until frequently the opportunity of saving life has passed and an operation, if performed at all, rendered futile by the practically moribund condition of the patient. By way of illustration, permit me to mention a few instances which have come to my notice, and in doing so I will ask you to bear in mind that every case alluded to has occurred in the practice of physicians regarded as competent, men who have had some experience, who are in earnest, who each and all enjoy the confidence of a considerable section of the public, and who, I believe, conscientiously endeavor to do their best for their patients.

1. Dr. "A" is called on Friday to see a child 8 years old suffering from pain in the belly, vomiting and constipation. He orders certain local applications and anodynes. On Saturday he is "afraid the child is developing appendicitis." On Sunday, the child being obviously worse, he desires the opinion of a colleague. The consultation takes place in the evening and an operation is decided upon for Monday morning. The abdomen being opened, a condition of acute general suppurative peritonitis is found, and so advanced that it is deemed impossible to do anything, so the wound is closed and death shortly follows.

2. Dr. "B" is called to a man, aet. 30, taken suddenly ill late on Thursday night. He diagnoses appendicitis, but temporizes. On Friday he decides that he will have to operate, but prefers to wait a little longer "in order to give time for adhesions to form and the abscess to be walled off."

On Saturday, urged by a colleague, he operates and finds the belly full of pus, with no attempt at walling off, and his patient dies on Tuesday from general peritonitis; sacrificed not to ignorance, but to hesitation and lack of decision.

3. Dr. "C" is called late at night to see a married woman 35 years old, taken suddenly ill with acute abdominal pain and faintness. He finds her collapsed, pale and almost pulseless. He consults a colleague and they agree that most probably they have to deal with a ruptured ectopic gestation sac and that they will operate next day. The operation takes place on a dying woman whose pelvis and abdomen are literally full of blood.

Surely it must be apparent that the delay of twelve hours or so was the factor which deprived this patient of whatever chance of life she had.

4. A woman between 20 and 30 years of age consults a doctor about a swelling on one side of her neck, which she finds interferes

with her breathing. He finds a mass of enlarged glands pressing on the trachea. He advises some local treatment and desires to be immediately informed should the condition grow worse. Two days later the breathing becomes alarmingly embarrassed. In consultation with a colleague the patient is found cyanosed and partially asphyxiated. Even at that critical moment it does not apparently occur to either physician that the one thing to do is to open the trachea there and then somehow, anyhow, with a pocket knife if need be. Instead, the ambulance is sent for, the patient taken into the operating room and death occurs from asphyxia before anything can be done.

5. A healthy man of middle age is seized with a well-marked and severe attack of renal colic. The attack lasts for several hours and is followed by complete anuria.

Is it not fair to suppose that it would soon become sufficiently obvious that the man had "anuria" from obstruction and that it was imperative to expose the kidney and, whether a stone were found or not, to at any rate attempt to re-establish function by providing drainage?

Apparently these deductions were not made, for the patient was allowed to lie for eight days with total suppression of urine and, of course, died.

At the autopsy it was found that there was only one kidney with a stone lodged in its ureter.

These briefly sketched histories of actual cases should be sufficient to illustrate my point that temporizing in practice is only too common and that it has disastrous results.

To what are we to attribute these sins of omission?

Is it that a sound clinician must be born and not made? Is it just "slackness" in method, a kind of mental laziness? Or is it pure carelessness and negligence?

In my opinion it is in none of these things that we find an explanation. I think it is simply an illustration of a defective educational system. You cram your students' heads with a lot of hard facts; you lecture them *ad nauseam;* you insist upon their being well up in their text-books, and you give them a certain amount of clinical instruction and practical work. Throw in, in addition, a certain amount of experience. Some men never learn from experience, and to no one is experience of value unless he is capable of appreciating its teachings. With all this is your product a good clinical observer?

I think the deficiency can be explained in this way. In the rush and hurry of modern life the one idea of parents, student and

teachers also is to turn out a qualified practitioner as soon as may be.

The student is in most instances only seeking a portal to what he considers a respectable and fairly well remunerated livelihood. He does not, and is not made to, realize his responsibilities, and he cannot fail to be impressed with the financial success of many practitioners who add to a mimimum of knowledge a smooth manner and plenty of push. It does not seem to be sufficiently realized that to enable a man to think intelligently it is necessary to train his mind just as he must exercise his muscles to play upon the piano. And to enable a man to think intelligently and reason logically a much more thorough preliminary training is called for than the average student of medicine obtains.

The actual professional curriculum is also faulty.

The acquisition of hard facts is essential of course—that goes without saying. But how little time and trouble comparatively is devoted to clinical instruction. In practice, an ounce of intelligent clinical observation is worth many pounds of book knowledge or laboratory tests.

There are far too many lectures—too many subjects—and not nearly enough practical work. Far too little teaching in clinical inductive methods.

To insure the public the full benefit of medical education and to enable the medical man to look back upon his work with satisfaction, it is necessary to acquire sound and logical mental methods. The physician must be able to observe the facts, to draw his inference therefrom, and, arriving at his conclusion, be prepared to act promptly and energetically; avoiding that temporizing and hesitation which in many other walks of life would be followed by swift annihilation—financial or otherwise—and in his own cannot fail to react injuriously on himself as well as prove disastrous to his confiding patient.

Higher standard of preliminary training. Much more practical training, to the exclusion, if need be, of some of the less important subjects and the inculcation of lofty ideals of practice—keeping in the background its commercial aspects—are to my mind great desiderata in the profession of the present day.

ACCOUCHEMENT FORCE AND CRANIOTOMY ARE NO LONGER JUSTIFIABLE IN VIEW OF THE SAFETY OF CAESAREAN SECTION.

By A. Lapthorn Smith, M.D., M.R.C.S. (Eng.);

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The position of the Caesarean, like many others of the most important operations in surgery, has undergone several rapid changes during the last few years. It began as a curiosity on dead women only, and with the sole object of occasionally saving the child. So that the death rate in its early days was 100 per cent. for the mothers and about 50 per cent. of the children.

The first change for the better was when some heroic operator proposed to perform the operation on women who were dying, but not yet dead, after an impossible labor of several days' duration. A few, perhaps 10 per cent., of these recovered, to the surprise of the operator's contemporaries, who probably looked upon him as mendacious for claiming that there were any maternal recoveries at all.

These rare successes, however, emboldened others to intervene earlier and earlier, with an ever-increasing success, until in 1874 Cazeaux and Tarnier estimated the death rate of the mothers at between 50 and 75 per cent. Then in 1892 we see by Coe's article in the Gynecological Society's Transactions of that year that there were sixty-eight in the United States during the previous decade, with a maternal mortality of less than 40 per cent. Near the end of his paper he prophesied that the next ten years would see a notable improvement in our statistics. Surely enough, on opening the 1903 volume of Transactions we see by Green's paper that the mortality at the Boston Lying-in Hospital was only one in nine cases, or eleven per cent., even in women who had already had a Caesarean section before. He does not give the mortality for the fifty done there, once on each women, but it was presumably still less.

As with ovariotomy, and as with hysterectomy for fibroid, so in Caesarean section, a lowering of the death rate induced surgeons to

operate earlier; and this in turn led to a still smaller mortality. The present death rate of about two or three per cent. is chiefly due to making the operation one of election instead of one of emergency. Up to ten years ago even the most favorable cases for operation were women with deformed pelvis, who had been in furious labor for many hours, and on whom repeated and forcible efforts had been made to effect delivery. The operation may have been as skilfully performed then as we can do it now, although perhaps not so quickly; so that we can safely say that the majority, if not all, of the deaths were due to the injuries received by the women from the futile attempts of nature or art to deliver them. The next great decrease in the mortality occurred only two or three years ago, when a few of the most courageous abdominal surgeons inaugurated a new era in the history of Caesarean section by not only improving the condition of the class of women who had formerly been operated on, but by adding two entirely new and more favorable classes. That is to say that, instead of waiting until the life of both mother and child have been jeopardized by the violent use of forceps, and then doing Caesarean section, they have gradually persuaded the family physician to do less and less damage; until now it quite frequently happens that we have an uninjured woman to operate on. When every family doctor becomes skilful enough to recognize that a given head cannot pass through a given pelvis without serious injury to either mother or child or to both, and advises Caesarean section before using forceps; or even when he ceases in his efforts with the forceps before he has done serious injury; or even if he could do a moderate amount of damage without infecting the mother; then in the hands of an expert Caesarean section would reach its highest perfection, namely, 100 per cent. of recoveries, which, indeed it has almost reached in this year of 1909.

But, beside this class of deformed or disproportionate pelvis, which still gives a very small percentage of deaths, there have been added two other classes of women, who, because they are operated on before any injury whatever has been done to the soft parts, promise to give a death rate as low as an average delivery in a private house, namely, about one-half of one per cent. for the mother, and still better for the child. One of these classes comprises the women with puerperal convulsions coming on just before the onset of labor. Up to a few years ago the best we could do for them was an *accouchement forcé*, which has a high death rate for both mother and child, even if the mother were in good condition. But the woman with puerperal eclampsia has been an anaemic woman for several months, and has a low opsonic index; so that

injury which a woman in good health but with a contracted pelvis might easily have recovered from, is fatal to her. It is probable, however, that even in these cases there will be one hundred per cent. of recoveries as soon as the whole mass of family doctors have been educated up to the point of abandoning entirely the *accouchement forcé* and of religiously refraining from doing any injury to the soft parts.

The other class, namely, those with placenta praevia, which is fortunately a very rare one, but which until a few years ago had a death rate as high as forty per cent. in Europe and ten in America for the mother, and much higher for the child, when treated by rapid delivery, now gives a mortality almost *nil* when delivery takes place by Caesarean section.

With all these improvements taking place, we are justified in assuring a woman with a deformed pelvis or with albuminuria or placenta praevia that she and the child run less risk from delivery by Caesarean section than by any other natural or artificial process, and that if she should become pregnant again and if any of these three things should happen for the second time, which they are not very likely to do, she can be delivered again and again by Caesarean section, with little, if any, greater risk than that of an ordinary confinement. So that if the patient and her doctor leave it to us to do as we think right, we will not sterilize her. But what shall be our attitude if the woman demands to be sterilized, so as to be saved from the inconvenience or expense or the slight risk which some might claim for the operation? I am inclined to think that in that case we are justified in complying with her request; not by removing the ovaries, but by taking out an inch or so of the uterine end of the tube and sewing the peritoneum over the interstitial part.

Vaginal Caesarean section has the great objection of taking valuable time when every minute counts; for, after cutting the cornu, you still have to do an *accouchement forcé* with all the danger of sepsis.

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TUBERCULAR CONJUNCTIVITIS.

By T. Alexander Davies, M.B., Toronto.

Baby H. Aet 7 months. About three months ago mother noticed sore spot on the skin of the lower right lid toward the outer side. She consulted a practitioner, who said it was constitutional, and that the baby would grow out of it. The mother says eyes have never been red, and was much surprised to see the condition of the conjunctiva on my everting the lids. The child feeds well from the breast, and the mother is in good health. The baby is also allowed arrowroot biscuits at irregular intervals. The baby sleeps well, is well nourished, and with the exception of frequent constipation, is apparently in good health. The mother says she has not had the time to give the baby the necessary attention as regards regularity of feeding and fresh air. They live in a flat. She used boracic lotion for the eye several weeks previous to the present consultation, this being the only treatment.

Examination.—Jan. 5th: Bulbar conjunc. of both eyes bright and clear. The right eye, O. D. appears smaller than the O. S. on account of swelling of the lids of former. The brownish spot which the mother first noticed three months ago is present on the skin of the R. lower lid, near outer canthus. On perforating this, a small amount of pus and serum exuded.

On everting the upper lid of the R. eye, there is present an irregular, diffuse, dull-red swelling of the conjunc., numerous lymph follicles, more or less discrete, being markedly affected, some of them presenting greyish-red tag-like granulations; others flatter, and bleeding from the mere evertion of the lid. The process involves the entire lid from the margin to the retrotarsal fold. The lower lid presented small reddish-yellow pin-head points, mostly confined to just within the tarsal plate. There is no marked exuberant granulations on the lower lid, such as are to be seen on the upper.

The condition is confined to the right eye. The left appears free.

Treatment since Jan. 5th: Lot. Ac. Boric., 25% Argyrol, p. 4 h. Ung. Hyd. Ox. Flav. 1%. Malted food. Fresh air.

Office Treatment.—Arg. Nit. 2% every fourth day, followed by 50% Argyrol.

(Result: Marked improvement.)

ABDOMINAL PREGNANCY PAST TERM.*

By W. J. Hunter Emory, M.D., Toronto.

Mrs. A., aet 35, gave history of normal pregnancy, which, according to patient's reckoning, should have terminated some three weeks prior to date of examination. Up to previous fortnight fetal movements had been frequent and strong; none felt in past two weeks.

Examination showed uterus normal in size and position.

Abdomen enlarged to correspond with period of full-term pregnancy, though somewhat less ovoid and prominent in median line.

Abdominal walls quite thick. A sense of elasticity was imparted on palpation over entire abdomen, with areas of distinct fluctuation and distinct solid masses could be felt here and there, but no fetal parts could be definitely made out, owing to the unusual thickness of abdominal wall.

Stethoscopic examination was negative. A probable diagnosis of abdominal pregnancy was made, with ovarian papillomata as an alternative possibility.

Operation was advised, and performed next day, resulting in the finding of a full-sized dead fetus in the abdominal cavity.

The placenta was found firmly adherent to the descending colon, meso-colon, and numerous coils of small intestine, occupying the whole left umbilical region, having no connection whatever with any of the pelvic organs.

On finding the fixation of the placenta to be so very firm over such a large area of important structures, all efforts at enucleation were quickly abandoned. The membranes were trimmed away, and the umbilical cord brought out through abdominal incision, surrounded by well of gauze, brought down well upon the placenta.

Around this the incision was closed, and patient put to bed. Slight traction was made upon the umbilical cord at intervals of a few hours for the first twenty-four hours, but this elicited no signs of yielding. On the third day the gauze was removed, there being no discharge, and temperature and pulse normal. The wound healed very quickly, the cord separating about the seventh day, much as separation occurs from infant. The convalescence was quite normal, with the exception of slight colicky pains, which

*Read before the Section on Surgery, Academy of Medicine, Toronto.

continued at intervals about the placenta site for several weeks, and then entirely disappeared.

The case illustrates three facts which seem of some interest from the standpoints of physiology and abdominal surgery.

First.—Fecundation, it would seem, must have taken place in this case in the peritoneal cavity.

Second.—Full-term abdominal pregnancy existed, in which there was no connection of any nature whatever with any pelvic organ.

Third.—Dr. Robert Morris, of New York, has said he would not be afraid to leave a pound of aseptic beefsteak within a healthy peritoneal cavity. This case proves the ability of the natural forces within the peritoneum to take care of a full-sized placenta.

For some weeks after the operation the placental mass could be plainly outlined by palpation, constantly diminishing in size, until it ultimately became indistinguishable.

DR. MARLOW: Referred to case in which he assisted Dr. Ross in removing a dead child from the abdominal cavity within a week after the death of the child. In this the placenta was successfully removed, though the bleeding was severe. Favored leaving the placenta *in situ*, and closing the abdominal cavity in attempting to remove a living child.

MEDICAL THOUGHTS, FACTS, FADS, FANCIES, AND FOIBLES.

BY JAMES S. SPRAGUE, M.D., PERTH, ONT.

There is no profession, calling or occupation in this or other lands which can claim a greater absence of leaders as medicine; and equally true is this, that medicine has but very few in its ranks who, unless for personal interests or other unworthy and non-professional motives, are advocating the necessity of opposition to the many modern and medical cults—encouraged by Reverend Doctors as Emmanuel Movements, patronized by fakirs—defamers of medicine. To those who may be termed as leaders we look vainly for objections and denouncements of such calamities and evils that these inane cults promulgate and encourage, especially injurious to the labors of medical men and the advancement of science, and not least to the teachings of the Church of Christ, whose disciples are too often influenced injuriously by following false guides in these our times, when unsettled beliefs and doc-

trines too frequently are entertained and announced by doubting, profoundly ignorant, or profoundly educated men, who cannot fully understand the simple teachings of the Saviour of men.

It is indeed lamentable to notice—even daily—in our public prints, the criticisms by those whom we are taught to call reverend, of our earliest beliefs—more and more cherished as the years teach us immortality. And yet these, or such as these, recognizing their influence over the souls of men is lessening, are, strange to state, among those who are either recommending Duffy's Whiskey or the encouragers or promoters of "a penny in the slot" medical cult, antagonistic to our researches and even the church.

Weltmerism apparently has had its day, and Osteopathy, in due time, had its origin in the same State—Missouri—and although with less backbone than Christian Science, this system, cult, or delusion still is striving in this, the banner Province of our Dominion, for recognition, and Major Craig, of East Wellington, has presented a petition from the Mount Forest Board of Trade to our Provincial Parliament, asking for incorporation, and no doubt a college, wherein will be taught Osteopathy, and wherein, no doubt, certificates qualifying or certifying to *Doctor in Osteopathy* as a prize, will be offered.

Why not legislation be enacted in the interests of Mrs. Eddy's disciples, and allow them to disgrace our civilization, the church and our honored profession, not least the universities, with their glorious records? It is hoped that the intelligence of our legislators will not dishonor the transactions of our Parliament, nor dishonor themselves, nor the sacred trust imposed on them by the electorate, by encouraging, tolerating or in any manner sanctioning this or any other delusion as worthy of an existence in our midst, and associated in every sense with the medical profession or its interests. The medical profession of our Dominion, and the people thereof, are victimized too often by fakirs and many crazed medical cults, organized by swindlers of no mean order, whose numbers are increasing even in proportion to civilization, the growth and stability of our state universities, the advancement of medicine, and the widespread interest for the public health; thus, there exists no demand for Osteopathy, Christian Science, Chiropractists, Vitopathists or Emmanuel Movements, unless we wish to allow visionaries to nurse their visions, delusions and other brain-storm theories that our national asylums and retreats may not become too congested. "Forgotten suns have toiled and burned" that we might live, and the civilization and refinement of the minorities among the workers will ever hold back those who discourage and impede the labors and altruistic researches of our profession. Yet, the

labor in such efforts is tedious, often unrecognized by the great unwashed and illiterate majority, who think they think, and yet do not.

Our profession, in remote periods of history, when in alliance with that "divine conjunction" (half-doctor, half-priest), knew no progress when thus throttled, but, freed from its stranglings and shackles, it has reached such achievements and glory as to incur the enmity, and even the envy, of the church; hence, either seeing "the glory departing out of Israel," or for increased power or more shekels, wants the restoration of affiliation—even an "Emmanuel Movement." Psycho-Therapeutics, yet without the qualifications, studies or licence of the state or province.

Although for more than forty years in practice (and yet my sign still swings), and in the thankful possession of perfect health, perfect peace, and abundant competence, surrounded by my books and office treasures, yet, with the intense love for and devotion to *Medicine* and its best interests, my prayer is that "pitcher be broken at the fountain" in my perishing body ere the word *Osteopathy* be found in the register of the transactions of our College of Physicians and Surgeons, or in the reports of the acts of our Parliament.

The influence, either for good or evil, so decidedly apparent in many of our medical journals is a consideration worthy of much study, especially by young medical men, whose self-respect, whose respect for all that ennobles the profession, and whose ideals may become wofully and irrevocably dethroned, or preserved, and with the years intensify his devotion to his work and his respect for his fellows. I know many journals that have a very demoralizing effect, and the young M.D., however brilliant, as subscribed, would silently and assuredly find himself enchained by views of common —yes, ignorant—writers, and by contributions of hired men, whose efforts are directed to the praise of compounds not in any sense ethical, and the debasement of our legitimate works on medicine.

Judge Riddell has prepared and delivered a series of lectures, of which "The Doctor in the Courts," "The Doctor as Judge, as Plaintiff, as Defendant, and as Witness," "Law and Medicine," "The Medical Expert as a Witness, etc.," which are of so important consideration as to reward every medical man, and there are in our cities—where are established Medical Faculties—others, who, with similar knowledge, could and most willingly would give such much-needed instruction and warnings. Why not, then, lectures, imperatively needed as these are, be regularly given during the medical course? Why not, also, lectures on purely professional interests, such as are found either in our Medical Ethics, or as

incidents or duties connected with practice—a study of the master minds, or of the Fathers in Medicine, the Antiquity of Medicine, Progress of Medical Thought, Modern Quasi-Medical and Delusive Cults?

Since the establishment of our Medical Council, much valuable time has been lost in discussions referring to matriculation qualifications, and such as now exacted are beneath what our age requires, and not equal to those of Quebec. If we are to maintain our profession as one of the trinity of learned professions, and to look for a Sydenham, a Stokes, a Sir Thomas Browne, a Hunter, or a master mind, either B.S. or B.A., must be the first gift, and acceptable one, too, of him who gives his heart to medicine, which is the "first of arts, without whose light all the rest would sink in night." Especially are these preliminary qualifications demanded, if doctors, as Gladstone prophetically said, are to become the rulers of nations; or if, as Virchow says, "Physicians are the natural attorneys of the poor, and all social problems and reforms should be largely worked out by them." If such obligations and duties await the life-work of doctors fresh from the mint, it is essential that they become prepared, and to remember that, although this age deals in realities, it is incumbent on each one of us to learn what Dr. A. Jacobi, of New York, a Father in Medicine, tells us: "Ideals are not for those only whose heads tower above ours, and the very soles of whose feet seem to walk over the clouds, but for all of us who take pride in admiring great examples and try to follow them."

The same reverend, learned and aged father wisely says: "Read your Hippocrates, my young friends." Such I repeat, and add: "Fellow-practitioner, read Sir Thomas Browne's "Religio Medici," and learn the nobility of medicine, and the nobility and scholarship of the author. Compare your learning with his learning and abilities, and bow your head. If you consider yourself a weak link in the medical chain, study your weakness. *Audi, vide, tace!* until you feel your strength, and do not attempt that which you cannot finish. (*Ne tentes aut perfice.*)

I hope that since we deserved the name of friends, that part of mine may live in thee, and move thee on to noble ends.—In Memoriam.

Finis opus coronat.

Medicine

GRAHAM CHAMBERS, R. J. DWYER, GOLDWIN HOWLAND, GEO. W. ROSS, WM. D. YOUNG.

Freud's Conception of the Psychology of Neuroses. By A. A. BRILL, PH.B., M.D., New York City. *Medical Record,* Dec., 1909.

Prof. Freud is happy in possessing several enthusiastic pupils, and A. A. Brill is perhaps the foremost. This is a brief paper, declaiming Freud's *theories,* and giving a good clear account of them.

Psychoanalysis is rapidly becoming more generally used, and psychotherapeutics more popular and more cultivated, and for these methods we are deeply in debt to the Freud school. Yet neither placing the basis of all these Psycho Neuroses on a sexual origin, nor acceptance of the influence of psychic shocks in determining motor and sensory changes, is wholly acceptable to all students of psychiatry. The danger in following such an origin is that we may delude our own minds as to its value by oversaturation, and accept far overreaching conjectures as facts.

G. W. H.

Relation of Rectal Diseases to the General Nervous System. ERNEST LAPLACE, M.D., LL.D., Philadelphia. *J. A. M. A.*

Laplace (rather) overemphasizes the relationships of rectal diseases to nervous diseases, both on anatomical grounds, and also secondary to such causes as constipation.

The result of this relationship of cutaneous and muscular nerves to the visceral nerve supply of the rectum allows local conditions, as hæmorrhoids and fissures, etc., to produce reflex and referred pains in remote regions, while the depression produced by the pain of these morbid processes acting on the pelvic sympathetic produces general depression of the nervous system.

Constipation is in truth a serious condition, as it allows of the absorption of noxious products which depress the nervous system.

G. W. H.

Neurasthenia in General Practice. By H. B. ANDERSON, M.D., L.R.C.P. (Lond.), M.R.C.S. (Eng.). *Can. Jour. Med. and Surg.*

Following these abstracts on psychoneuroses with the views of a proctologist urging rectal causes and a psychiatrist localising on psychical disorders, we have an excellent paper by Anderson on the neurasthenias from an internist's standpoint. Causation, he affirms to be psychic, overstrain, toxemias, heredity (U.S.W.). Symptomology also derived from psychic motor, sensory and vaso-motor activities, evidenced (*a*) by such general signs as fatigue, depression, headache, insomnia, pains and loss of weight; (*b*) by disturbed functions, as for instance, palpitation, throbbing, hyperchlorhydria, intestinal disorders, indicanuria, frequent micturition; lastly, by secondary symptoms, as anemias, autointoxication. Finally, he concludes by urging not only the use of psychotherapy, but of all forms of treatment, best suited to the case, whether they be Weir Mitchell and Rest, Hydrotherapy, Diet or other well-known methods.

G. W. H.

Cerebro-spinal Meningitis; Clinical Observations and Serum Treatment. By LOUIS FISCHER, M.D., New York. *New York Medical Journal,* October, 1910.

Cases of cerebro-spinal meningitis may be mild, abortive or severe.

The severe ones are most fatal to babies of one year and under, but yet the mortality, even at this age, in common with all other ages, has been lessened by the *serum* treatment.

The symptoms of the late epidemics were: Sudden onset, with chill; respiration frequently Cheynes Stokes; vomiting; frontal or occipital pain; sensitive tendons; Kernig's sign; opisthotonus; arthritis; petechial eruption; photophobia and nystagmus.

G. W. H.

Psychiatry

W. C. HERRIMAN, ERNEST JONES.

The Traumatic Neurosis. By PEARCE BAILEY. *New York Med. Journal*, Jan., 1910.

Bailey considers that the "traumatic neurosis is distinct from other psychoneuroses in origin, in the mould in which its symptoms are cast, and in the peculiar feature which conditions its prognosis." This feature is of course the matter of litigation. He holds, however, that the wish for a large verdict does not play the important part generally thought, and that more important is the natural desire for revenge. E. J.

Experimental Studies on the Aetiology of Acute Poliomyelitis. By STRAUSS and HUNTOON. *New York Med. Journal*, Jan. 8, 1910.

This paper is based on the study of six fatal cases. The chief conclusions are: (1) The disease can be produced in a *Macacus rhesus* by intraperitoneal inoculation from a fatal human case. (2) Attempts to transfer it from one monkey to another have, up to the present, been unsuccessful. (3) The cerebro-spinal fluid of acute cases does not contain the virus in an infective state, and the reported bacterial findings in the cerebro-spinal fluid are due to either contaminations or secondary invaders. (4) When the disease is clinically recognisable the virus is probably no longer present in the blood. (5) From the close resemblance of the disease to rabies, in its anatomical changes, symptoms, and mode of transference, it is probable that the virus is not bacterial, but protozoan in nature. (6) Acute poliomyelitis is due to an actual infection, not to any poisoning by a toxin. E. J.

Ophthalmology

D. N. Maclennan, W. H. Lowry.

Excision of Lachrymal Sac Before Operations on the Eyeball. In *La Clinica Oculistica,* August, 1909.

Calderaro gives the results of his experience with this operation from a bacteriological point of view. His conclusions are briefly as follows: The number of organisms of all kinds is diminished, and within the first few days the virulence of those remaining is lessened; if the eyes be tied up for a few days, the bacteria increase both in number and virulence. After some months the conjunctiva usually shows in examination no pathogenic germs, but the usual saprophytes, but if the eyes be tied up again, the pathogenic germs reappear, but in diminished virulence, in about a third of cases.

He has not found probing of the stricture to be of as much service in lessening the number of bacteria, as removal of the sac. Removing of the lachrymal gland, with the resulting diminution of tears, tends to increase the growth of pathogenic organisms.

W. H. L.

The Influence of Adrenalin in Intraocular Tension. *Ophthalmoscope,* December, 1909.

This is a review of Rubert's investigations in connection with the use of adrenalin in glaucomatous eyes. He says that to use adrenalin indiscriminately upon the eyes of elderly people is a mistake, and to instil it into an eye affected with glaucoma is very wrong unless the patient is under immediate and constant observation. He quotes a number of instances where adrenalin seemed to cause exacerbation of the glaucoma symptoms. He speaks of one case of absolute hæmorrhagic glaucoma, in which the instillation of two drops of solution caused such an acute attack that the eye had to be enucleated. On the other hand, other instances are given where the use of the adrenalin was of decided benefit in glaucoma patients. It seems that there are two varieties of action. Either the adrenalin acts beneficially, causing a decided fall of pressure within the eye, or it has the opposite action, causing a rapid rise of intraocular pressure, with the resulting serious

consequences. The author, therefore, is of the opinion that one should never prescribe adrenalin to out-patients who are liable to glaucoma, but that it is often of great service to patients who can be kept under constant observation. W. H. L.

The Premature Appearance of the Photo-Motor Reflex During Fetal Development. MAGITOT, in *Ann. d'Occulistique*, March, 1909.

Magitot gives the results of his investigations after having examined fifty prematurely-born infants. The light reflex was faintly present at the end of the fifth month of gestation, was more marked during the sixth month, and by the middle of the eighth month became as active as it is at full term. The author considers that the appearance of the reaction during the fifth month is in agreement with the known development of the visual cells, origin of the nuclei of the third nerves, and partial maturity of the sphincter pupillæ of that period. W. H. L.

Cyclodialysis. WALTER L. PYLE, of Philadelphia. *American Journal of Surgery.*

The object of the operation is to reduce intraocular pressure by the establishment of an artificial communication between the anterior chamber and the suprachorioidal space. The technique, briefly, is to make an incision with a keratome into and through the sclera at a point 5mm. from the limbus; insert an ordinary iris spatula between the chorioid and sclera, push it forward into the anterior chamber, and by means of gentle side movements of the spatula, to separate the ciliary body from the sclera.

He says the operation should be gravely considered in primary glaucoma, when high tension, absence of anterior chamber and widely dilated pupil militate against the performance of iridectomy as dangerous, and in fact almost impossible. It is indicated in glaucoma when one eye has already been destroyed by glaucoma malignum, or when it is undesirable to confine the patient to bed, because of extreme nervousness, persistent coughing, great prostration, or old age. He states that cyclodialysis has proved of advantage in certain cases of secondary glaucoma, viz.:

1. Cases of anterior synechiae, when iridectomy did not reduce the tension.

2. Cases of glaucoma following the extraction of cataract, provided, of course, that the edges of the coloboma are in proper place.

3. When the lens has been dislocated into the vitreous, as in these cases the inevitable escape of vitreous during the performance of an iridectomy is a positive danger. W. H. L.

Rhinology, Laryngology and Otology

GEOFFREY BOYD, GILBERT ROYCE.

Aural Emergencies in Infants and Children. By J. F. MCKERNON, New York. *The Post-Graduate,* Feb., 1910.

In this paper the author details the more common ailments affecting the ears of children, and mentions some simple measures for their relief and cure. In examining the ear for earache, it is best to wipe out epithelial debris and wax rather than syringe it out, as the latter produces congestion of the membrana tympani, and so clouds the diagnosis. For the simple congestion due to a slight cold and consequent swelling of adenoid tissue or a beginning tonsilitis, he recommends a weak solution of cocaine and adrenalin in camphor water. Simple syringing with hot water will often relieve.

For marked bulging of the drum, any drops are contraindicated, the appropriate treatment being a free incision, preferably a long, curved marginal one. This should be followed by syringing with hot salines, boracic acid solution, or 1/4000—1/10000 bichloride of mercury. The use in the external auditory canal of drops composed of laudanum and sweet oil should be condemned, as it clogs the canal should drainage be necessary, as well as acting as a culture media for germs.

In the removal of foreign bodies care should be taken not to injure the canal in any way, but to use the syringe first before resorting to instruments.

In eczematous conditions, first the cause such as acrid discharges, etc., should be removed, then the surface painted with acetum cantharides, followed by a soothing ointment. In accidental punctures of the drum membrane, all that is required is cleansing with saline or ..... antiseptic.

Impacted cerumen should be removed by the syringe, first softening it with peroxide of hydrogen or saturated solution of bicarbonate of soda.

Unexplained high temperatures are often caused by ear disease, and so the necessity of frequent examinations during the course of

infectious diseases, etc., becomes evident. The reason why many ears continue to discharge indefinitely after an attack of acute otitis is fourfold. First, the ear is allowed to rupture spontaneously, this rupture taking place too high, so that drainage is poor. Second, the presence of lymphoid tissue about the mouth of the Eustachian tube, preventing drainage through the tube to the throat. These lymphoid masses should be removed, and their presence may be suspected should a free drainage through the drum membrane fail to relieve a continuous discharge.

Reviews

International Clinics. By leading members of the Medical Profession throughout the world. Edited by W. T. LONGSCOPE, M.D., Philadelphia, with the aid of many collaborators, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels, and Carlsbad. Volume IV. Nineteenth series. 1909. Philadelphia and London: J. B. Lippincott Company.

This volume is devoted to treatment, medicine, surgery, Röntgenology, gynecology, obstetrics, genito-urinary diseases, pediatrics, parasitology, laryngology and pathology. One of the best articles of the volume is by Simon Flexner, M.D., on the preparation and uses of antimeningitis serum. Dr. Flexner explains the mode of action and manner of administration of the serum, and gives indications for its use.

The other articles of the book are, with two or three exceptions, good. Among others, we think the following worthy of commendation: "Treatment of Cancer by Fulguration," by Pierre Fredet, Paris; "The Use of Tuberculin in Treatment," by Louis Hamman, Baltimore; "The Early Diagnosis of Cancer of the Uterus, with Operative Technic," by Thomas S. Cullen, Baltimore.

The volume as a whole maintains the high standard of previous productions of the work.

G. C.

A Text-Book of Physiology: for Medical Students and Physicians. By WILLIAM H. HOWELL, Ph.D., M.D., LL.D., Professor of Physiology, Johns Hopkins University, Baltimore. Third edition; thoroughly revised. Octavo of 998 pages; fully illustrated. Philadelphia and London: W. B. Saunders Company. 1909. Cloth, $4.00 net; half-morocco, $5.50 net. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

The object of the text-book is well carried out in its contents, and it is to present in brief, compact form a modern physiology, well up to date, and at the same time to avoid all unnecessary theories and matter that is not absolutely of value to the readers it is meant for.

To-day a "Physiology" must be at the elbow of a modern practitioner, and the necessity is well shown by the placing of Physiology as an advanced subject in the fifth, as well as in the primary, work of the medical student.

This book will satisfactorily suit both the college student, and even more so the thoughtful physician who fears that rust is commencing to play havoc with the groundwork on which his professional ability rests. G. W. H.

A Text-Book of the Practice of Medicine. By JAMES M. ANDERS, M.D., Ph.D., LL.D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia. Ninth Revised Edition. Octavo of 1326 pages; fully illustrated. Philadelphia and London: W. B. Saunders Company. 1909. Cloth, $5.50 net; half-morocco, $7.00 net. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

On reading this last edition of Anders' Medicine, the first thought that impresses one is the similarity in arrangement to the popular text-book of Osler. Indeed it is Osler, but with the advantage that it is issued in 1909, whereas the other was published in 1905, and it is therefore much more suitable for those desiring a newer text-book. In some regards and on some subjects, besides being more modern, it is also better than Osler, and perhaps one could adduce in favor of this statement that Anders handles his therapeutics in more satisfactory style. The more recent additions that are interesting are such subjects as the "Hemolytic Serum Test in Gastric Carcinoma, Chronic Poliomyelitis in Adults, Grocco's Sign in Pleurisy, Serums in Meningitis, Leukæmia, and many others. G. W. H.

A Text-Book Upon the Pathogenic Bacteria. For Students of Medicine and Physicians. By JOSEPH MCFARLAND, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College, Philadelphia. Sixth Revised Edition. Octavo of 709 pages; fully illustrated, a number in colors. Philadelphia and London: W. B. Saunders Company. 1909. Cloth, $3.50 net. Canadian Agents: The J. F. Hartz Co., Ltd.

The author of this text-book has prepared for the medical student and general practitioner a book of convenient size, which is not too technical in character, and from which may be obtained

a good knowledge of Bacteriology. This sixth edition has been brought well up to date by freely drawing upon the publications of the various men interested in this subject in other countries. An attempt has also been made by foot-notes to give some of the more important references to these publications. The volume is well illustrated by numerous plates, which show the various steps in bacteriological technique, the morphological and cultural characteristics of the pathogenic bacteria, and the lesions which they produce in man. In the preparation the author's endeavor has been to arrange the subject matter systematically and practically as regards the chapters and pages. The volume is compact; it contains seven hundred pages, one hundred and one illustrations, and is well bound and indexed. O. R. M.

W. B. Saunders Company, the medical publishers, of Philadelphia and London, have just issued a new edition—the thirteenth—of their handsome Illustrated Catalogue. It contains some twenty new books and new editions, and besides numerous black-and-white illustrations, there are two color cuts of special value. We strongly advise every physician to obtain a copy—sent for the asking. It will prove a ready guide to good medical books—books that we all need in our daily work.

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COMMENT FROM MONTH TO MONTH.

What the Local Health Officer Can Do in the Prevention of Typhoid Fever is well set out in the *Public Health Reports* of the United States, by Dr. L. L. Lumsden. As others have said before, typhoid fever is a disgrace to civilization, and its prevention is one of the greatest problems with which sanitarians have to deal.

That its mortality is a large one is seen from a comparison of statistics of different countries. In Scotland, for the period of 1901-1905, the mortality was 6.2 per 100,000 of the population; Germany, 7.6; England and Wales, 11.2; Belgium, 16.8; Austria, about 19.9; Hungary, 28.3; Italy, 35.2; in the United States estimated at about 46.0.

The incidence of typhoid fever in any community to any great degree stirs up the lay mind, which then becomes alive to the dangers of an extensive outbreak. Then the question is asked, why was it not prevented; and woe betide the hapless health officer if he has not kept a keen edge upon his observations.

Epidemiologic studies go to show that this is a communicable disease, spread from person to person. Germs from the excreta gain access in some way to the alimentary canal from typhoid fever patients and bacillus carriers; and there seems no reason to doubt

that it is directly transmissible from the sick to the healthy, or indirectly so, that is both contagious and infectious. Therefore the prevention of typhoid fever must take into consideration that there is danger not only from the patients themselves, but as well from the various vehicles, as water, milk, fingers, food, flies, etc.

First—The local medical health officer must become informed of the best-known methods of prevention. This, Dr. Lumsden states, consists largely in the care of excreta from sick persons and of proper general sewage disposal.

Second—He should secure the prompt report of recognized cases and of suspected cases, so that preventive measures may be begun early. The difficulty of making prompt diagnoses is recognized by all physicians from the symptomatology alone, and as these unrecognized cases possess elements of extreme danger, it is important that the health officer be promptly informed of even the suspected cases. This should be made a legal requirement. As in diphtheria, there should be laboratory facilities to aid in diagnosing suspected cases.

Third—The medical health officer should advise with the attending physician and family as to the most efficient methods of prevention at the patient's bedside, and should see that these are carried out. That contact infection plays a rôle in the spread of the disease is borne out by the fact that about 20 per cent. of the cases in the District of Columbia, in 1907 and 1908, gave a history of direct or indirect association with previous cases in the febrile course of the disease. Therefore typhoid fever is not always a water-borne disease pure and simple. Such being the case, reasonable isolation is advisable. It is essential in carrying out bedside disinfection of the excreta that the disinfectants are made properly and used properly.

Fourth—Have the preventive measures continued as long as the dejecta are infective. It cannot be too strongly brought home to patients and their attendants that disinfectants must be as efficiently used during convalescence as during the active stages of the disease. The safe guide for cessation of these would be bacteriologic examination.

Five—Discover bacillus-carriers and safeguard against the spread of infection from them. This would involve much activity on the part of the health officer, and means an inspection of premises where foods and beverages were sold to those families in which there had been unusual occurrences of the disease. It would mean also inspection of servants—and one is reminded of the case of "Typhoid Mary," a New York cook, who carried the disease into every family whose service she entered. Any such bacillus-

carrier should certainly be prohibited handling any food or beverage to be consumed by man.

Six—Secure proper disposal of sewage. It is almost superfluous to say this should be done of all persons, whether sick or well, but especially for the ambulant and convalescent.

Seven—Prevent the introduction of infection from without through the water supply, the milk supply and the general food supply. Money is needed for this; money, the sinews of sanitation, even to the extent of a costly filtration plant for the water or a municipal pasteurizing plant for the milk.

Eight—Secure the co-operation of practising physicians. The health officer and the physicians of a community should work hand in hand in the best of harmony.

Nine—Exercise an influence in the local medical society, so that the society may be a school of instruction in the principles of prevention, as well as of the cure of disease. In this society local problems of sanitation could be illuminated.

Ten—Make the health office educative. Properly prepared articles for the local press would be of the most far-reaching influence.

Canadian Medical Association.—A little over two months and the 43rd annual meeting of the Canadian Medical Association will have passed into history. Under the guidance of Dr. Wright, the President-elect, and Dr. Wishart, the Chairman of the Committee of Arrangements, all the general committees as well as the sections are working right willingly for an unusual success of the meeting on the 1st, 2nd, 3rd and 4th of June.

In the sections it is understood the programmes are filling up nicely, and that there is going to be unusually good and interesting papers.

The Entertainment and Transportation Committee are arranging for two general excursions, one to Niagara Falls and the other to the Ontario Agricultural College at Guelph.

For the purposes of transportation, the transportation companies and their respective passenger associations will couple in the matter of rates the meetings of the Canadian Medical Association and the Canadian Dental Association, so that it is quite safe to say that return, for single fare, will be assured.

We would enjoin our readers to keep the above dates open, so as to avail themselves of the pleasure and profit of attending this meeting.

Rabies in Canada, or, more correctly speaking, in Ontario, has recently become of such pronounced dissemination throughout the western part of the Province as to call for conjoint action on the part of the federal and provincial authorities.

Writing with a good degree of authority, and, from his position, with an unusual knowledge of the subject, Mr. Charles H. Higgins, B.S., D.V.S., pathologist to the Department of Agriculture, Ottawa, gives a concise history of Rabies in Canada in the January issue of the *Montreal Medical Journal.*

Although occasionally observed in the Dominion, there has never been up to the present time any pronounced outbreak. Prior to 1899, Niagara Falls and its vicinity recorded outbreaks; and between that date and 1905, Dr. Higgins states no material sent to his laboratory gave unmistakable evidence of the presence of the disease.

A case of a man being bitten by a wolf in 1904, reported from Victoria, B.C., contracting hydrophobia, is not considered an authentic one by Dr. Higgins.

Outbreaks have been reported from time to time in the Niagara Peninsula since 1905, traced generally to dogs across the river.

In Manitoba an unusually long incubation period of ninety-three days has been reported in a horse, but the usual incubation period is from fourteen to twenty-five days.

The statement in Dr. Higgins' paper, that "the Pasteur treatment is furnished to physicians in the United States by the Public Health and Marine Hospital Service," is an interesting one to Ontario physicians in view of the fact that the "scare" in this Province has been so acute as to drive practically everyone bitten by a dog to New York for treatment.

It will be eminently satisfactory to the medical profession in Ontario that the Government of the Province has taken the matter up, and that hereafter there will be no necessity for anyone to scurry off to New York as soon as bitten by a dog, even although it is "feared" that particular dog has rabies.

When compulsory vaccination is sought to be set aside by a bill at the instance of a private member in the Ontario Legislature, the subject of smallpox looms up interestingly large.

From the *Public Health Reports* of the United States we extract a few items in connection with the extent of smallpox in that country, and especially Germany, where vaccination and re-vaccination are compulsory.

In the United States, in 1907, there were 17,220 cases of small-

pox, with 74 deaths; in 1908, 35,174 cases, with 92 deaths. This shows a small mortality for a comparatively large number of cases, and looks as though smallpox is not the dreaded and dreadful disease it once was.

Germany had 345 cases in 1907, as against 256 in 1906. The deaths in 1907 were 63, a mortality of 17.97 per cent, a death rate far in advance of what is recorded in the same year in the United States, and which would indicate a greater severity in the disease than on this side of the Atlantic.

In the five preceding years, in Germany the deaths were, respectively, 47, 30, 25, 20 and 25.

Of the 345 cases in Germany in 1907, 22 died who were unvaccinated; 14 died unknown as to vaccination; 3 died who were unsuccessfully vaccinated; two died who were vaccinated too late; ten died who had been vaccinated once; three died who were revaccinated too late; nine died who had been revaccinated.

The West Toronto Territorial District Society met in the Academy of Medicine at the call of its representative on the Ontario Medical Council, Dr. J. S. Hart, on the afternoon of the 2nd of March. Of the two hundred-odd medical practitioners in the district, barely one dozen answered the call. A fine showing, this; a manifest lack of interest in the affairs of the Council.

That only those universities which had medical teaching bodies should be represented on the Council was the unanimous opinion of the meeting. It was felt, also, that there were too many representatives on the Council, and that its affairs could be better conducted by a much smaller body, one speaker instancing the General Medical Council of Great Britain, with about 34 members to a medical population of some fifty thousand, while in Ontario the ratio was something like 23 to three thousand. A reduction in the number would also save considerable expense.

Although the homeopaths might jealously defend their representation, the impression was very general that that representation as now constituted—five—was most unfair to the medical body throughout the Province.

Whilst it has been generally considered that there was a great deal of unrest in the profession throughout the Province on Council matters, the attendance at this meeting would seemingly warrant one in saying it is not particularly apparent in the territorial district of West Toronto. It was quite evident there was satisfaction with the stewardship Dr. Hart had rendered for the confidence reposed in him.

News Items

DR. GORDON BELL, Winnipeg, has returned from Boston.

DR. LAUTERMAN, Montreal, is abroad.

DR. BRETT, Banff, Alberta, has gone to Vienna for graduate work.

DR. E. E. MEEK has been appointed Medical Health Officer of Regina.

DR. E. S. POPHAM, Winnipeg, has returned from a visit to England.

TRACHOMA has been discovered in school children in Regina and Winnipeg.

THE Lady Grey Hospital for Tuberculosis was opened at Ottawa on February 15th.

DRS. R. BOULET and L. De L. Harwood, Montreal, have returned from Cuba and Mexico.

MR. J. C. EATON has recently donated $250,000 for the surgical ward of the new Toronto General Hospital.

DR. J. S. MATHIESON has been elected President of the Brandon Medical Society, and Dr. E. C. Beer, Secretary.

THAT the Manitoba University, Winnipeg, should be a state-aided university is the opinion of a majority of the commission enquiring into its affairs.

THE Western Hospital, Montreal, has decided not to amalgamate with the Royal Victoria, same city. The hospital is sound financially and medically.

THE new Toronto General Hospital will have 36 beds for the eye, ear, nose and throat departments; 39 beds for gynecology; 145 beds, general surgery; 150, medicine; 9, emergency; 36, obstetrics. This will be 124 more beds in the public wards than in the present hospital, and 22 more in the private and semi-private wards.

PASTEURIZED milk is now supplied 1,200 children annually in the Sick Children's Hospital, Toronto, and to 12,000 outside patients. The hospital has its own pasteurizing plant.

DR. CHARLES F. MARTIN, Montreal, has gone on a two months' trip to the Mediterranean.

DR. GEO. D. PORTER, travelling medical secretary of the Canadian Association for the Prevention of Tuberculosis, has left on a lecture tour of Western Canada to the coast.

THE Verdun Protestant Hospital for the Insane, Quebec, admitted 197 patients last year. The total population is 783, the largest in the history of the institution.

SASKATCHEWAN Bureau of Health is to wage active war against tuberculosis. Local leagues are to be established in forty-one electoral districts. A sanatorium is contemplated. Dr. M. M. Seymour, Regina, is chief of the Bureau.

DR. J. L. TODD, McGill University, Montreal, has been awarded a gold medal by the Liverpool School of Tropical Medicine for sometime research work in connection with sleeping sickness on the coast of West Africa.

DR. W. A. R. MICHELL, Toronto, late of the Shackleton Antarctic expedition, gave an interesting address before the Aesculapian Club on the evening of the 11th of February. Dr. Michell recently received from His Majesty the King a handsome bronze medal.

DR. JOHN M. PIPER, Toronto, died on the 7th of February of acute nephritis, aged 55 years. Before coming to Toronto four years ago, he practised for 25 years in London, Ont., where he was surgeon to the 7th Fusiliers. He was a graduate of Victoria of the class of 1880.

THE Victorian Order of Nurses, Toronto, attended 709 patients the past year, necessitating 9,399 visits by the nine nurses in the service. In addition, 510 infants received attention. Forty additional Toronto doctors employed the nurses during the year. The receipts were $6,078.09.

THE ex-house officers of the Toronto General Hospital, of which there are now nearly three hundred, will hold their annual banquet at the King Edward Hotel on Easter Monday evening. Dr. Roland Hill, of St. Louis, will deliver the scientific address, following which the usual toasts will be drunk. It is expected that the first presentation of the gold-headed cane will take place. This has been awarded to Dr. Thos. Cullen, of Baltimore, who was considered to have made the best contribution of any ex-house officer to medical literature last year.

THE new buildings which are being erected for the accommodation of the Medical Faculty of the McGill University, Montreal, and to replace those which were destroyed by fire three years ago, are now approaching completion, and will, it is hoped, be ready for occupation in the early summer. The Medical Faculty has therefore decided, with the sanction and approval of the Principal and the Governors of the University, to hold the next Annual Convocation, for the conferring of degrees in medicine in the new building, and to arrange for the formal opening ceremonies at the same time; and to further signalize the event by carrying out a long-contemplated plan for a reunion of all her graduates. His Excellency the Governor-General has consented to be present, and a provisional programme has been arranged. All graduates are cordially invited to be present, and it is hoped that they will be able to accept. A more formal invitation and a completed programme will be sent later.

THE Fourth Annual Meeting of the Canadian Hospital Association will be held in Montreal on Easter Monday and the following Tuesday, March 28th and 29th. Mr. H. E. Webster, Superintendent of the Royal Victoria Hospital, Montreal, is President. Dr. Christian Holmes, of Cincinnatti, and other eminent hospital workers will be present. One feature of the meeting will be a visit to the various Montreal hospitals, with demonstrations on some special features of their work. All hospital superintendents and hospital trustees are eligible for active membership, and anyone else particularly interested in hospital work is eligible for associate membership. For further information in regard to the meeting, application may be made to the Secretary, Dr. Brown, Toronto General Hospital. Copies of last year's proceedings can be had from him on application.

Publishers' Department

IMPORTANT NOTICE.—Those of our readers who are interested in the various forms of Physiologic Therapeutics (including Hydrotherapy, Electrotherapy, Massage, Hyperemia, etc.) will be glad to know that it is proposed to shortly inaugurate a new journal devoted solely to the delineation of the progress made in these lines of therapeutic endeavor. *The American Journal of Physiologic Therapeutics* will be published bi-monthly, and the subscription price will be $1.00 a year. The names and addresses of all interested physicians should be sent in, and those desirous of subscribing at once may enclose their remittance when writing. It is to be hoped that a widespread interest may be aroused in this matter. Write *now,* while this is fresh in your mind, to *The American Journal of Physiologic Therapeutics,* 72 Madison Street, Chicago.

THE CAUSES OF ARTERIO-SCLEROSIS.—In a recent address, Dr. Osler discusses arterio-sclerosis (*Brit. Med. Journ.,* Dec. 25, 1909). Though there were sixty-two theories of its causation, he thought the three main factors were time, tension, and toxins. [Osler is not averse to the use of alliteration.—Editor.] As to the first, atheroma of the aorta was not in all cases senile; it was exceptional to find no patches of arterial degeneration in any body *post mortem,* and even children might show some slight foci of fatty degeneration. It might be a purely senile change, but the influence of heredity was marked, and arteries designed to wear till 70 might go to pieces at 40. It depended on the nature of the rubber tubing; or, again, the rubber might be good, but was subjected to bad usage. This brought him to the second factor—tension. It was the pace of the machine that counted, and vessels were not made for constant stress. There were two main types of stress: (1) The tension of life, when the candle was burned at both ends. He instanced the New York Stock Exchange man, who lived hard, smoking, eating, and drinking freely; at 40 there were knocks at the door, and creditors appeared in the shape of dyspnea, angina, etc. (2) The second type was muscular tension, due to over-exertion. The liability of cavalrymen to popliteal aneurysm was noted, and right-handed workers were found to be prone to arterial degeneration in the right arm more than in the left. In the experiment of the rabbit suspended head downwards for a few minutes

daily, at the end of 140 days there was marked arterio-sclerosis of the vessels of the upper part of the body. Toxins, the third factor, were divided into endogenous and exogenous, and of these the former were the most important. These were the waste products, the clinkers or ashes, which irritated the endothelium and kept up a high tension. Too much food was eaten, as if we were stoking our engines to draw the Edinburgh express, and then put them in the station yard or to draw trucks. Quakers, temperate in drink, were not so in food, and were specially liable to arterior-sclerosis. The theories of intestinal intoxication, as promulgated by Metchnikoff, and earlier by Glisson, had led to the lactic acid and sour-milk treatment. Of the exogenous toxins, those of the specific fevers were the most important and could cause degeneration even in children. Alcohol, tea, coffee, and tobacco were other types of exogenous toxins. For those with tendencies towards arterio-sclerosis, the guiding motto was: "Nothing too much"—the life of the tortoise, not that of the hare.—*Med. Review of Reviews.*

Collier's for February 12th devotes considerable space to a consideration of the way in which the consumer is robbed by the practice of putting food of all kinds into cold storage, to be sold when winter comes on. The subject of whether food deteriorates to such an extent as to make it unfit for human consumption has not, to our knowledge, been thoroughly worked out. The carnivora, in a wild state, do not eat some food till it has begun to decay; in fact, were it not for the odor then disengaged they would be unable to find it. Savages have a liking for putrefying meat, and, among civilized people, many connoisseurs do not care for game till it has become indeed gamey. There is a story to the effect that Chinese epicures have a fancy for eggs fifty or a hundred years old; if this is true, the liking for such eggs must be a cultivated fad of the rich, for after the first year or so the rest of a century can have little effect.

What poisonous effect, if any, long keeping in a low temperature may have upon the carcases of domestic animals, butter, cheese, eggs, etc., is at least as important a problem as the price of food so kept, and *pace* the antivivisectionists, some interesting dietary experiments might be inaugurated in the physiological laboratories —on lapdogs, for instance, who are more accustomed to high-priced food than most young children upon whom otherwise the results of such experiments are most likely to fall.

It is not unlikely that cold storage affects different articles of diet differently. While, for example, prolonged chilling has superb

results when applied to champagnes and other white wines, it is fatal to all the ruby vintages, which must be coddled near the grate. Similarly, we venture to suggest that cold storage might be excellent when applied to polar bear steaks, but bad for Delmonicos of hartebeest.—*N. Y. M. J.*

THE BURDEN OF THE SICK POOR SHOULD BE ASSUMED ENTIRELY BY THE COMMUNITY.—It is not fair to make an exception, and require physicians to bear any greater proportion of the burden of a community than other citizens. Custom alone is responsible for singling out one class and expecting its members to give special service of the most skilful and responsible character without reasonable recompense. The old idea that the hospital physician or surgeon derived adequate compensation from the experience acquired in experimenting or operating on poor patients—as a result of which greater success, more prestige and larger fees could be obtained in private practice—has been exploded. Hospital and dispensary training is immensely valuable, but the greater skill and knowledge obtained is as essential for raising hospital efficiency as private efficiency. The main consideration in the whole proposition is the patient. Through misfortune and the force of circumstances, he becomes sick, has no funds, and has no relatives or friends who can minister to his needs. He may be sorely afflicted, but under skilful treatment, good nursing, proper watching and feeding, nine times out of ten he can be restored more or less promptly to an earning status. In other words, the majority of the sick poor can be changed from a state of dependence to a state of independence—made into working, constructive members of society by hospital treatment. The gainer in the transaction is society, and society therefore should assume the entire responsibility. On no equitable basis can any man, just because he happens to be a physician, be expected to bear any extra share of the economic burden of the social dependent, and yet to require a doctor to administer treatment and give his time, knowledge and skill without reasonable remuneration, means just this and nothing else. From every angle it is unfair. The economic problems of physi-

cians are no different from those of other men, with the exception that they are often larger and more complex. Doctor's families must be fed, clothed and properly educated, as well as those of men of other pursuits. The wherewithal is derived solely from the practice of medicine—the treatment of the sick. To reduce the doctor's income by requiring him to treat the dependents of his community without pay, is no more just than it would be to require the clothier, grocer, butcher, baker, or any other purveyor of necessities to supply any and every poor person with what he needs to keep him warm or from starving. The necessity for medical treatment is rarely more urgent or essential than that for food and protection from the elements. No, there exist no sentimental, ethical, economic or other reasons why a medical man should give his services—except in emergency—without a fair and reasonable remuneration. Any contention to the contrary is a mistake, or sophistry, pure and simple.

In order, therefore, to save the most unselfish and self-sacrificing class of men on earth from still further sacrifices, every thoughtful man should unite to bring about correction of the hospital-dispensary-clinic abuse. Organization on the basis previously outlined means first and foremost increasing the efficiency of our medical institutions, and second, conserving the best resources of the medical profession. More than anything else, however, it means an equitable utilization of the talents and skill of the whole medical profession, and ultimately, when every competent physician is officially part of a public health system, it is reasonable to expect an era of freedom from disease such as the world has never seen.—*Am. Med.*

I have made frequent use of Resinol, and have found it an excellent salve in some very stubborn cases of skin diseases, where such a salve was indicated, and shall use it freely in the future—C. C. Jolliffe, M.D., New York City.

APPENDICITIS.—L. G. Guerry, Columbus, S.C. (*Journal A. M. A.*, January 1), reports his experiences with a consecutive series of 545 cases of appendicitis operations, with only 2 deaths, these occurring in the first 100 patients operated on. This experience proves, in his opinion, that there is a factor in the surgical mortality that is not fully appreciated or provided against. In this total of 545 there were 240 chronic cases calling for an interval operation, with no deaths, as might have been expected. Of acute cases, 92 patients were operated on within 36 hours. His rule, so far as he has one, is, he says, to operate as soon as the diagnosis is

made, provided it can be made within 36 hours. After that the pathologic conditions are different; the third and fourth day cases are the ones that furnish the mortality statistics. Guerry holds that there is a definite tendency to localization in cases of appendicitis complicated with suppuration; there were 213 cases of this kind in the series; 68 of these were first seen on the third or fourth day of the disease. The pulse in most cases was 135, temperature 104° F., vomiting, distention, pinched features and some delirium were also present. None of these patients was operated on at once, but all were treated according to the Ochsner method, which he thinks is life-saving, at least in the practice of the ordinary surgeon and practitioner. Guerry emphasizes the fact that none of these patients was operated on immediately, and none died. It must, he says, have been genuine insight in Ochsner to recognize that the chief factor in dissemination of the peritoneal infection is the vermicular movement of the small intestine, and that physiologic rest is the rational treatment of the diseased process, thus enabling Nature the chance she seeks to localize the disease. Gastric lavage, also, is rational, as it carries off the regurgitated contents of the small intestine and favors the attainment of physiologic rest of both organs. Guerry does not wish to be considered extreme, but he desires to emphasize the importance of utilizing and aiding the natural forces, and of using surgical discrimination and judgment in these cases. In almost all cases, he operated through the McBurney incision; when drainage is needed, he drains through a stab wound to one side. The rule is to remove the appendix, but there are exceptions to this rule. He believes it better to enter the peritoneal cavity by Ware's modification of McBurney's method, pack off the infected area and remove the diseased tissue. One of his patients who died had renal tuberculosis, and succumbed on the eighth day with post-operative anuria. The other fatal case was that of a child, who had been ill 10 days, and died of a continuation of the peritonitis.
