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Original Contributions

THE DIFFERENTIAL DIAGNOSIS OF CEREBELLAR TUMOURS

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THE problems relating to the diagnosis of intracranial tumours are matters no longer of theoretic interest only, but of urgent practical importance. This is so because in every case the question of operation, whether with a radical or a palliative object, arises, and in few conditions does success in treatment depend more closely on accuracy in diagnosis than it does here. In no condition so desperate as that of intracranial tumour have the results of treatment shewn in recent years a more marked and sustained progress and at the present time they compare by no means unfavourably with those obtained in the case of intra-abdominal tumours. In order to secure still better results improvement is necessary on the part of both the diagnostician and the operator; it is only with the former possibility that this paper is concerned. It is very rare that a physician can attain to any high degree of skill at the same time in the niceties of neurological diagnosis and in the elaborate technique of intracranial surgery, so that collaboration is usually necessary between the neurologist and the surgeon. The surgeon demands that the diagnosis be made as *accurately* as possible, so

that his task is thereby simplified, and as *early* as possible, so that operation may be undertaken while the patient's general health is yet unimpaired and before the tumour has extended so far as to render hopeless the attempt at removal. Intracranial tumours are sufficiently common to make it necessary to bear them in mind as a possible diagnosis in every case of nervous disease, as is illustrated by the fact that I have myself examined sixteen cases of this nature in the past twelve months only.

In the present paper I do not propose to describe any individual cases, but shall merely offer some general remarks concerning the differential diagnosis between tumours of the cerebellum and those elsewhere in the cranial cavity, paying most attention to the difficulties that are greatest in actual practice. These remarks are mainly based on a study of some twenty cases of cerebellar tumour I have observed in the past few years. Most of them were operated on, several by Sir Victor Horsley.

It will save much repetition if I first give a rapid review of the symptoms that are most characteristic of cerebellar tumour, and then consider the differential points later. I will omit the indirect signs produced by pressure of the growth on neighboring structures. The *general* symptoms of intracranial tumour are usually very pronounced when this is situate in the cerebellum. The headache, which is invariably confined to a sagittal plane, is severe; the optic neuritis is early and rapid in onset and intense in character, and the vomiting and vertigo are frequently very distressing. Besides the general feeling of giddiness and unsteadiness that may occur with any intracranial tumour, we here meet with a special form of vertigo that consists in a peculiar sense of lateral rotation. On closer investigation we find that to the patient both his own body and external objects seem to be turning in the same direction —away from the side of the lesion.

The *attitude* and *gait* shew the following features. The head is held in a position of lateral flexion, the ear on the side of the lesion being approximated to the corresponding shoulder; the head is drawn backwards and is also rotated so that the face looks away from the side of the lesion. These three features make up what is called the cerebellar attitude. When standing the patient is unsteady, though more so subjectively than objectively; the unsteadiness is not appreciably increased on shutting the eyes, so that Romberg's sign is absent. The patient stands with a broad base and

rests his weight chiefly on the leg of the side opposite to the lesion. There is frequently present a considerable degree of lordosis. The gait has two special features. The patient reels as if drunk and tends to stagger and fall over on to the same side as the lesion. Again, in walking towards a given point, he gradually deviates from the appointed direction, describing a path that is curved, with the concavity on the side of the lesion.

The *ataxia* of cerebellar disease is peculiar in being of the dynamic variety, thus differing from the static ataxia of, for instance, tabes or peripheral neuritis. It is, in other words, a dysmetria, being due, not to a lack of precise information from the periphery as in these diseases, but to a defect in the central regulating mechanism of co-ordination. It is, therefore, not dependent on, and indeed is usually unaccompanied by any sensory changes or any diminution in acuity of the "muscle-sense." The ataxia is always more marked in the upper than in the lower limb, and is usually confined to the homolateral side. It is manifested in several ways. During the performance of such an act as pointing to an object, or touching the tip of the nose, irregular inco-ordinate movements appear. Sometimes they have a tremor-like character, but they differ from an intention tremor, such as occurs in insular sclerosis, by not increasing towards the end of the act, and in disappearing as soon as this is completed. Indeed, a limb that is maintaining a fixed attitude, such as being held out straight, is held frequently preternaturally steady, a point to which we shall later refer. The carrying out of a complex movement frequently shows a defect that Babinski has termed "cerebellar asynergy." For instance, if the patient is told to straighten a lower limb that is flexed at both hip and knee joints he will extend first the leg and then the thigh, and not both simultaneously as in the normal. Again, he is unable to carry out any rapidly reciprocating movements, a symptom known as dysdiadochokinesia. Also this occurs on the same side as the lesion, so that, for instance, the patient cannot rotate his hand by the alternate movements of supination and pronation so rapidly on this side as he can on the opposite side, and he will frequently compensate for this incapacity by rotating the arm at the shoulder-joint when he is tested in this way.

A cardinal side of cerebellar disease is *hemi-paresis*. This paresis altogether differs from that produced by cerebral disease, or from that produced by interference with the pyramidal tracts. It

is distinguished by being more pronounced in the trunk than in the limbs, and in the lower than in the upper limb, by never affecting the face, by being of a flaccid and not a spastic type, and by being unaccompanied by pain or any other sensory disturbance. Further, there are none of the changes in the reflexes so characteristic of pyramidal affections, such as ankle clonus, heightened activity of the deep reflexes, abolition of the abdominal reflexes, inversion of Mendel's reflex, and the appearance of Babinski's plantar sign and its allies, the "fan" sign, Oppenheim's Schäfer's and Remak's signs. The *hypotonia* that accompanies this paresis is a highly important differential sign. It is shown by the diminished resistance to passive movements, by the flaccid feel of the muscles and the greater mobility of the joints. Special tests by which it can be revealed or estimated are: the extent to which passive hyperextension at the knee is possible (the knee-angle sign), the extent to which the seventh cervical spine descends below the level of the great trochanter when the patient tries to touch his toes without bending his knees, and by a useful test applied most conveniently with the forearm in the following way: If someone is powerfully flexing his forearm against resistance and we suddenly remove this resistance, the forearm will flex to a certain extent and will then recoil. If cerebellar ataxia is present then the forearm will continue to flex even to the maximum possible extent, and there will be no recoil. It is important to remember that the hypotonia of cerebellar disease differs from other forms in not being correlated with absent knee-jerks.

Of the *eye-symptoms* three are of especial importance: nystagmus, sixth nerve weakness, and skew deviation. Cerebellar nystagmus is characterized by being most marked when the patient looks towards the side of the lesion, in this respect differing from nystagmus of labyrinthine origin, by being of a slow and rather coarse kind, and in sometimes being more marked in the homolateral eye. It is practically always lateral in type. The paresis of the sixth nerve is an exceedingly frequent symptom; there is commonly also a dissociated paresis of the opposite internal rectus muscle so that it is weak in lateral movement of the two eyes, though not in convergence. In the latter case there may be a secondary conjugate deviation of the eyes away from the side of the lesion, a symptom of much greater significance than isolated affection of the sixth nerve. There are several kinds of skew devia-

tion of the eyes. The commonest is the Magendie type, in which the homolateral eye looks downwards and inwards and the contralateral eye outwards and slightly upwards. It is usually a temporary phenomenon and, therefore, has carefully to be watched for.

The general characteristics of cerebellar tumours are further worth remembering, namely, the tendency of the symptoms to progress in definitely marked-off steps, and the continual variation in the activity of the deep reflexes.

If I were asked to place the above-mentioned signs in order of their diagnostic value I should do so as follows: First ataxia, then the characteristic vertigo, the hypotonia, paresis, nystagmus and skew deviation. With this clinical picture in mind we may next consider some of the problems of differential diagnosis that most frequently arise.

Of *superatentorial* tumours those that give rise to the greatest difficulty in this respect are tumours of the frontal lobe, of the optic thalamus, and of the corpora quadrigemina. It is uncommon for a cerebellar tumour to be confounded with one in the parietal, temporal or occipital lobe. It can be thought to be situate in the *Rolandic area* only if the observer mistakes for an attack of *petit mal* one of the giddy spells that occur in cerebellar disease, and which sometimes gravely impair consciousness. In cerebellar attacks, however, there are never any local twitchings, as there are in the Jacksonian attacks; even in the true cerebellar fit there is no clonic stage, only a tonic condition of the muscles that lasts for a variable time. The subsequent paralyses are also of a totally different kind in the two affections.

A *parietal* tumour may occasionally be a source of embarrassment in diagnoses. It gives rise to a lack of dexterity in the limbs, which, however, is due to an astereognosis, or sometimes to sensory asymbole, and so is quite different from cerebellar ataxia. When the tumour extends far back in the parietal lobe it may produce conjugate deviation of the eyes, but in such a case there will probably be present a contralateral homonymous hemianopsia or else a mind-blindness for objects, together with evidence of visual aphasia.

Frontal tumours give rise to many symptoms resembling those of cerebellar tumours. In both cases there may be present nystagmus, conjugate deviation of the eyes, speech disturbance, unilateral tremor of the limbs, and even the so-called cerebellar attitude of

the head. The conjugate deviation of the eyes in frontal tumour is, however, an irritative phenomenon, not, as in cerebellar tumour, a paralytic one, and the two can thus be readily distinguished. The speech disturbance is of a different kind, being aphemic and not dysarthric. The tremor has a different character, being very fine and rapid; there is never present the typical cerebellar ataxia, though in making this observation care must be taken not to confuse the motor apraxia of frontal disease with the ataxia of cerebellar. Hemiparesis, when present, is on the opposite side and is of the cerebral type, with spasticity and the characteristic changes in the reflexes. Symptoms, such as anosmia, apraxia, bitemporal hemianopsia, agraphia and motor aphasia, may occur that are never found with cerebellar tumour, and on the other hand cerebellar symptoms, such as the typical gait, forced vertigo, hypotonia, lordosis, and skew deviation of the eyes, are not found in cases of frontal tumour.

Tumours of the *optic thalamus* can very easily be mistaken for cerebellar tumours, and a case well illustrating this fact was recently reported by Dr. Heggie and myself to the Ontario Academy of Medicine. The hemi-paresis is slight, and still more striking is the fact that it is hypotonic. Vertigo and the cerebellar attitude of the head may occur, and further the involuntary irregular movements that constitute a cardinal sign of thalamic lesions are sometimes very hard to distinguish from cerebellar ataxia. However, with tumours of the thalamus there are always pronounced sensory changes, particularly loss of deep sensation, and marked irritative symptoms, such as pain and paresthesia. Implication of the third nerve nucleus is common, most often manifesting itself as a bilateral mydriasis. Further, in all the cases of thalamic disease so far reported there has been some implication, however slight, of the motor part of the internal capsule, so that changes in the reflexes indicative of a pyramidal affection are present. In the resulting hemiparesis the facial muscles are affected in a peculiar way, in that mimetic movements are more paralyzed than volitional ones.

It is sometimes impossible to distinguish a tumour of the *corpora quadrigemina* from one of the cerebellum. A few points of value are that the deafness is an early symptom and not a late one, as in cerebellar disease, that it is on the side opposite to the tumour, that the affection of the third nerve, causing most often external ophthalmoplegia, is one of the first signs, that hemianopia

may occur, and that the ataxia and tremor are frequently bilateral. Paresis when present is frequently bilateral, and is always spastic, being due to implication of the pyramidal tracts.

The difficulties of distinguishing cerebellar tumours from other *sub-tentorial* tumours are even greater than in the case of supratentorial ones, and here accuracy in localization is of vital importance because on it depends the operability of the case. Tumours of the *pons* and *medulla* are relatively easy to distinguish. The optic neuritis is late in appearing, and the general symptoms are not pronounced. Vertigo and ataxia may occur, but not of the cerebellar variety. The sphincters are frequently affected, and there are often vaso-motor and respiratory disturbances. The paralysis may be on one or both sides of the body, but is always spastic and is accompanied by evidences of affection of the pyramidal tract, such as Babinski's plantar sign, etc. The lower cranial nerves are always affected, and in very characteristic ways. The paralysis of them is intense and permanent, and is often bilateral. The nerves affected are grouped according to anatomical features. Bilateral paralysis of conjugate movements of the eye is a frequent symptom, but not skew deviation or typical nystagmus. When the lowest group of cranial nerves is implicated, then there will be present a crossed paralysis of one of the four recognized types, named after Avellis, Hughlings Jackson, Schmidt and Tapia respectively. The speech disorder cannot be told from that found with cerebellar disease.

Tumours of the angle between the pons and cerebellum, called the *cerebello-pontine angle,* are hardest to distinguish from cerebellar tumours. It is an important diagnosis to make, for, as Frazier has well shewn, the route of operation should be quite different in the two cases. Thanks to the observations of Holmes, Stewart and Weisenberg, we are now in a position to make the diagnosis in the majority of cases. Tumours of the cerebello-pontine angle are of two kinds. They grow either from the pia covering the under surface of the cerebellum, or more often from one of the middle group of the nerves in the posteria fossa, usually the eighth. They are most often fibromata, frequently with myxomatous degeneration, but sarcomata and endotheliomata are also met with here. They tend to press more on the middle peduncle of the cerebellum than on the pons, and hence clinically resemble cerebellar tumours more closely than pontine ones. The most im-

portant sign of tumours of the cerebello-pontine angle is the early and intense affection of cranial nerves. The seventh and eighth nerves are practically always paralyzed, and frequently also the fifth, sixth and tenth. When the tumour presses on the cerebellum or its peduncle then typical cerebellar ataxia and gait, homolateral paresis and hypotonia will occur. The paresis and hypotonia are, however, only very slight. A contralateral paresis due to pressure on the pyramidal tracts is common; this will, of course, be spastic and will shew the characteristic changes in the reflexes, such as Babinski's sign, etc. When this spastic hemiplegia is present the patient will in standing rest his weight on the homolateral leg, and not, as in cerebellar tumour, on the contralateral. Two other valuable signs may be mentioned. First, a coarse tremor is frequently present in the homolateral arm when it is held out horizontally, whereas, as was mentioned above, this arm is held preternaturally steady in cerebellar tumour, provided no hydrocephalus is present. Secondly the feeling of subjective rotation is towards the side of the lesion, whereas in cerebellar tumour it is towards the opposite side.

Before concluding I might add a few remarks on the important practical question of how to determine the side of the lesion, once its site in the cerebellum is known. This is a matter that frequently causes considerable embarrassment, but the following points are of service in helping one to decide. The general rule is that every symptom of cerebellar tumour is either confined to, or most marked on, the same side as the lesion, but there are several fallacies of observation that have carefully to be guarded against. For instance, the patient as a rule tends to deviate towards the side of the lesion when asked to walk towards a given point. Later in the course of the disease, however, he becomes aware of this tendency and tries to counterbalance it. In so doing he advances with the shoulder on that side higher than and in front of its fellow, and we are thus able to detect the process. It may often be observed that on good days he actually over-compensates this defect and deviates towards the opposite side, a fact that easily leads to a false conclusion, whereas on bad days he deviates towards the side of the lesion. Again, although the symptoms of cerebellar tumour are, as a rule, paralytic in nature, yet occasionally they may be irritative, and will then be in the reverse direction. The cerebellar attitude of the head is notoriously misleading in this respect, for

when it is due to irritation the head is in the opposite position to the one that was described above in this connection. A similar remark applies to the direction of the skew deviation of the eyes. Further, the increase of general intra-cranial pressure that is so great in these cases may give rise to false localizing signs that are frequently on the opposite side to the lesion. As is well-known, the paralysis of the sixth nerve is particularly unreliable in this respect, and I have several times seen it occur on the opposite side to the tumour. The signs on which one can most rely to determine the side of the lesion are as follows: The ataxia, hypotonia and cerebellar paresis are invariably most marked on, and often confined to, the side of the tumour. The movements of the nystagmus are slower and have a wider range in the direction of the lesion than in the opposite direction. The homolateral arm is held extended more steadily than the contralateral one. Lastly, when the patient is rotated in a chair and the movement is suddenly stopped, the sense of subjective rotation is less intense and the succeeding eye deviation and nystagmus are less marked when the chair has been rotated towards the affected side than towards the other. Here, however, as elsewhere in localization diagnoses, care should be taken not to lay excessive stress on any single symptom, but to attach different standards of value to the different symptoms and then to make a diagnosis on the general clinical picture present.

GALLSTONES

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PERHAPS an apology is due the members of this Association for trespassing upon their time with a paper on a subject so common as gallstones, but the very frequency of its occurrence and the difficulties which seem to exist in many cases in arriving at a diagnosis must be my excuse for so occupying your attention.

It is quite true that gallstones are present in many people without producing any symptoms, and without exciting any suspicion of their existence. Statistics tell us that in people under the age of twenty years gallstones are present in two or three per cent. Over twenty years in about ten per cent. Only in a small proportion of these cases do they cause symptoms that demand the attention of the physician. The early recognition of the pathologic condition produced by calculi is necessary if one would avoid the serious results which frequently follow neglected cases. Without considering the more remote complications which are produced in long-standing cases, one has but to think of the inflammatory action in the immediate vicinity of the gall bladder and bile ducts to form some appreciation of the irreparable damage which results. We all know of the danger of adhesion of the gall bladder to neighboring organs after repeated attacks of cholecystitis. The stomach and duodenum seem to be the organs which are most frequently found attached to the gall bladder. From such attacks the bile ducts themselves perhaps suffer the most. In these neglected cases stenosis of the cystic duct is often seen, and occasionally we have as well stenosis of the common duct. This was very well illustrated in a case which came under my notice some time ago. The patient, Mrs. N., age 35, had been for about fifteen years suffering from what was diagnosed as indigestion. At times she would remain quite well apparently, but every month or so would have a "dyspeptic" attack. Some time before I saw her her physician suspected that she had a "gastric ulcer." She frequently had attacks of vomiting and occasionally vomited blood. When I saw her she was very anemic and had a somewhat yellow tinge, but did not at that time have any typical gallstone attacks. Later on the jaun-

dice became more marked, and as medical treatment seemed to be of no avail, an operation was advised. Assisted by Dr. Parke, of Woodstock, I made an incision and found the gall bladder quite adherent to the pylorus. The adhesions were with some difficulty broken up, the gall bladder was opened, and I found a small quantity of black fluid mixed with bile. Some small concretions like sand were scooped out, and with some difficulty a probe was introduced into the cystic duct. An attempt was made to pass the probe through the common duct into the duodenum, but this was found impossible. I made a digital examination of the common duct, but could detect no stone, and as the patient was not in very good condition we decided not to proceed further, but simply to drain. There was not a very free flow of bile through the tube, but sufficient to cause her jaundice to lessen considerably, and she was able to take food with comfort. She left the hospital much improved, and in about a month from the time of her operation the fistula closed. The improvement in her condition did not continue, and after four or five weeks had elapsed a second operation was advised, with the object of dilating the common duct if possible and removing the gall bladder. She refused any further operative interference, however, and gradually sank. An autopsy was performed, when the liver was found to be somewhat enlarged, and the stricture in the cystic duct again contracted, a small quantity of bile being found in the gall bladder. The common duct contained no stone, but was very much contracted, its walls much thickened, and it was with difficulty that a very fine probe was passed. There seemed to be no doubt that the strictures were the result of injuries sustained on account of the former presence of gallstones. This condition of stricture of the common duct does not seem to be very common. Mayo Robson reports a case in which he had to make a new passage for the bile by doing a cholecystenterostomy, which was quite successful. I have no doubt that had the condition here been recognized several years before and an operation performed the stenosis of the common duct would have been avoided, as well as the fatal result of my unsuccessful operation.

It would be interesting in considering this subject to inquire into the conditions favoring the formation of gallstones. That most gallstones are composed almost entirely of cholesterin is an undisputed fact, but the origin of this substance is still somewhat obscure. It is thought by some to be formed in the gall bladder

and bile passages, but it may be found in other mucous passages as well. Cholesterin is held in solution by the bile salts, and the diminution of these may account for its precipitation, and as a result we have a splendid nidus for the formation of a calculus. A large increase in the amount of cholesterin present probably favors the formation of gallstones. As the bile salts are produced by the metabolism of nitrogenous foods, one would expect that meat-eaters would suffer less from this affection than others. That this is so, to some extent at least, seems to be proven by the fact that in Germany there is a larger percentage of this affection than in England, where so much meat is consumed. Stagnation of the bile contributes to the formation of gallstones, and consequently any habit of life which favors this stagnation should be avoided. There can be no doubt that the indolent life led by many fleshy women and some stout men favors the formation of these concretions.

The bacterial origin of gallstones is now most generally admitted, the organism most often found being the bacillus coli communis and bacillus typhosus. The staphylococci and streptococci have also been found capable of causing calculi.

In the Johns Hopkins Hospital about thirty-three and one-third per cent. of the operations performed for cholelithiasis gave a history of typhoid fever.

Experiment has shown that a foreign body when placed in the gall bladder of a guinea pig may stay there indefinitely without producing any inflammatory action or precipitating the salts. If, however, these bodies were previously infected with virulent microorganisms, they would produce inflammatory action and precipitation of the salts. An interesting fact about this, however, is that this sediment shows no tendency to cohere. The bacteria must be attenuated before they will cause the adherence of the sediment to foreign bodies.

If one bears in mind the bacterial origin of gallstones, and remembers too that anything which interferes with the free discharge of bile has a tendency to promote their formation, one will easily see that constipation must be regarded as a contributing cause in this affection. If the peristaltic action of the bowels is abnormally low and the secretions in the mucous glands reduced, it naturally follows that a smaller amount of bile passes into the intestines. Partly on account of want of stimulation, but also on account of

the congested condition which exists in the mucous membrane of the bile ducts, the passage of the bile is impeded, and in this way stagnation is produced.

In cases of chronic cholangitis minute casts from the small bile ducts in the liver find their way into the gall bladder and there become the nuclei for gallstones.

How frequently one notices that gallstone affection is associated with numerous other pathologic conditions. The reason for this is somewhat difficult to determine. That such is the case must be, I believe, the experience of most of us. In two cases which have come under my notice recently there was presented a similar train of symptoms. Mrs. B., age 32, presented herself at my office suffering from pain, which was continuous in character, and situated in the right loin. Her temperature was 100, pulse 95. Upon making a hurried examination, a mass was found in the right iliac region, and, although the walls were very thin, it was found impossible to make a thorough examination on account of the rigidity and excessive tenderness. She gave a history of repeated attacks of indigestion, for which she had had treatment frequently. She had lost a great deal of flesh in the last two or three years, and suffered very greatly from headaches and backaches. Upon making a vaginal examination an enlarged retroflexed uterus was discovered, which, too, was quite tender on pressure. The cervix was severely lacerated and the perineum very much relaxed. She was taken to the hospital and placed under an anesthetic, when it was found that the tumorous mass which presented quite distinctly upon her previous examination in my office had entirely disappeared. This somewhat confused my diagnosis of an appendix containing pus, and, having in mind the possibility of a dilated gall bladder, I made an opening to the right of the rectus, high up, and discovered a very much elongated and distended gall bladder coming down over the appendix and adherent to it. The adhesions were broken up, the appendix removed, the gall bladder opened and some three hundred calculi removed therefrom. A probe was passed into the common duct and the gall bladder sutured to the abdominal fascia. The bile soon flowed freely through this opening, but at the expiration of two or three weeks the fistula had not closed. She was then placed under an anesthetic, the cervix and perineum were repaired and the uterus brought forward and held in position by a shortening of the round ligaments. At the same time the edges of

the fistula were scraped, and the fistula itself was swabbed out with a solution of argent. nit. The patient made a good recovery, but the fistulous opening still continues, and I am of the opinion that a gallstone in the common duct has escaped detection. The patient is in good health and is entirely free from pain.

A second case very similar to this was Mrs. J., age 27. Three years ago a difficult confinement left her with a torn uterus and perineum. For some two years she attempted, by means of tonic and rest, to avoid an operation for their repair, which she was told she must have. She became very nervous, and during the last six months complained of pains in different localities, more severe, however, over McBurney's point and in the region of the gall bladder. These attacks of pain became very severe at times, when I was asked to see her. She had been prescribed for by at least half a dozen different physicians during the two years of her ill-health, but none of them had ever made a diagnosis of gallstones. The pain in the region of the gall bladder was attributed by some to indigestion, by others to the retroflexed uterus, which also existed. She consented to an operation, and, assisted by Dr. Parke, I repaired the cervix and perineum, fastening the uterus forward by Gilliam's method; the appendix was at the same time examined and found constricted at one point. As she had complained of considerable pain here, it was thought best to remove it. Though the patient had been under the anesthetic for a prolonged period, I determined to examine the gall bladder, as she had assured me I had to do everything at the one operation. Gallstones were found, and as quickly as possible removed and drainage established. The patient suffered severely from shock, but after recovering from this progressed very rapidly, and has gained about thirty-five pounds in weight and is feeling well.

Just why gallstones sometimes complicate these cases is not easily explained. I believe, however, that the reason most probably is that a retroflexed uterus or an inflamed appendix so interfere with normal conditions of health as to produce marked changes in the secretions, and that the bile is so influenced as to make the probability of gallstones being formed much greater than it otherwise would be.

Has it ever occurred to anyone that heredity had any influence in the causation of gallstones? That it has I am not prepared to say but I have noticed from time to time that members of the same

family suffer from this condition. At the present time I have under my care a patient who is suffering from gallstones. A few months ago I assisted at an operation on his sister, from whose very much thickened gall bladder three stones were removed. This woman's daughter has had several attacks of gallstone colic, and her sister is at the present time suffering from the same disease. This is at least suggestive, and is perhaps the most marked of any of the cases which have come under my notice.

Briefly the symptoms of gallstone colic are severe pain coming on suddenly and paroxysmal in character, and often accompanied by rigor. The seat of the pain is usually in the right side on a line between the ninth costal cartilage and the umbilicus. In occasional cases the pain is found to be on the left side, and in these conditions Mayo Robson states that he has usually found adhesions existing between the gall bladder and the stomach. After the pain disappears the tenderness in the region of the gall bladder is usually very marked. Vomiting frequently comes on, but is usually late in the attack and frequently is a sign of the termination of the seizure. Jaundice is presented in some of the cases, but usually is not seen until some time after subsidence of the attack, and in many cases is entirely absent, so that while present it is a valuable sign, yet the fact of its being absent does not by any means contraindicate gallstones. In severe colic collapse is often seen, sometimes so severe as to make one think of perforation of bowel or stomach.

In arriving at a diagnosis of this disease, one does well to bear in mind those affections with which it is most frequently confused. There are very few patients suffering from gallstones who have not been told at one time or another that the trouble was dyspepsia or indigestion or flatulent colic, and in many cases of dyspepsia it is very difficult to exclude gallstones, as the two are so closely associated. In acute dyspepsia, however, the pain is confined to the region of the stomach rather than of the gall bladder. The painful attacks can usually be traced to the ingestion of unsuitable food. In dyspepsia relief can be much more easily obtained by suitable treatment. Appendicitis is frequently confused with gallstones. In typical cases of appendicitis there would be, of course, little difficulty, but we all know how varied are the symptoms accompanying appendicecal attacks. The pain may be high up; in fact, in many cases the only pain and tenderness complained of

at first is in the region of the stomach. Over McBurney's point one may press pretty deeply without causing the patient to complain. At the expiration of twenty-four hours, however, this cannot be done, and the excessive soreness seems to be transferred from the epigastric to the right iliac region. Rise of temperature, early vomiting and absence of pain in the right scapular region, point to the existence of the appendicitis. One must bear in mind, too, the frequent occurrence at the same time of cholelithiasis and appendicitis, as has been pointed out by Dr. Ochsner, of Chicago. Renal calculus frequently simulates gallstone colic, but here, if care be taken in the examination of the urine, one is usually able to detect blood cells after an attack of pain. Movable kidney sometimes gives rise to pain similar to that of gallstones, and where the kidney passes over to the median line it is quite often mistaken for a distended gall bladder. If, however, a distended gall bladder is free from adhesions it may usually be distinguished from a movable kidney by the possibility of swinging it from left to right. Where adhesions are present this cannot be done, and occasionally the diagnosis is made extremely difficult. Duodenal and gastric ulcer must also be thought of, and here we must rely upon the association of pain with food. In duodenal ulcer pain occurs two or three hours after ingestion of the food. In these cases it must not be forgotten that occasionally the common duct is involved in the inflammatory action which occurs and jaundice is occasioned. The occurrence of this is likely to deceive us and point to gallstones, if we are not on the alert. In malignant growths reliance must be placed upon the gradual onset, loss of weight, and gradual but continual loss of strength. In these cases usually the jaundice is persistent, and this fact alone should cause one to be very suspicious. Acute and chronic pancreatitis frequently simulate gallstones. The tenderness and pain here are usually to be found in the epigastric region rather than to the right of it. It is often impossible to diagnose acute pancreatitis from cholecystitis, but fortunately drainage of bile ducts is the proper treatment in both cases.

Hysteria, of course, must not be forgotten. In these cases the nervous make-up of the patient, pains in other parts of the body, and absence of jaundice will aid very much in the diagnosis.

Clifford Albut has drawn attention to hepatalgia as a disease which is frequently confused with gallstones. "This malady," he

says, "is usually mistaken for gallstone colic, and in one case an operation was performed under the erroneous impression. The attacks last from a few minutes to a few hours and may end in vomiting.

Having decided that we have a case of gallstones with which to deal, what plan shall we adopt? I shall not attempt in the time at my disposal to go fully into the treatment of the disease, but in a word might say that in the first place medical treatment should be given a fair trial, as in many cases it will be successful. Dieting with systematic exercise, accompanied by the taking of large quantities of water, has cured many a case of cholelithiasis. I have not the slightest doubt that if physicians encouraged their patients to drink water in larger quantities there would be fewer cases of gallstones and less necessity for operations. Perhaps the drinking of large quantities of fluids should be looked upon rather as a prophylactic than a curative measure, as there can be no doubt that a small amount of fluid in the body will have the effect of causing a thickening of the bile and thus more likelihood of the cholesterin being deposited and gallstones being formed.

Then, too, one must remember that there is such a thing as spontaneous cure of gallstones. The stone or stones may, of course, escape from the ducts, thus terminating the attack and clearing the gall bladder, or, as happened in a case of mine not long since, the gall bladder became adherent to some portion of the intestine, probably the duodenum. A fistulous opening was established between the bladder and duodenum, and the stone, which apparently was the only one present, passed through this opening into the intestine, and was recovered per rectum.

My patient, Mrs. M., age 47, had what was supposed to be congestion of the liver in 1896. At that time there was considerable swelling over the region of the liver. For eleven years no further attacks occurred, when on July 1, 1907, she became ill with what seemed like an attack of indigestion. There was no severe pain, but over the right epigastric region there was a fullness which she said resembled gas on the stomach. There was no nausea or vomiting, and after four or five days of this "uncomfortable" feeling, this stone, which weighs a drachm and a half, and measures slightly over three inches in circumference, was passed per rectum.

Should medical treatment fail, however, in producing a cure,

one should have no hesitation in recommending operative interference, and the operation par excellence is a cholecystotomy. In many cases, however, it is impossible before making the incision in the abdominal wall to determine just what operation is necessary, and one should never open a gall bladder who is not prepared to do anything in that region which may be found necessary.

In certain cases removal of the gall bladder will be advisable. In the following conditions the elasticity and contractility of the viscus is irreparably gone, and a cholecystectomy is indicated.

1. In cases where adhesions to stomach or bowel are numerous and likely to recur after being broken down.
2. A gall bladder with very much thickened walls, due to a long-continued cholecystitis.
3. Stricture of the cystic duct.
4. Gangrene.
5. Perforation.
6. Empyema.

While there are some surgeons who contend that a gall bladder should never be removed, because, as one says, we never know when the occurrence of malignant disease in the common bile duct or pancreas will make it necessary for us to use the gall bladder in doing a cholecystenterostomy, yet the cases in which this might be necessary are obviously so few that I think we may safely dismiss the objection.

Society Proceedings

THE CANADIAN MEDICAL ASSOCIATION

THE forty-third annual meeting of The Canadian Medical Association opens in this city on the first instant under the Presidency of Dr. Adam H. Wright, of Toronto.

The meeting takes place in the Convocation Hall of the University of Toronto, and judging from the following splendid list of addresses and papers, the 1910 meeting should be one of the best on record:

Address—Dr. W. A. Evans, Chicago.
Address—Dr. Charles E. North, New York, and others.
Symposium on Exophthalmic Goitre—Medical Aspect, Prof. McPhedran, Toronto; Surgical Aspect, Dr. F. J. Shepherd, Montreal.
Symposium on Psycho-Neuroses—Dr. J. J. Putnam, Boston; Dr. August Hoch, New York; Dr. W. Hattie, Halifax; Dr. Ernest Jones, Toronto. Discussion by Drs. C. K. Clarke and Helen MacMurchy, Toronto.
The Psycho-Neuroses from the Standpoints of the Neurologist—Dr. Joseph Collins, New York.
Medical Education—Dr. J. C. Connell, Kingston.
Typhoid Carriers—Dr. W. T. Connell, Kingston.
A Discussion of the Causes Interfering with the Regular and Continuous Development of the Child—Dr. A. D. Blackader, Montreal.
Anterior Poliomyelitis—Dr. C. K. Russel, Montreal.
Diphtheria—A. H. Gordon, Montreal.
Title to be announced—Dr. D. A. Shirres, Montreal.
Orthostatic Albuminuria—Dr. Graham Chambers, Toronto.
Treatment of Acne Vulgaris by Vaccines—Dr. Geo. W. Ross, Toronto.
Title to be announced—Dr. R. D. Rudolf, Toronto.
Title to be announced—Dr. A. R. Gordon, Toronto.
Title to be announced—Dr. R. J. Dwyer, Toronto.
Title to be announced—Dr. W. F. Hamilton, Montreal.

Patent Medicines—Dr. John Ferguson, Toronto.

Sudden Attacks of Pain in the Pyloric Region—Dr. Goldwin Howland, Toronto.

A Comparison of the Results in Pulmonary Tuberculosis in Institutions and Private Practice—Dr. J. H. Elliott, Toronto.

The Blood in Pulmonary Tuberculosis—Dr. A. F. Miller, Kentville, N.S.

Experimental Intra-Thoracic Surgery, with a Resume of Recent Progress in the Use of the Differential Pressure Apparatus —Dr. Von Eberts, Montreal.

Gangrene—Dr. E. W. Ryan, Kingston.

Perforation of the Intestines in Typhoid Fever—Dr. Geo. E. Armstrong, Montreal.

Appendicitis in Children—Dr. T. Wood.

Duodeno-choledochotomy, with Report of a Case—Dr. Jasper Halpenny, Winnipeg.

An Interesting Case of Diaphragmatic Hernia—Dr. J. M. Cotton, Toronto.

Fractures about the Elbow Joint—Dr. W. E. Gaillie, Toronto.

Tumor of the Cerebrum, with Presentation of Patient—Dr. Geo. A. Bingham, Toronto.

Title to be announced—Dr. Murray MacLaren, St. John, N.B.

Title to be announced—Dr. Ingersoll Olmsted, Hamilton.

Title to be announced—Dr. Gibson, Sault Ste. Marie.

Title to be announced—Dr. W. G. Turner, Montreal.

Title to be announced—Dr. A. Mackenzie Forbes, Montreal.

The Neurasthenic Conditions: Referable to the Eye, Ear, Nose and Throat—(*a*) The Eye, Dr. R. S. Minnes, Ottawa; (*b*) The Ear, ——; (*c*) Nose and Throat, Dr. Jamieson, Montreal. Discussion by J. P. Morton, Hamilton.

Nasal Polypi—Dr. C. C. McCullough, Fort William. Discussion by Dr. Geoffrey Boyd, Toronto.

The Diseased Tonsil—(*a*) Its Effects upon the General System, Dr. W. P. Caven, Toronto; (*b*) Its Surgical Treatment, Dr. J. G. Sutherland, St. Catharines. Discussion by Dr. Price-Brown, Toronto.

Trachoma—Dr. H. S. McKee, Montreal.

Title to be announced—Dr. R. H. White, Montreal.

Reflex Nasal Neuroses—Asthma, Hay Fever, ——; Paroxysmal Sneezing, Dr. C. M. Stewart, Toronto.

Ectopic Gestation—Dr. Munroe, Saskatoon, Sask.

Obstetrical Technique—Dr. Bogart, Kingston.

Obstetrical Diagnosis—Dr. Little, Montreal.

Title to be announced—Dr. Evans, Montreal.

Early Diagnosis of Uterine Cancer—Dr. A. C. Hendrick, Toronto.

An Attempt to Produce Immunity to Scarlet Fever—Dr. Wm. Goldie, Toronto.

Pericarditis in Children, with X-ray Photographs—Dr. Jos. S. Graham, Toronto.

The Operative Treatment of Congenital Hydrocephalus—Dr. Edward Archibald, Montreal.

Examination of Feces and Urine for Typhoid Bacilli, Especially in Typhoid Carriers—Dr. W. T. Connell, Kingston.

Title to be announced—Dr. C. P. Howard, Montreal.

Title to be announced—Dr. J. J. McKenzie, Toronto.

Title to be announced—Dr. T. G. Brodie, Toronto.

The Estimation of Nitrogen and Ammonia in Urine—Dr. J. B. Leathes, Toronto.

Traucoma Bodies—Dr. W. H. Lowry, Toronto.

Rabies—Dr. J. A. Amyot, Toronto.

Title to be announced—Dr. A. H. Caulfield, Gravenhurst.

A Critique of the Wassermann Reaction and Its Modifications—Dr. J. G. Fitzgerald, Toronto.

On a Modification of the Wassermann Reaction in the Diagnosis of Syphilis and the Parasyphilides—Dr. Geo. W. Ross, Toronto.

Interpretation of Public Health Laboratory Reports—Dr. D. G. Revell, Edmonton.

The Occurrence of a Fat Splitting Ferment in the Urine in Cases of Pancreatitis—Dr. Edward Archibald, Montreal.

Title to be announced—Dr. C. B. Keenan, Montreal.

Some Notes on the Biology of the Uncinaria Americana—Dr. F. B. Gurd, New Orleans.

Concerning the Development of the Spirocheta Duttoni—Dr. J. L. Todd, Montreal.

Typhoid Meningitis—Dr. W. J. McLachlin, Montreal.

Title to be announced—Dr. S. B. Wohlbach, Montreal.

The Action of Drugs on the Salivary and Bronchial Secretions—Drs. A. H. Taylor and V. E. Henderson, Toronto.
Title to be announced—Dr. J. C. Beatty, Gravenhurst.
The Clinical Estimation of the Coagulation of the Blood—Dr. R. D. Rudolf, Toronto.
Biliary Cirrhosis of the Liver—Dr. O. R. Mabee, Toronto.
The Clinical Examinations of Feces—Dr. F. W. Rolph, Toronto.
Congenital Cardiac Disease—Drs. Maude E. Abbott and Joseph Kaufmann, Montreal.

We are in a position to know that our esteemed confrere, Dr. Adam Wright, in conjunction with a splendid Committee of Arrangements, has done a good deal of hard work during the past winter to ensure the success of this meeting. From present appearances, it would seem as if the meeting would be one of the most successful held since the inception of The Canadian Medical Association, and we would strongly urge our readers to immediately arrange for a few days' holiday, making Toronto their Mecca for the next week or so. We think we can bespeak for all visitors, no matter from whence they hail, a hearty reception on the part of their brother practitioners in Toronto. As our readers are aware, the annual fee for membership is $5.00, this amount to include a copy of the Official Journal of the Association, the publication of which, we understand, however, is still somewhat in the dim and distant future. Apart from the scientific side of the meeting, the Entertainment Committee have not in any way neglected their duties, as, on the forenoon of Thursday next, there will be an excursion by steamer "Turbinia" to Port Dalhousie, thence by electric railway to Niagara Falls. Refreshments will be served on the steamer with dinner at the Clifton House, the members returning to Toronto the same evening. There has also been arranged an excursion by special C. P. R. train to Guelph, as guests of the Guelph Medical Society, in order to visit the Ontario Government Farm and other points of interest. This latter excursion takes place leaving Toronto on Saturday next, at 11 a.m.

The General Secretary, Dr. George Elliott, 203 Beverley Street, Toronto, will be found, as usual, on the spot, affording, with his usual courtesy, all necessary information.

The annual meeting of The Canadian Medical Protective Association will be held on Friday afternoon at 5.30, when its

President, Dr. R. W. Powell, of Ottawa, will submit his annual report.

A discussion on Dominion Registration will be opened by Dr. Roddick on the evening of the first day of the meeting, following the address in Medicine.

In addition to the Presidential Address, there will be one in Medicine by Dr. Herringham, of London, England; one in Surgery by Dr. J. B. Murphy, of Chicago, and a third in Obstetrics by Dr. Henry C. Coe, of New York.

The Milk Commission will report on the afternoon of the first day, and several leaders in this field from the United States will contribute to the discussion.

Two Symposia have been arranged, to which the various sections will contribute: one on Exophthalmic Goitre, the medical aspect of which will be treated by Prof. McPhedran, of Toronto, the Surgical by Prof. F. J. Shepherd, of Montreal, and the Pathological by a gentleman from New York; and another on Psycho-Neuroses, of which Drs. J. J. Putnam, of Boston, August Hoch, of New York, W. Hattie, of Halifax, and Ernest Jones, of Toronto, will each present various aspects.

Medical Education will be dealt with by Prof. J. C. Connell, of Queen's University, Kingston.

All of the above will be given in the Convocation Hall during the afternoon or evening sessions before all the members.

There will be Sections in Medicine, Surgery, Obstetrics and Gynecology, Pathology, Pediatrics, and Diseases of the Eye, Ear, Nose and Throat. These will be held each forenoon. Most extensive programmes have been prepared for each, some seventy papers in all being already promised. The Sections in Medicine, Surgery, Obstetrics and Pathology will each hold three morning sessions, *commencing at* 9.15 *on Wednesday the first of June.* The attention of members is especially called to the hour of meeting so that there may be no disappointment. The Section of the Eye, Ear, Throat and Nose, and the Section on Pediatrics, will each hold one session only, viz., on Thursday next, the second of June.

W. A. Y.

THE AMERICAN MEDICAL EDITORS' ASSOCIATION

THE forty-first annual meeting of The American Medical Editors' Association, composed, as it is, of over two hundred of the principal Medical Editors of the United States and Canada, opens at St. Louis, Mo., next Saturday, June fourth, with Headquarters at the New Planters Hotel. Dr. W. A. Young, of Toronto, who was elected President at the meeting at Atlantic City a year ago, will occupy the chair. Owing to a very considerable amount of hard work done by the Executive Committee, who have met frequently during the past six or eight months, the ensuing meeting will be one of the best ever held in the history of the Association. It is expected that there will be a large attendance of medical editors from all over the United States and Canada. The meeting should be one full of the keenest interest to those engaged in medical editorial work, as can be judged from the following Programme of Papers and Discussions:

President's Address—Dr. W. A. Young, Toronto, Ont.

"The Weekly Medical Journal."—By Dr. F. P. Foster, New York. Discussion by Dr. G. Kreidler, Cincinnati. Dr. J. L. Moffatt, Brooklyn.

"The Original Contribution and its Relative Value as Compared with Abstracts, with Special Reference to the Best Method of Making Abstracts."—By Dr. T. G. Atkinson, St. Louis. Discussion by Dr. W. B. Snow, New York. Dr. J. R. Phelan, Oklahoma City. Dr. H. M. Simmons, Baltimore.

"The Value of a Society Journal for Publishing Transactions as Compared with Issuing Proceedings in Bound Volume Form."—By Dr. S. L. Jepson, Wheeling. Discussion by Dr. N. W. Wilson, Buffalo. Dr. W. H. Neilson, Milwaukee.

"Book Reviews."—By Dr. F. C. Lewis, New York. Discussion by Dr. F. H. Martin, Chicago. Dr. C. L. Stevens, Athens. Dr. K. W. Millican, Crescent.

"Mechanical Construction."—By Dr. F. P. Davis, Enid, Okla. (By invitation.) Discussion opened by Dr. H. V. Wurdemann, Seattle.

"Editorial Construction."—By Dr. John Ferguson, Toronto Discussion opened by Dr. J. J. Cassidy, Toronto.

"What Shall We Print."—By Dr. A. S. Burdick, Chicago. Discussion opened by Dr. E. C. Register, Charlotte.

"The Advertising Agency."—By Dr. H. V. Wurdemann, Seattle. Discussion opened by Dr. W. Anderson, San Francisco.

"Editorial Individuality."—By Dr. C. F. Taylor, Philadelphia. Discussion by Dr. C. Strobach, Cincinnati. Dr. H. M. Whelply, St. Louis.

"The Extension of Advertising Patronage."—By Dr. J. MacDonald, Jr., New York. Discussion by Dr. E. A. Van Der Veer, Albany. S. DeWitt Clough, Chicago. (By invitation.)

"Blackmail and Its Relation to Journalism."—By Dr. J. J. Taylor, Philadelphia. Discussion by Dr. J. Gradwold, St. Louis. I. V. Barth, Esq., St. Louis.

"The Patent Medicine Liar and False Certifier."—By Dr. C. H. Hughes, St. Louis. Discussion by Dr. F. E. Daniel, Austin. Dr. C. Fassett, St. Joseph. Dr. T. D. Crothers, Hartford.

"The Possible Assistance of The Medical Press to The Department of Public Health."—By Surg. Gen'l H. C. Wyman, Washington. Discussion by Dr. Wm. Porter, St. Louis. Dr. Henry D. Holton, Brattleboro.

"Editorial Revision."—By Dr. Heinrich Stern, New York. Discussion opened by Dr. M. A. Goldstein, St. Louis.

"The Make-up of The Medical Journals, with Reference to Ease of Preservation of Its Contents for future Reference."—By Dr. John McRae, Calumet. (By invitation.) Discussion opened by Dr. J. Punton, Kansas City.

"The Value of Medical Advertising."—By Dr. H. E. Lewis, New York. Discussion by G. L. Harrington, N. Y. Dr. J. R. Phelan.

"The Volume Index of Medical Journals."—By A. T. Huntington, New York. Discussion opened by Dr. Jas. P. Warbasse, New Work.

We would strongly urge upon all of our confreres who take an interest in Medical Journalism to be present at St. Louis, remaining over for the meeting of The American Medical Association which opens in the same city on Tuesday, June seventh.

Canadian Journal of Medicine and Surgery

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Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., *must be* in our hands by the first of the month previous to publication.

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Editorials

HEMORRHAGIC DISEASES OF THE NEW-BORN

UNDER the heading of "Hemorrhagic Diseases of the Newborn," Dr. Osler ("Practice of Medicine," p. 747) describes three hemorrhagic diseases: (1) Syphilis Hemorrhagica Neonatorum; (2) Epidemic Hemaglobinuria; (3) Morbus Maculosus Neonatorum. In the first of these affections the child may be born healthy, or there may be signs of hemorrhage at birth, followed by extravasations into the skin and bleeding from the navel or from mucous surfaces Jaundice may be noted. The post-mortem shows extravasations into the viscera, with syphilitic changes in the liver and other organs. The second of these diseases, epidemic hemaglobinuria (Winckel's Disease) occurs occasionally in an epidemic form in lying-in hospitals. It is a fatal disease, appearing about the fourth day after birth, and its principal symptoms are: jaundice, gastro-intestinal disorder, fever, rapid breathing, and sometimes cyanosis Albuminuria and methemoglobinuria are noted. The post-mortem reveals a swollen spleen and multiple punctiform hemorrhages.

In the third disease mentioned here, viz.: Morbus Maculosus Neonatorum, bleeding usually supervenes during the first week. The disease is usually of short duration; in fatal cases death occurs in from one to seven days. The temperature is often elevated. Dr

Townsend, Boston, who has written more largely of and reported more cases of it than any living man, thinks it is of infectious origin: on account of its general nature, self-limited character, the presence of fever, and its greater prevalence in hospitals. The bleeding may be associated with hematogenous jaundice. His mortality is 79 per cent.

Dr. Machell, Toronto, reported fourteen cases of "Acute or Spontaneous Hemorrhages in the Newly-born" in a paper published in THE CANADIAN JOURNAL OF MEDICINE AND SURGERY, April, 1907. In the first and second cases the temperature is not recorded. In the third case there was an elevation of temperature, 100-101° F., with nose-bleed and purpura on the arms and legs; general jaundice. In the fourth case there was hemorrhage from the bowel, with vomiting of bright blood, slight jaundice, temperature not over 101°F. In the fifth case, hemorrhage from the navel, melæna and petechiæ were noted—temperature never less than 103° F. In the sixth case, petechiæ on arms, hands, roof of mouth and a large cephalhematoma were observed; bleeding from one nostril, from the stomach, from around the cord and into the cellular tissue about the left orbit also occurred; temperature 101-102° F. In the seventh case hemorrhage began when the infant was one day old. Purpura melæna, vomiting of blood, were observed; temperature not given. In the eighth case, melæna, vomiting of blood, and ecchymosis were noted; temperature normal, respirations 24. In the ninth case vomiting of blood and melæna were noted

In the tenth case hemorrhages began from the mouth and intestines on the first day; general jaundice was also observed. In the eleventh case vomiting of blood was noted; temperature 101 4-5° F. In the twelfth case there were extravasations in the suprarenal capsules, hematoma of the liver and a subdural hemorrhage. In the thirteenth case vomiting of blood was noted. In the fourteenth case there was melæna. The mortality was 64.71 per cent.

Dr. Machell discards syphilis and hemophilia as etiological factors in his cases. Several of them appear to belong to the category described as Morbus Maculosus Neonatorum, in which hemorrhages from different parts of the body beginning during the first week of life, an elevated temperature, and the occasional association of hematogenous jaundice are the chief symptoms observed. The therapy employed, viz., gelatine internally and externally as a hemostatic; ergot, chloride of calcium and adrenalin, for a similar reason, and the saline solution per rectum, do not seem to have been responsible for such curative results as were obtained.

In the *New York Medical Journal,* April 23, 1910, an editorial notice appears of a new treatment for what is entitled "Hemophilia Neonatorum," by Dr. John E. Welch, pathologist of the New York Lying-in Hospital. Twelve cases were treated and all but one of them recovered. The treatment used by Dr. Welch was the subcutaneous injection of normal human serum. As evidence of the fact that the disease he treated is not a hemophilia, Dr. Welch points

out that traumatism is not a necessary or even a usual occasion of the hemorrhages noted. When the bleeding proceeds from the stump of the navel it usually starts from points in the stump between its base and the ligature. Hemorrhages also occur from the vagina, urethra, mouth, nasal passages, intestine and even the skin. Dr. Welch also exhibited an apparatus for procuring and preparing the human serum. It will be a matter of great satisfaction if Dr. Welch's treatment should prove successful in the hands of others, and one more exceedingly fatal disease should prove amenable to a remedy devised by medical science. J. J. C.

THE ORPHANAGES OF ONTARIO

DR. R. W. BRUCE SMITH, Inspector of the Hospitals and Charities of Ontario, in the fortieth report of his department, just to hand, notes that the number of children in the orphanages of Ontario is much less than for several years. This decrease of children in orphanages meets with his approval, and the only criticism he makes is that the orphanages are not depleted fast enough. As an evidence of the demand for children to be adopted, we learn that the Children's Aid Societies throughout Ontario have more applications for children to be adopted than can be supplied. The majority of people taking English children express a preference for native Canadians, but have to be content with children brought out

from the orphanages of Great Britain, and the principal reason for this restriction is that many native-born Canadian orphans have been committed to the orphanages with the expressed understanding that they must be kept there and not given out for adoption into private homes. This arrangement is not approved of by Dr. Smith, who says: "No matter how kindly cared for they may be in these institutions, there is lacking some of the elements that make for rugged upbuilding of character."

It must be admitted, on the other hand, that the desire of a widow to have the society of her own daughter, or the assistance of her own son, after some years of institutional life, is a very commendable one. Besides, looked at even from the standpoint of those who invest in other people's children, the character of a child is not simply the outcome of environment, and some Canadian orphan children, sprung from weakly or dissipated parents, may not turn out well, or may even do discredit to the best of foster parents. The adoption of children whose ancestry on both sides is not known must be regarded as a venture.

The fact that in Ontario such ventures in foster parenthood are cheerfully, even ardently, made, shows that love for children lies deep in the human breast, and that a home, even a luxurious one, is considered incomplete without children. If we are justified in believing that the low birthrate of Ontario, viz.: 25.6 per 1,000 of population (1908), is due to the voluntary limitation of families, it is just as fair

to think that, in many instances, the evident readiness to adopt orphan children in Ontario is an attempt to give a halo to voluntary barrenness.

Whatever the motives of foster parents may be, the future of an adopted orphan in a respectable home ought to be dowered with advantages not obtainable in the best of orphanages. There will be individuality and a sense of independence, unfelt in the society of an orphanage, a feeling of having a father and a mother instead of being nobody's child or the child of a poverty-stricken, perhaps an unloving parent, seen at long intervals; a freedom to form associations with some children and to discontinue relations with others. Then there will be incidentally less exposure to the contagious diseases of childhood There will be a more refined society in a good many cases; or a chance of introduction, in some instances, to good business, or perhaps professional life,—in fact, a future such as opens before the best-born child in the land.

All adopted orphans, however, do not drop into such delightful niches. A childless tradesman's wife may adopt an orphan girl, to be a companion to herself and to do the chores about the house; an orphan boy may be made to work slavishly on a farm, with no advantages in store, though it is freely acknowledged that these orphan children are looked after by Provincial inspectors, who solicit correspondence from them and attend to their complaints.

Institutional life has well-marked advantages—order, method, control, supervision and, especially,

training in some form of wage-earning industry. Girls are taught to sew, mend clothing, to do house-cleaning, cooking and other domestic work; boys are trained as bakers, tailors, shoemakers. Family life is the acme, but a perfected institutional life, particularly for the wayward or weakly children, is a close second. Besides, as Dr. Smith says, "The domestic management of the orphanages of Ontario is carefully and prudently looked after. Hence, it is reasonable to suppose, that the managers of these orphanages must be persons of superior merit, equal in talent and ability to the best of foster parents, willing and able to radiate a very beneficent influence on the mental and moral natures of their orphan charges." J. J. C.

THE HOSPITALS OF ONTARIO

FROM the report of Dr. R. W. Bruce Smith, Inspector of Hospitals and Charities of the Province of Ontario, for the year ending 30th September, 1909, we learn that the records of the year indicate the continued success and progress of the hospitals of this Province. The total number of patients in the seventy-one public hospitals was 48,788. The number of deaths during the year was 2,963, which gives a percentage of deaths to patients under treatment of 6.07. The total expenditure for the support and maintenance of the hospitals (including capital account, $314,947.51), amounted to $1,594,751. The

average cost per day of each patient was $1.23, a rate which compares favorably with the maintenance rates of the hospitals of the United States.

Adequate fire protection is now provided at nearly every hospital, there being not only proper facilities for escape in case of fire; but also fire-extinguishing appliances, always ready for use, in the event of a fire occurring.

Hospitals having been established in the different counties, people living in every part of Ontario will be afforded advantages in the treatment of disease which not long ago were only to be found in the larger cities. So true is this, that, to-day, the medical and surgical equipment of many hospitals, in the smaller towns, is superior to what is found in some of the older hospitals in the large cities.

Some of the Toronto hospitals, (names not given) are criticized on account of lack of accommodation. which has resulted in a disposition to crowd poor patients, admitted on municipal orders, into poorly ventilated wards, while private and semi-private patients get rooms in the best parts of the building.

Looking at a public hospital, in its true light, as a refuge for the sick poor, Dr. Smith insists, that Toronto hospitals should be compelled to give as comfortable wards for the use of the poor patients as are found in the hospitals of the small towns of Ontario. He states that hospitals neglecting to provide such accommodation are unworthy to share in the Provincial and municipal grants to public hospitals.

J. J. C.

WHY ARE THE AUTOS OF PHYSICIANS "HELD UP" DAILY BY THE POLICE?

THAT the men who have given their best years to the study of the saving of life, and their hours unstintingly to the service of suffering humanity, should, when suspected of breaking the Speed By-law, be treated as ruffians going on a joy ride is a disgrace to the police system of a city the size of Toronto.

The physicians of this fair city *are gentlemen,* and, by courtesy, servants of the public, but *not serfs under Russian rule.* If, on going to a case where perhaps death seems imminent, a doctor exceeds the ten-mile limit or takes a shorter turn of a corner by a quarter of an inch, he is summoned to the Police Court, and there, when giving a true and proper explanation of the circumstances, he is interrupted by a police inspector who seems to have more than his share of assurance, and adds, uninvited, his opinion, and gives it in spite of the magistrate presiding over the court. Whether this inspector is to be taken seriously or just as a preacher values the family parrot when it swears him out of the house, after just adding a saintly "Amen" to his prayer, is a subject worthy of discussion. It has been stated by several medical men who during the past few months have been summoned for supposed infraction of the Motor By-law, that a certain police official of Irish extraction has seemingly taken it upon himself to *not only prosecute* (one doctor said "persecute"),

but *also try* the case, to the utter extinction of Magistrate Kingsford or other luminary who happens to be on the bench and who is paid to dispense justice. Is this the reason that a physician the other day described the afternoon Police Court as being nothing short of a "Bear Garden"? Is Magistrate Kingsford going to allow this man to run his court for him, or may physicians expect to have justice meted out to them by him? Is it true that police constables are assembled monthly to have read to them the list of convictions that each has secured and the number of times that each constable has appeared in the Police Court to give evidence, and that those securing the smaller number of convictions are told they must do better in the future, so that, inferentially, it is not unreasonable to suppose that those who are most successful in securing convictions will be most likely to be rewarded by promotion? Can the Chief of Police deny that any of his Inspectors have taken this position? We can hardly credit this. Again, why are summonses withheld more than twenty-four hours, after which it is impossible for the defendant to recollect exactly the circumstances of the case? The statute as to speed has not been in any way amended since first it became law—why, may we ask, this sudden determination to enforce the law against physicians?

Will the police authorities be good enough to tell us whether there is one case on record where a physician in Toronto, through careless driving of his motor car, has done any bodily harm to any other individual

on the street? We understand, on good authority, *that the only case of injury occurring in Toronto this year from furious driving on the part of a motor cyclist was when a police constable ran down a boy on a bicycle, thereby hurting him.* Why are not the same laws applied to the police as are enforced against citizens? Might it not be wise to amend the by-law governing street traffic, making it incumbent on all carriages, whether horse driven or driven by gasoline, to light their lamps from sundown to sunrise?

It would seem as if the method adopted to catch motorists in the act of breaking the speed limit is for the constable to stand at or near the foot of Avenue Road or other hill and by means of a stop watch "clock" the auto as he thinks it leaves the summit of the slope and until it reaches a certain spot near the foot. No allowance seems to be made for passing street cars or other vehicles, which might perhaps occlude the constable's view and render his testimony valueless. Why, if necessary, cannot the police authorities adopt the method in vogue in England, where two constables are placed on the road and the motorist is clocked by one man as he passes a certain spot and by another on reaching another spot further on, and, as soon as the driver is halted, the two constables get together and compare figures, in that way convincing the supposed offender of his infraction or non-infraction of the law?

Is it true that the "expert" who is usually employed by the police to test the running qualities of

the car, whose owner has been summoned for breaking the speed by-law, is paid $5.00 for his hour's labor in so testing and a similar amount for giving his evidence in court on the same case? That looks like getting a conviction no matter what is the cost. Pretty good fee for a machinist, considerably exceeding what a physician is paid for spending, perhaps hours, in order to give evidence in the Assize Court.

It seems to us that the Board of Control in this city should be willing to grant some special privileges to physicians who use motor cars by passing in Council an ordinance similar to that at present in existence in Rochester, N.Y., and which for some years has been found to be eminently satisfactory. The following is an exact copy of the by-law:

CITY OF ROCHESTER, N.Y.

Mayor's Office, ..., 1910.

....., M.D., the bearer of "Physicians' Street Permit" badge No. ....., is hereby granted the privileges of an "ordinance relating to nuisances," amended June 17, 1896, to read as follows:

"Sec. 7. No person shall drive or ride or cause to be ridden or driven any horse or other animal upon any public street or place within the city of Rochester at a speed exceeding six miles per hour, under a penalty and fine of not less than five dollars nor more than fifty dollars for each offence."

This section shall not apply to public and private ambulances while on duty responding to actual calls for assistance; nor shall it apply to horses or vehicles of any physician when actually engaged in professional work in responding to emergency calls, provided the said physician shall have in his possession a permit issued by the Mayor of said city.

.....Mayor.

Similar by-laws have been in force for several years in Philadelphia, Chicago and other large cities in the United States, and only a few weeks ago the city of Baltimore fell into line, granting physicians using motor cars special privileges along the highways. *Such an ordinance should immediately be introduced in Toronto.* Medical practitioners are not men who would abuse this privilege in any way, and the adopting of such an arrangement would save endless trouble. W. A. Y.

A LITTLE EMBARRASSING, DON'T YOU KNOW?

It is with deep regret and some surprise that we chronicle the fact that the President of the Ontario Medical Council has not accepted the offer we made him in our May number. Dr. Hardy is so well known for his desire to husband the finances of the institution over which he presides and to advance the welfare of the profession, that we had expected him to accept our offer with alacrity. His alacrity is, however, not what you might notice.

On reference to page 247 of the last Announcement, we find that Dr. Hardy spoke as follows: *"I would like to call your attention to the fact that the expenses of this College are constantly increasing. 'In* 1907 *our balance in the bank was* $65,161.00; *in* 1908 *the balance in the bank was* $48,359.00, *and in* 1909, $44,745.19.' *To my mind this decrease in the funds on deposit is a most serious condition of*

affairs, as at the present rate in ten years we shall practically be in debt.'' We repeat our offer already made, to publish in detail and at our own expense, the expenses of the Ontario Medical Council as alluded to in our last issue, if Dr. Hardy will furnish them.

Dr. Hardy in his letter has stated that the information might be obtained from our representative, Dr. J. S. Hart. We have applied to Dr. Hart—(who moved in Council, *vide* Announcement 1909, page 380, that the expenses be published in detail)—for the information which the profession insist upon being furnished with. Dr. Hart, in conversation with us, hesitates to furnish this information saying that to furnish it would place him in a very embarrassing position. Dr. Hart is certainly in the difficult position of explaining to his constituents *why* this is embarrassing to him. We leave him on the horns of his dilemma in the hope that before the elections in October next he may have succeeded in extricating himself.

In spite of the determined and fatuous refusal of the Council to furnish this information, we shall yet get it, *even if the rights of the members of the College of Physicians and Surgeons have to be determined by the courts.*

We commend to the careful perusal of our readers page 389 of this issue, on which will be found a letter from Dr. J. M. MacCallum, a member of the Council, who has forwarded us the official stenographer's report of a portion of the debate at the

special meeting in December last. What little game is the smooth, mild-mannered representative of the University of Toronto up to now? Is he trailing a red herring across the track, and does he wish us to believe that the Medical Council will *really* correct the abuses we complained of? These extracts show beyond a doubt that the Council has no intention to correct these abuses, but that *they have all along been well aware that the abuses which we have charged did and do still exist.* They show that Dr. Temple, Dr. McColl and Dr. MacCallum—for this we give them due credit—were all very ready to bring these matters to the attention of the Council, and the Council opined that *it was really too dreadful for words* and speedily transferred the surplus just the same as per usual. Why did not these members have the moral courage to go a little further and move to have the matter investigated? *Who got the money* and how did they get it? Some of the ways in which they got it we have shown in our May issue. Perchance, in our July number we will try to show other methods by which these facile digesters assimilated the surplus. The Council may rest assured that we will yet publish "who got it"—so that the electorate may purge it of the men who, for the sake of petty graft have dragged in the mire the name of the College of Physicians and Surgeons of Ontario. W. A. Y.

FOUR THOUSAND A YEAR FOR A MEDICAL HEALTH OFFICER: TEN THOUSAND A YEAR FOR A CITY COUNSEL

THE remarks have been many and very much to the point in respect to the position of Medical Health Officer for Toronto.

The position with its munificent (?) income has been gracefully declined with thanks by a capable man, Dr. Charles Hodgetts, one who is well fitted to fill that office. Another splendid man has been spoken of, but it cannot be said that Dr. Amyot seeks the office and his acceptance (at the date of writing) looks doubtful.

While few men indeed are so small in character that either political bias or salary tempts them rather than a desire for work they are equipped to do, still it is not worthy of the City of Toronto to offer so small a salary to the one who is held responsible for the lives of its citizens and hand out a cool ten thousand dollars per annum to its City Counsel. The physician who will accept the position of Medical Health Officer for this large and growing city, if competent for such an office, must of necessity be advanced enough in his private practice to be making more than four thousand dollars a year, unless he has retired from active practice and is able to live on his investments or his wits. The age of anesthesia arrives too soon for a man of ability to provide properly for the future of his family on four or five

thousand dollars a year and work night, noon and morning answering every summons of the City Council or every cry of mad dog or measles in this big city, with the alacrity of a bell hop.

The position of Medical Health Officer carries with it no "flowery bed of ease," little glory and less cash; few will seek it, but we trust that someone, a martyr, a scientist, and a gentleman, will have its greatness thrust upon him, and let us fervently ask for another Saint's Day to be added to the list.

W. A. Y.

DR. CHARLES HODGETTS JOINS THE FEDERAL SERVICE

At the date of writing we understand that official announcement by the Chairman of the Conservation Commission will shortly be forthcoming of the appointment of Dr. Charles Hodgetts, Secretary of the Ontario Provincial Board of Health, to take charge of the Health Branch of the Commission work. The Commission contemplate a far-reaching campaign of education and of practical endeavor in respect to the Prevention of the Spread of Tuberculosis, the Pollution of Streams by Sewage, Municipal Sanitaria, etc. This work will be undertaken by both Federal and Provincial Governments.

We heartily congratulate Dr. Hodgetts upon his important promotion and wish him God-speed in his new sphere of duty. W. A. Y.

Editorial Notes

Baking Destroys Pathogenic Bacilli

Dr. Auché, of Bordeaux, has incorporated tuberculous sputa in the dough of loaves of bread of different sizes, and found that, in every instance, the bacilli had lost their virulence after baking He has also made observations on other microbes, which he placed in bread, introducing into the dough active cultures in bouillon of B. typhosus, B. paratyphosus, B. dysentericus, B. coli, streptococcus pyogenes, staphylococcus aureus, and a variety of proteus. The results of his observations have been communicated to the Biological Society of Bordeaux and appear in *La Semaine Médicale,* 1910, No. 9, xxxv. In all these cases the results obtained were negative—that is to say, culture media, sown with fragments of the bread taken from the parts inoculated remained sterile, whereas, when sown with pure cultures unaffected by heat, the tubes grew abundantly. So far, therefore, as the above mentioned organisms are concerned, Dr. Auché thinks, that they are destroyed in baking, and that, apart from any accidental contamination of the surface, after taking it from the oven, bread may be considered a thoroughly aseptic article of diet.

The Automobile as a Sanitary Agent

The use of automobiles is now so general and extensive that it has become commonplace, and no longer attracts attention. That it is an added source of danger in crowded streets is apparent; but the swiftness it gives to vehicular locomotion bids fair to override the protests of dodging pedestrians. As a supplanter of the horse, it is doing for the streets of cities a very important service in preventing the accumulation of horse manure. The feces of the horse are dangerous to health, more

dangerous than the feces of any other quadruped kept in civilized communities.

Flies breed in horse manure; tetanus swarms in it. Why should not drays, express wagons, milk wagons and all four-wheeled vehicles be changed into automobiles? An automobile does not run away and endanger life and property during its wild career. It can be left at the sidewalk, while the driver goes indoors. It is enormously powerful. These are some of the reasons which make for its general employment as a traction agent; but the most far-reaching reason in favor of its general utilization is the improvement in the bacteriology of street dust, which will follow the disappearance of the horse from our streets.

The "Third Degree"

One reads with astonishment of the horrors of the so-called "Third Degree," as applied by the police to friendless, timid prisoners.

At the Special Sessions in New York City, last April, a prisoner, who was indicted for first degree murder, made a confession, which he afterwards repudiated. He said that the confession had been wrung from him by cruelty; that he had been starved, prevented from slaking his thirst, and compelled to remain awake, until, driven to the verge of collapse, he said many things which were not true.

Justice Crane, who tried the case, very properly remarked that the police should apply the golden rule in handling a prisoner, treating him as they would want to be treated.

Justice Crane's remarks recall the Christian ideal, which should permeate the official behavior of the police, as well as the bench and the bar. And yet in the Great Republic, where all men are equal, the police bow down to mammon. A well-to-do prisoner, like Thaw, is treated by the police with every courtesy; eminent counsel almost fall over each other in their anxiety to assist in the presentation of his case, while a friendless, suspected

prisoner like Boehm is treated to the third degree. Should not the prison physician have advisory powers in such cases? If exercised in a judicious manner, the efforts of the police to unearth crime, and bring suspected criminals to the bar of justice are most praiseworthy. Suspected prisoners, however, should not be treated as criminals until guilt is proved, and only then should they get the punishment meted out to them. A prisoner should not be forced to answer questions, until he can do so intelligently, and until he is protected by counsel.

If not protected by counsel, there is all the more reason why a friendless prisoner should not be exposed to the extractive efforts of the police. If there is no other protection to invoke, he should be permitted to look for the protection of the prison physician.

Rest After Meals

All animals and many savages go to sleep, when they have eaten. Would that civilized man would imitate them! Unfortunately he does the very reverse; in most cases, no sooner is the meal down than he tries to resume his ordinary occupations and, perhaps, this is one of the reasons why dyspepsia is so common nowadays. Worse still, a man is expected to speak at a lunch or dinner, in such a way as to attract the attention and merit the applause of his hearers. Looked at from a physiological standpoint, such an intellectual effort is a hindrance to the speaker's digestion, since it withdraws from that function the energy which is devoted to his address. Under such circumstances, common sense would suggest, that a speaker at a lunch or dinner would just trifle with his viands, instead of doing credit to the chef. His dyspeptic listeners, of course, need not restrain their appetites, and, if they do not eat too fast, may not be harmed by such a repast; because repose, assisted by a good cigar, produces the somnolent condition, which shortens the period of digestion.

And if the proceedings are not too short, and the period of

repose last for, say, a couple of hours, some bad cases of dyspepsia from insufficiency may derive a good deal of benefit: from faring well and listening to other men speaking ill or well, at lunches and dinners.

A Death from Hydrophobia

The long incubation period of rabies cannot be understood, if the virus travels through the blood vessels of the bitten part; but becomes more intelligible, if we admit that it reaches the nerve centres through the sheaths of the injured nerves. The known fatality of bites by mad dogs about the face and head, and the brevity of the incubation period in such cases are also explainable upon this ground, the injured nerves being so close to the brain axis. G. E. Seaman, a soldier of the Norfolk Regiment, stationed at Gibraltar, was bitten by a mad dog. He and another man, who was bitten at the same time, were sent to the Pasteur Institute, Paris, in September, 1909. Seaman's comrade died within a month, but he returned to England, and no symptoms of hydrophobia occurred until a week before his death, when he complained of pain in the elbow of the arm which was bitten. The pain spread to the shoulder and then to the back of the neck. He was admitted to the Hackney Infirmary, March 29th, 1910, and a diagnosis of hydrophobia was made. During his terrible sufferings Seaman was quite sensible, and was able to give a collected and rational account of his illness and of the treatment he had received at Paris. Towards the end, he complained of great difficulty of breathing, and he prayed the doctor to cut his throat, so that air could be got into his respiratory organs. A post-mortem was made, but nothing was found except a little inflammation of the brain and kidneys.

In the report of this case, which appears in *The British Medical Journal,* April 2, 1910, p. 851, nothing is said about the condition of the spinal cord.

That the chief symptoms of hydrophobia are due to morbid changes in the cranial nerves, and that death in this disease is

the result of paralysis of the respiratory and vaso-motor centres may be accepted, when the predilection which the virus of rabies seems to have for the brain-axis is remembered. In Seaman's case, the incubation period lasted for six months, during which time the rabic virus was engaged in travelling upwards from the injured nerves in his arm, until it reached the brain-axis, the Pasteur treatment not having been successful in establishing immunity to hydrophobia.

The most important part of the treatment of such a case would be the surgical treatment of the bitten part. The patient should be placed under the influence of a major anæsthetic and a careful excision made of any tissues, which have received the imprint of the rabid animal's teeth. Free bleeding of the bitten parts should be encouraged, in order to provide an outlet for any rabic saliva which may have found lodgment in the bitten part, and the use of the cupping glass over the incised parts would be helpful to promote the cleansing of the wounds. "It is best," says Osler, "to keep the wounds constantly open for at least five or six weeks." The open wounds should be douched, guttatim, to assist in the elimination of any hidden virus. A preventive treatment of this scope would be more likely to be followed by immunity to hydrophobia than cauterization of the bites with the actual or thermo-cautery. Antiseptic solutions are generally recognized as of secondary value. The treatment recommended should be applied, within twenty-four hours of the bite, and should be thorough, all abrasions about the fingernails or the slightest fissure in a lip being sufficient to admit the virus. Pasteur's treatment by vaccination has reduced the mortality to about five per cent—a result that is pretty constant all over the world. This figure, however, cannot be taken as absolute, for, undoubtedly, patients are treated, who might not have taken hydrophobia, or who were not bitten by an animal proved to be rabid.

J. J. C.

PERSONALS

We extend our congratulations to Dr. and Mrs. D. C. Meyers on the recent addition to their family.

Dr. R. D. Rudolf had recently conferred upon him in absentia, the Fellowship of The Royal College of Physicians, London.

Dr. D. King Smith, of Wellesley Street, has received the honor of being elected a member of the American Dermatological Society.

Dr. and Mrs. F. N. G. Starr leave for England next month. Dr. Starr intends attending the meeting of The British Medical Association in London.

Drs. J. J. Cassidy and John Ferguson intend attending the meeting of The American Medical Editors' Association at St. Louis, which opens on the fourth instant.

Among those who attended the recent medical meeting in Washington, D.C., were Drs. F. N. G. Starr, A. McPhedran, R. D. Rudolf, Alex. Primrose and Perry Goldsmith.

The names of Drs. Amyot and John Noble, of Toronto, and George Acheson, of Galt, have been mentioned in connection with the appointment of Toronto's new Medical Health Officer, though up till the time of going to press the appointment had not been decided upon.

Errata.—We regret that, owing to an oversight, the name of Dr. Ernest Jones, of Toronto, was omitted as one of the authors of the paper, "A Test for the Diagnosis of General Paralysis in the Insane," and which was published in our "May" number under the sole authorship of Dr. George W. Ross, of Toronto.

The name of Dr. Helen MacMurchy was recently submitted to the Board of Education for appointment as Medical Inspector to the Public Schools of Toronto. We think that the choice of Dr. MacMurchy is in every respect a wise one. Dr. MacMurchy having, not only the ability to fill such a position, but a special fitness for work of this kind.

Correspondence

The Editor cannot hold himself responsible for any views expressed in this Department.

Managing Editor

THE CANADIAN JOURNAL OF MEDICINE AND SURGERY:

DEAR DOCTOR,—Will you permit me to quote from a verbatim copy by the official stenographer of the discussion that took place in the Medical Council at its special meeting in December, 1909, on the subject of the Council's finances? This will be printed in the next Announcement. I had drawn attention to some discrepancies—as they seemed to me—in the accounts of the Examiners and asked for an explanation from the Chairman of the Finance Committee.

Dr. Hart said as follows: "Our Financial Department is badly organized. We have a Treasurer who does his work honestly and we have the Chairman of our Finance Committee, against whom I would not cast any suspicion; but no one of these men is in a position to scrutinize the accounts. What can we do?"

Dr. Temple (Chairman of the Finance Committee): "Dr. Hart has properly asked the question, What can we do? We must do the thing ourselves. In the present system there must be some alteration. I do not mean to say one single member of the Council has ever done anything that is wrong; but certainly, as the accounts stand at present, they are in a very unsatisfactory state. Our expenses are simply enormous. Something ought to be done, and I think the Council should appoint some person who would take cognizance of these affairs without throwing anything personally upon any member of the Committee that has to do it. I would not question any man's statement. If he says that it is correct, I would pay it and that is the end of it."

Dr. MacCallum: "I can understand Dr. Temple's position, but I think this Council ought to do something. It was for the purpose of drawing attention here to it that I spoke."

Dr. Temple: "It is a matter simply of duty; I can't help myself. It is in black and white that a gentleman presenting his account to the Treasurer, that he has to pay it."

Dr. McColl: "As belonging to the Finance Committee, I think that where the whole trouble is is in allowing everybody to send in their own bills, even from this Council, and from others outside, and I think if this Council would give the power to the Finance Committee to simply tax what each man's railway expenses should be and the amount of time that is necessary for him to come here, and go and write out his cheque without him having to certify to it, it would get over the difficulty. We know where every man has come from; we can easily find out in ten minutes the amount of time he loses before or after, without travelling in the middle of the night, and tax the bill accordingly; and if the Committee meet early in the session they can easily have that part arranged, and then the only part left after that would be to ascertain the number of days the Council actually sat, and for the Examiners the same thing. I am willing, as far as I am concerned, that any two or three members of this Council should decide for me what time I lose in coming and going, and that can all be done in the early part of the session, and all that has to be added after that is the daily allowance. I do not see why the same thing cannot be done in connection with the Examiners, and all this trouble will be gotten over and it will be done in the proper manner."

After some further remarks by Drs. Vardon, Gibson, Cormack and Henry, the President, Dr. Hardy, said: "Unless the Finance Committee brings in a report on this question nothing can be done, and there is no use taking up time in discussing it. At the next session, probably, something will be done definitely to define it."

Dr. MacCallum: "Is it in order that this matter be referred to the Finance Committee?"

The President: "I do not think so, I think you will be out of order."

Dr. MacCallum: "That means it will have to be put over till the July meeting."

The President: "I think so."

I shall content myself with stating that I have been a member of the Council since July 1st, 1909. For the regular meeting of July, 1909, I received $120.00, as fixed by the Finance Committee (vide page 332 of the last Announcement); for the Special Meet-

ing held in December, 1909, lasting three and one-half days I received $70.00.

However great the Council's shortcomings in your eyes, a perusal of these extracts may perhaps persuade even you, Mr. Editor, that it, at least occasionally, seeks to do the proper thing. I might say more on this subject. My "log-rolling propensities," so evident to your gentle correspondent, "Irate Practitioner," tempt me once more to shoulder my peavy; but I refrain.

JAMES MACCALLUM.

Toronto, May 16th, 1910,
112 College Street.

Managing Editor

CANADIAN JOURNAL OF MEDICINE AND SURGERY,

145 College Street:

DEAR SIR,—It seems from your editorial regarding Council expenditures that there is some difficulty about arriving at the facts, and it has occurred to me that if each member of the Council would supply you with information regarding his own receipts the difficulty would be very easily overcome.

As the representative on the Council of Victoria University I took my seat at the Kingston meeting in 1907, and I drew for that Session $60.00, plus $16.30 for mileage. For a Special Session on October 4th, 1907, in Toronto, I drew $15.00, making a total of $91.30 for that year.

For the Session of the Council in July, 1908, I received $100.00, the daily allowance having been increased by By-law from $15.00 a day to $20.00. In the autumn of that year there was a Special Meeting lasting three days, for which I received $60.00, and I received $15.00 for a Committee Meeting, making a total for 1908 of $175.00.

For the Session of 1909, July, the Finance Committee recommended that the Sessional Indemnity be a straight $120.00, together with the usual mileage rate and travelling days in addition (see page 332, Announcement for 1909-10). I therefore received $120.00 for that July Session, and for a Special Session in December, 1909, which lasted three and a half days, I received $70.00, making a total for that year of $190.00.

I think it most desirable that all the detailed expenditure of the Council should be published, and I hope that the President of the Council will see his way clear to accept your offer to print it without cost to the Council if the Council feels that it is too expensive an undertaking for itself.

Yours faithfully,

F. N. G. STARR.

Toronto, May 3rd, 1910.

The Managing Editor,

CANADIAN JOURNAL OF MEDICINE AND SURGERY,
Toronto:

SIR,—The President of the College of Physicians and Surgeons complains of your editorial calling attention to the increasing expenditure of the Medical Council. He complains that your totals are incorrect, because you included the stenographer. I think it was magnanimous upon your part to include the stenographer.

Your editorial and Doctor Hardy's reply impelled me to look up my Council Announcement, and regarding that Special Educational Session that the Doctor speaks of as lasting three days, I find the cost was $2,704.30. I find, too, that twenty-eight members attended that Session. Upon inquiry I find that members of Council receive $20.00 a day, so that each member is entitled to $60.00 for that Special Session. Twenty-eight members at $60.00 means a cost of $1,680.00 to the College. Where did the balance of $1,024.30 go?

Can the President answer?

Can the Treasurer answer?

Can the Registrar answer?

Can the Auditor answer?

Can the Chairman of the Finance Committee answer? (The President claims that he safeguards Council expenditure.)

Can some members of the Council *tell where* that Thousand odd dollars *did* go?

PRACTITIONER.

Obituary

DEATH OF DR. JOHN D. WILSON OF LONDON, ONT.

It was with great regret that the medical profession learned from the daily press that Dr. John D. Wilson, one of the best known physicians in Western Ontario, died at his home in London on the morning of May 16th. Dr. Wilson had battled for nearly five weeks with a severe attack of septic poisoning, contracted while operating on the tonsils of a little girl. Notwithstanding the fact that everything known to medical science was done for him, the doctor passed peacefully away on the date mentioned. Dr. Wilson's death means that Ontario has lost one of its scientific physicians and his patients a very dear friend. We take this opportunity of extending heartfelt sympathy to his family.

News of the Month

A LARGE DEPUTATION OF MEDICAL MEN WAIT UPON THE BOARD OF CONTROL

PERHAPS the largest deputation of physicians that has ever waited upon the Board of Control did so on Tuesday, May 17th. On that date nearly two hundred medical men waited upon the Acting Mayor and Board of Control urging the appointment of Dr. John Amyot to the position of Medical Health Officer for the City of Toronto. It is perhaps safe to say that the consensus of opinion throughout the profession, both in Toronto and elsewhere, is that Dr. Amyot is undoubtedly the man who should receive this important appointment. The doctor's scientific and executive abilities were urged before the Board of Control by such speakers as Dr. Alexander McPhedran, Dr. A. A. MacDonald, Dr. R. A. Reeve, Mr. Irving H. Cameron and Dr. J. J. MacKenzie. We trust that even ere our June issue appears this appointment will be made.

THE ACADEMY OF MEDICINE ELECTIONS

THE annual meeting of The Academy of Medicine, Toronto, took place at No. 9 Queen's Park on Tuesday, May 3rd. There was a splendid attendance of Fellows, and the meeting was eminently satisfactory. In the absence from the city of Dr. A. McPhedran, the retiring President, Vice-President Dr. A. A. MacDonald took the chair, and had on his left the retiring Honorary Secretary, Dr. H. J. Hamilton. After the minutes of the last annual meeting had been duly read and adopted, the reports of the different committees were put in, each one receiving careful attention. These reports showed The Academy to be in a splendid condition, especially that of the retiring Honorary Treasurer, Dr. D. J. Gibb Wishart.

It is with great satisfaction that we find The Academy to be on the upward trend, especially as to the steady increase in membership and interest taken in its different sections. We take this opportunity of congratulating the different committees upon their work during the year now closed. Perhaps the greatest interest was taken in the report of the Nomination Committee, their slate being adopted throughout with one exception, that of Honorary Treasurer. Dr. D. J. Gibb Wishart decided to retire from that office, feeling that the time was opportune for so doing and desiring to give someone else a chance of occupying that important position. Dr. W. A. Young was elected to succeed Dr. Wishart. The following is the list of those who will occupy office for the ensuing year:

President.—Dr. A. A. MacDonald.

Vice-President.—Dr. N. A. Powell.

Honorary Secretary.—Dr. Harley Smith.

Honorary Treasurer.—Dr. W. A. Young.

Council.—Dr. J. F. W. Ross, Dr. R. A. Reeve, Dr. H. J. Hamilton, Dr. W. H. B. Aikins, Dr. H. B. Anderson, Dr. E. E. King, Dr. J. M. Cotton, Dr. D. J. Gibb Wishart.

ANNALS OF MEDICAL PRACTICE PURCHASED BY THE NEW ENGLAND MEDICAL JOURNAL

The New England Medical Monthly, for twenty-nine years edited and published by Dr. William C. Wile, of Danbury, Conn., has been purchased by the Annals Publishing Company, of Boston, and will be combined with the *Annals of Medical Practice.*

The New England Medical Monthly, incorporating the *Annals of Medical Practice,* thus becomes the most representative medical monthly publication with the largest circulation in New England.

Dr. Francis D. Donoghue, formerly editor of the *Annals of Medical Practice,* will continue in charge of the consolidated journals.

BOOK REVIEWS

The Practice of Osteopathy. Its practical application to the various diseases of the human body. Illustrated with 108 half tone engravings. By CHAS. H. MURRAY, A.B., B.D., D.O., Author of Genuine Osteopathy, The Osteopathic Truth, Practical Health Hints, and The Successful Promotion of Genuine Osteopathy. All for the Osteopathic Profession. The Elgin Osteopathic Publishing Company, Elgin, Ill. 1909.

That ninety-nine per cent. of so-called Osteopaths deserve the reputation of being quacks, there is little or no question. That, however, does not mean that all of those who practice, what is known as, Osteopathy are in that class. There are undoubtedly certain conditions which can be benefited by osteopathic treatment (if in proper hands), and those conditions the author of this book calls attention to. What a pity that the treatment has fallen, in the very large majority of instances, into the hands of such an ignorant class of people, who care for naught but the shekels.

Mr. Murray's book has many good features and can be commended to medical practitioners as containing a lot of material that should prove interesting. The book is fully illustrated.

Emergency Surgery. For the General Practitioner. By JOHN W. SLUSS, A.M., M.D., Professor of Anatomy, Indiana University School of Medicine; Formerly Professor of Anatomy and Clinical Surgery, Medical College of Indiana; Surgeon to the Indianapolis City Hospital; Surgeon to the City Dispensary; Member of the National Association of Military Surgeons. Second edition, revised and enlarged with 605 illustrations, some of which are printed in colors. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1910.

Sluss' Emergency Surgery has evidently found a place for itself among medical readers, as it is only a short time since we

were favored with the first edition. Emergency Surgery is a handsomely bound, small-sized book of seven hundred odd pages, gotten out by the publishers in first-class style. The book is divided in all into twenty-seven chapters and covers in a fairly complete manner for a small volume Surgery as it is dealt with in the emergency operating room. The book is written in such a way that the general practitioner can pick it up at a moment's notice, and it should undoubtedly serve as a guide to him in a time of uncertainty.

We find that a new chapter on the General Technic of Laparotomy has been added to the second edition, and the subject has been dealt with most carefully and at some length. We notice also that Spinal Anesthesia has been described in detail. The illustrations are capital.

Functional Nervous Disorders in Childhood. By LEONARD G. GUTHRIE, M.A., M.D., F.R.C.P.; Senior Physician to Paddington Green Children's Hospital, etc. London: Henry Frowde, Oxford University Press; Hodder & Stoughton, Warwick Square, E.C.

"The object of this book is duly set forth in the introductory chapters. In brief, it is to emphasize the truism that the neurotic child is the father of the neurasthenic adult. Many nervous and other ailments are the outcome of neurotic or emotional temperaments, and all are aggravated thereby. It is held that early recognition of these simple facts by medical men may help to lessen the prevalence of neurasthenia in the rising generation." These are the opening sentences of the preface to this little work. We can heartily endorse the author's words, and his efforts have been successful. No work on pediatrics goes into the functional disturbances of childhood a tithe so deeply, nor puts matters so clearly and helpfully as Dr. Guthrie. How frequently are we at our wits' end to treat cases of neurotic children! Here we get invaluable hints on subjects merely touched on in systems and larger handbooks—Disorders of Sleep, Moral Failings, Enuresis, Cyclical Vomiting, Epilepsy, Chorea—the ties of many other functional nerve strains, taken up, discussed, and treatment suggested, in a masterful, satisfying manner. The little book is very cheap, and if purchased from the Canada Law

Book Company, 32-34 Toronto Street, 40 per cent. discount is allowed. A. B.

Spondylotherapy. ALBERT ABRAMS, A.M., M.D., F.R.M.F. Published by The Philopolis Press, San Francisco, Cal.

This is a very strange book. The author himself says it is really a pioneer effort. The burden of its story is that spinal reflexes are all-pervasive and that wonderful influences may be called into exercise by various forces brought to bear upon the spine.

There is brought together by compilation an aggregation of statements showing an entire absence of discrimination and balanced judgment.

There is much in the book to stimulate thought, and it would be safe in the hands of a man of experience, but would be an unsafe guide to the inexperienced or the routinist.

From many sources is gathered an *olla podrida.* Much of it is good and much of it not only useless but dangerous; moreover, it is jumbled together without reason, plan or system.

B. E. M.

Claims Arising from Results of Personal Injuries. The relation injury bears to disease and disease to injury. A treatise showing how personal injuries may affect various diseases, and how certain diseases may add to claims for accidents by protracting recovery. By W. EDWARD MAGRUDER, M.D., Associate Professor of Clinical Medicine, College of Physicians and Surgeons; Visiting Physician Mercy Hospital and Bay View Asylum; Medical Examiner and Adjuster for Life, Accident, Health and Liability Insurance Companies, Baltimore, Md. Price, $2.50. The Spectator Company, 135 William Street, New York. Chicago office: 159 La Salle Street.

This book is one that will be found particularly useful to Medical men interested in Insurance work. There have been quite a number of alterations of recent months to the Act dealing with the subject of Workmen's Compensation, a subject which has also been dealt with recently in both England and Germany. This book comprises in all over two hundred pages, and is divided into thirty chapters. Some of the subjects dealt with

are: "Pneumonia and Its Complications," "Traumatic Tuberculosis," "Traumatic Appendicitis," "Diseases of the Kidney following Accidental Injury," "Traumatic Epilepsy," "Traumatic Apoplexy," "Traumatic Meningitis," "Traumatic Insanity," "Traumatic Heart Disease," "Spinal Injuries and Associated Diseases," "Some of the Paralyses Associated with Injuries," "Some Nerve Injuries," "Traumatic Neuroses," and "Hernia in its Relation to Accidental Injury."

We can commend Dr. Magruder's work to our readers, it being well worth the price charged by the publishers, namely, $2.50. W. A. Y.

Modern Surgery: General and Operative. By J. Chalmers DaCosta, M.D., Professor of Surgery and of Clinical Surgery in the Jefferson Medical College, Philadelphia. Sixth Edition, greatly enlarged. Octavo of 1,502 pages, with 966 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, $5.50 net; half-morocco, $7.00 net. Canadian agents: The J. F. Hartz Co., Ltd., Toronto.

DaCosta is rapidly approaching the two-volume series. The fifth edition contained 1,283 pages, the present 1,502.

Among some of the new work is that on Arteriorraphy, founded on the investigations of Murphy, Carrel and Matas; Crile's arterio-venous anastomosis for effecting transfusion of blood; Brewer's tubes for transfusion; the use of Halstead's aluminum bands for aneurism, etc. Bier's treatment has a place, as has also some of the new work on vaccines.

The new work on the "operative treatment of recent fractures" is somewhat bold for an author who has formerly produced a text-book, and to the author we would say, All honor for having the courage of his convictions, for we know some surgeons who constantly *knock the method* by word of mouth and yet frequently practise it. It is a forward step when the author says, "All compound fractures require operation," for to us it does seem absurd to risk a deformity when the accident has already shown us the way to secure an anatomically perfect result. We shall expect that in the next edition the author will go further and advocate operation in all fractures of the shaft of the femur and in many others.

The work on Hare Lip and Cleft Palate still needs some amendment. Why should a mother be compelled to gaze at her babe with an uncomplicated hare lip daily and hourly for from three to six months when the lip might be repaired within an hour after birth, and be all ready for nursing a few days after the milk comes into the breasts? Why should a child struggle to learn to talk with a cleft palate until it is two years old, when it might be learning to speak with a sound palate as soon as it begins to coo and prattle? F. N. G. S.

Myomata of the Uterus. By HOWARD A. KELLY, M.D., Professor of Gynæcologic Surgery at Johns Hopkins University, and THOMAS S. CULLEN, M.B., Associate in Gynæcology at Johns Hopkins University. Large 8vo.; 700 pages, with 388 superb illustrations by August Horn and Herman Becker. 1909. W. B. Saunders Company: New York and London. Toronto: J. F. Hartz Co., Limited.

This regal volume is the outcome of a study of 1674 cases of uterine myomata submitted to operation by its author between the opening of Johns Hopkins Hospital, in 1889, and January 1st, 1909. In the series every possible variety found in this class of tumor is represented. Every complication and degeneration illustrated, and the methods of treatment as well as the results of treatment are fully made known. With such a wealth of material at their disposal, the authors have thought best to leave to others a study of the literature of the subject. The evolution of modern technique in the operative procedure has been taken up so recently and in such a comprehensive and masterly manner by Dr. Chas. P. Noble that the authors content themselves with describing only such methods as they have personally made use of. Incidentally the very large part taken by Dr. Kelly in simplifying these procedures and in lessening the dangers of operation becomes an outstanding feature. The deaths are given in full on the principle that more can be learned from failures than from successes. In the earlier periods the mortality reached 5 or 6 per cent., but in the last 300 operations it fell below 1 per cent. To earlier diagnoses and surgical relief, as well as increased experience and improved technique, must be accorded the credit of this brilliant result. With few exceptions, the illustrations are original. To say that

they are up to the standard established by Max Brödel in preparation, and by the W. B. Saunders Company in reproduction, will convey to every physician an idea of their beauty, accuracy and clearness. Nothing finer has been seen by this reviewer. Canadian practitioners will note with pleasure the graceful dedication of the work to the memory of Dr. L. M. Sweetnam, of Toronto. N. A. P.

Diseases of the Nose. By ERNEST B. W. IGETT, M.A., M.B. (Cantab). Surgeon to the Throat and Ear Department of the Charing Cross Hospital; Surgeon, London Throat Hospital, and Throat and Ear Department, Great Northern Central Hospital. London: Henry Frowde, Oxford University Press; Hodder & Stoughton, Warwick Sq., E.C. This book can be procured from the Canada Law Book Company, 32-4 Toronto St., Toronto, at 40 per cent. discount.

It has been a great pleasure to read this book of the Oxford Medical Series. The author says the book was intended to be read, as it was written, rapidly, from cover to cover. While the style of the author admits this rapid reading, there is altogether too much valuable matter in it to permit such rapid reading without serious loss. The chapters devoted to Adenoids and the Nasal Septum are particularly well written. The same may be said regarding the Accessory Nasal Sinuses. There are 89 illustrations in the book, the majority drawn by the author from nature expressly to explain the text. This is one of the best of the small books dealing with the Nose, in fact we know of no book in which diseases of the nose are more fully or completely set forth. P. G. G.

Heart Disease and Thoracic Aneurysm. By L. J. POYNTON, M.D., F.R C.P. (Lond.), Assistant Physician to University College Hospital, and Physician to Out-patients, the Hospital for Sick Children, Great Ormond, etc., etc. London: Henry Frowde and Hodder & Stoughton. Toronto: The Canadian Law Book Company, 32-34 Toronto St., at 40 per cent. discount. 1907.

Dr. Poynton is so well known by his writings on the bacteriology of acute rheumatism that a work from him on heart

disease and aneurysm is read with unusual interest. This little book of some 300 pages, as one might expect, deals with the subject from both pathological and clinical standpoints in a very concise, practical and up-to-date manner. The author states that the diplococcus rheumaticus, described by himself and Paine, is the infective agent in both simple and ulcerative endocarditis, the tonsil being the common port of entry. While all may not yet be prepared to accept the author's claim as fully established, there is no doubt a growing disposition in favor of his views.

The book is of convenient size, and is worthy of a place in the busy physician's library. H. B. A.

Diseases of the Larynx. By HAROLD BARWELL, M.B., London, F.R.C.S., Eng.; Surgeon for Diseases of the Throat, St. George's Hospital; Laryngologist Mount Vernon Hospital for Diseases of the Chest; Consulting Surgeon for Throat and Ear Diseases, Cripples' Home for Girls; Consulting Laryngologist, National Association for the Establishment and Maintenance of Sanitaria for Workers. London: Henry Frowde, Oxford University; Hodder & Stoughton, Warwick Sq., E.C. This book can be procured from the Canada Law Book Company, 32-4 Toronto St., Toronto, at 40 per cent. discount.

This is another one of the Oxford Medical Manuals which should appeal strongly to the practitioner and student who wish to have diseases of the larynx plainly and concisely under review. This is a splendid little book and one which should be very popular. The illustrations are also exceedingly well chosen.

P. G. G.

BACTERIOLOGICALLY CLEAN MILK*

The subject of a pure milk supply, especially for the use of the sick, is one of the utmost importance. Since the appointment by the Academy of Medicine, Toronto, of a Milk Commission to go into the subject of Toronto's milk supply this topic has been brought quite prominently under the attention of the public generally.

That a large percentage of cases of sickness in Toronto, during the past decade, have been due to nothing more or less than the impure milk that has been delivered to the citizens generally there is no question. The list of such cases is always largely increased during the warm weather, on which we are now entering, so that it is felt that medical practitioners will be keenly interested at this particular season in knowing what is being done by at least one large city dairy in their attempt to supply the medical profession with a clean, pure milk. Erindale Farm was the first to receive the seal of the Academy of Medicine for the purity of their milk. Messrs. Price & Sons, Limited, heralded with pleasure the Academy of Medicine Milk Commission and expressed their willingness to immediately live up to any regulations that might be enforced. This firm have always expressed a keen desire to supply milk that will be found as nearly as possible free from all bacteria, and, judging from the recent reports they have received from the Commission, their efforts have met with success, one of the recent analyses made showing that Price's milk contains less than five hundred bacteria to the c.c. This condition of affairs will undoubtedly redound to their credit and be the means of instilling the greatest confidence on the part of the public in their product.

Judging from the Commission's requirements being lived up to by Erindale Farm and the fact that Messrs. Price & Son are receiving every month certificates of the most favorable character, goes to show that they are trying to conduct their dairy on truly scientific principles.

* Publisher's Department.