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Original Articles

THE OLD AND THE NEW GYNECOLOGY.*

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When I received the cordial invitation from your Secretary to address you for a few minutes on a theme which may seem to be somewhat hackneyed, I hesitated long before accepting the honor; first, because of my aversion to public speaking, and secondly, because I could not seem to hit upon a topic of general interest. Finally, I concluded that, since I had been engaged in special work for just twenty-five years, under conditions that favored a thorough acquaintance with the many changes which have occurred in obstetrics and gynecology during that period, you would pardon me if I ventured to gather up the tangled threads of my personal experience and give them to you for what they may be worth. Such a paper must necessarily be of a rambling character, because the field is too vast to cover in one, or in several, evenings.

I cannot help contrasting the present relations of my fellow-countrymen with our brothers "across the border" with those which existed a quarter of a century ago. Then we were strangers, distant and reserved; now we are indeed colleagues and *friends*. Our hearts are still filled with the same grief which saddens yours. We wept with you over the grave of the "Peacemaker," that kind and gentle spirit, a true democrat, but "every inch a king," who did so much to remove ancient prejudices and to make us all feel

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that we have one common mother country. Thank God, we are no longer strangers. There is a broad, well-beaten trail between your fair land and ours. You may build your prospective fleet of battleships, but the friendly invasions cannot be stayed.

In medicine, especially, we have a common interest, nor do we need to quote the well-known saying of Voltaire: "Il n'y a pour quiconque pense ni Francais, ni Anglais; celui qui nous instruit est nôtre compatriote."

I am especially desirous of emphasizing the progress of the obstetric and gynecic arts because, at the present day, one hears on every side that gynecology as a specialty is on the wane; that it has outlived its usefulness and will soon be merged in general surgery. It would hardly be necessary to deny this statement before an audience of medical teachers, for never before has greater attention been paid to these allied subjects in our colleges. Witness the recent report of the Committee on Obstetrics and Gynecology of the American Medical Association. But it is undeniable that such an impression does prevail among the profession. Before I sit down I hope to convince you that we have just begun to touch upon the mysteries of the pelvis, and that, so far from being moribund, gynecology has a future even more glorious than its past. If I were in the least disposed to be egotistical, such a feeling would always be dispelled when I call before my mental vision a quiet library in my native city, to me a shrine, where sits day after day in serene, beautiful old age, my (yes, *our*) dear friend and teacher, Dr. Thomas Addis Emmet, long past fourscore, with eye undimmed and mind as clear and vigorous as it was twenty-five years ago. Always studying and writing, always cheerful and optimistic, though long since retired from active practice, he is still a keen observer of current events. He is the old and the new, the spirit of eternal youth. "My work is done," he said to me not long ago, "and I am waiting for the call." As our poet-naturalist has beautifully expressed it:

"Serene I fold my hands and wait,
For lo! my own shall come to me."

When we think of *his* half-century of work, and work that will endure long after our little ephemeral tasks are finished and forgotten, we of the younger generation must feel humble indeed.

"I know so little," said that great pioneer of abdominal surgery, Keith, when asked why he had made such infrequent

contributions to the literature. In such a spirit let us review the little that we have done in gynecology, and think of what remains to be accomplished.

In his scholarly presidential address before the American Gynecological Society in 1896, Dr. William M. Polk presents an admirable summary of the advances in obstetrics and gynecology since the birth of the Society, twenty-one years before. Ten years more have passed, and we can chronicle still greater changes, not only in the line of improved surgical technic, but, what is to me far more gratifying than mere operative statistics, the scientific application to diagnosis and treatment of the facts furnished by the patient workers in the laboratory. It is unnecessary to remind you to what degree bacteriology has aided us during the last decade, or how the misnamed "luck" (I hate that word) of the past has become the calm certainty of to-day. Gynecology and Obstetrics, especially the former, have suffered most at the hands of their over-enthusiastic followers. In no branch of medicine have there been so many fads and fancies, so much of what old Virchow humorously denominated "Gehirn-schweiss; keine echte Secretion." It seems almost incredible to us, who have passed through the storm and stress period, that such wild and varied theories could have been championed by such distinguished leaders of medical thought. Rivers of ink (and blood) flowed in the days when that brilliant meteor of science, Lawson Tait, flashed across the sky. His pen was almost as mighty as his sword, and rash were those who entered into a controversy with him. The mighty impetus which he gave to abdominal surgery has reached its highest level in that little town in Minnesota, whither we all wend our ways to learn real lessons, not only in surgery, but in that broad humanity which makes one feel that the spirit of the Great Physician still broods over this commercial age. From Birmingham to Rochester, from Tait to the Mayos, is a far cry; but let us not forget what we owe to the brilliant, though erratic, surgeon who at one time rightly boasted that he "tapped the clientèle of the world."

I shall never forget, on my return from foreign study in 1884, whither I had gone fresh from the school of Sims and Emmet and Thomas, returning with a mixture of advanced German and conservative English views, to find that Tait had thrown the surgical world into a ferment by forcing upon its attention not new theories, but convincing *facts*. Thomas, quick to assimilate recent ideas and prompt to work them out practically, had already begun to diagnose and operate for tubal disease. I recall the fact that,

long before this time, as his interne in the Woman's Hospital, I had assisted him in the first vaginal ovariectomy and ventro-fixation, operations which were original with him, as he knew little of German surgery and less of pathology. It was only a step to the diagnosis and operative treatment of ectopic gestation, hitherto regarded as a condition to be treated by electricity before rupture and "expectantly" afterward. Then came the *furor operandi*, which swept over the United States and Canada, until he who could not report a series of laparotomies (with a mortality of 25 per cent.!) could not lay claim to be even a local gynecologist. Strangely enough, at this very time puerperal sepsis was still regarded as a "visitation of Providence," and Thomas himself was advocating intra-uterine douches at intervals of two or three hours (!)—also with a high mortality—and we knew practically nothing about the prevention of the dread scourge of the lying-in room. Conservatism was most unpopular in those days, and thousands of prolapsed, slightly cystic ovaries were sacrificed, which to-day would not be touched, with dismal psychical sequela, even when the patient recovered from the operation. Pathology and exact clinical diagnosis were lost sight of in the face of the prevailing dictum: "When in doubt, open the belly and find out."

Having early learned the truth of the old saying, "In *mediis tutissimus ibis*," I felt that a reaction was bound to come and that surgeons would realize that "recovery" was not synonymous with "cure," and took my stand firmly against the unreasoning and indiscriminate spaying of women in the absence of proper indications. I have lived to see the pendulum swing so far in the direction of ultra-conservatism that I have written several papers protesting against attempts to save portions of organs that were hopelessly diseased. With the visit of each foreign surgeon, we Americans (who excel even the French in the adoption of passing fads) have in turn extirpated the uterus in every case of adnexal disease. We have gone wild over the crude clamp-operation of Jacobs and Segond, have tried to improve on the normal ovary, à la Pozzi, by ignipuncture and partial resection, and have even abused such a reasonable operation as myomectomy by exsecting a few visible fibroids and leaving scores of smaller nodules to give future trouble. We have fixed every palpable kidney, removed the appendix on the single indication of local pain, shortened the round ligaments in cases of complete procedentia—in fact, have jumped from one extreme to another. I do not spare my countrymen, "*quorum pars fui*."

It is refreshing to note that the day of surgical fads has given place to psychological isms, in which, at any rate, less physical harm is done. I confess to an excusable sense of pride when I think what gynecology has done for abdominal surgery, though I admit frankly that the general surgeons have just cause for complaint because of the rapid extension of pelvic surgery to the abdomen. My conscience does not trouble me, for while I hold that every gynecologist should be prepared to deal intelligently with any complication that he may encounter in the course of an ovariectomy or hysterectomy, he has no right to deliberately perform an operation upon the gastro-intestinal tract which he has not done more than a dozen times. Gynecologists will learn in time to respect the old saying of Æsop, "Let the cobbler stick to his last."

On the other hand, our friends, the general surgeons, are not always at home in the pelvis. This is delicate ground, but "I speak that I do know." How often have I seen successful appendectomies fail to cure the patient because the surgeon was content to remove the offending organ alone, and did not discover accompanying disease of the right tube and ovary! So firmly has this been impressed on my mind that, even in an acute case, I usually explore the pelvis before searching for the appendix.

We have quite enough to do to perfect the arts of obstetrics and gynecology, between which there can be no legitimate divorce. If the medicine of the future is to justify the dictum that "prevention is better than cure," even though our pockets suffer at the expense of increased scientific knowledge, every practitioner who attends a case of labor must possess what Tyndall called the scientific imagination. "Fifty per cent. of my income is furnished by the obstetrician," said Dr. Emmet to me at the outset of my professional career, and we still count on the active co-operation of the accoucheur in that respect. It ought not to be so. Watch your obstetric cases throughout the entire period of gestation; know before labor begins when to expect dystocia. I abhor "meddlesome midwifery" as much as did the wise old English masters of obstetrics, and have little sympathy with the advanced (?) school, who would prepare every lying-in room as if for a laparotomy, and carry to an ordinary case of labor all the paraphernalia necessary for a Caesarian section. Nature is a tricky jade, but let us give her a chance. I doubt not that in large lying-in hospitals, the latter operation and pubiotomy have become unduly popular, to the exclusion of the premature induction of labor and skilful manual and instrumental delivery. Granted that the neurotic women of this generation are

radically different from their sturdy mothers and grandmothers, so much the greater reason that we should learn to handle them at least as skilfully as our teachers. When I remember how Isaac E. Taylor could coax the foetal head carefully and patiently through a contracted pelvis with his old-fashioned straight forceps, I do not feel very proud of my foetal mortality with the improved axis-traction. After all, we are not so much wiser than our predecessors, and do well to heed the injunction, "Remove not the ancient landmarks which the fathers have set up." But in one respect at least we have the advantage of our forbears. We can insure perfect asepsis, and can anticipate the work of the gynecologist by careful repair of lesions of the soft parts immediately after delivery. Let us no longer be content with saving the lives of the mother and child, even after the most difficult delivery. Let our ambition be to leave the mother in just as good condition as we found her. I shall not repeat, what I have so often written, that it is not enough to simply suture raw surfaces, but we must repair the deeper, invisible tears of the pelvic floor which are the direct cause of future displacements. Union of the lacerated sphincter ani (and he who has never had this accident has not had many difficult cases) must be deliberately and aseptically effected, with the confident expectation of primary union.

Let us not be content to dismiss an obstetric case two or three weeks after delivery. Examine the patient four or six weeks later and you will be surprised to find how often the uterus is retroverted, even after a perfectly normal confinement. Many of these displacements right themselves with simple postural treatment, and the majority are cured by the judicious use of a pessary. In fact, the late Dr. Paul F. Mundé, a strong, honest man, admitted as the result of his vast experience that these are practically the only cases which are really "cured" by this useful instrument (about 5 per cent. of all cases of simple retroversion). Why not try one, and thus save the patient a subsequent Alexander's operation or ventro-suspension?

It is affirmed that sepsis should practically be an unknown factor in modern obstetrics. This may be true in well-equipped hospitals, where the mortality from this cause has been reduced to less than one per cent., but it is not the case in the homes of the poor, at least in New York City, where so many women are attended by midwives. The statistics of the Board of Health, as well as the experience of those who are connected with our public hospitals, still shows a most reprehensible proportion of septic

cases, even after normal labor. In fact, a prominent obstetrician recently stated in my hearing that there had been only a slight lowering of the death-rate from puerperal septicemia (excluding criminal abortion) during the past decade. This is a significant commentary on our boasted modern asepsis, and may well furnish food for serious thought. In my own experience, hardly a week passes in which I am not called upon to operate (often in desperate cases) for the relief of septic conditions which were clearly avoidable. We may well turn from our brilliant statistics of laparotomy, and ask if there is not more useful work to do in the line of prophylaxis.

The concentration of our minds upon abdominal operations inevitably diverted our attention from the less spectacular, but equally useful, plastic surgery. I distinctly remember when it was considered as rash and injudicious to repair a lacerated cervix and perineum at the same sitting; in fact, I assisted the late Dr. James B. Hunter at his first "combined" operation. Later, plastic surgery again came to the front, and numerous were the new methods of restoring the torn perineum. Flap-operations in perineorrhaphy and the closure of vesico-vaginal fistula, popularized by Tait, had their day, and were found wanting. Permanent results, not mere rapidity of execution, form the true test. Emmet was the first to call attention to the true pathology of so-called laceration of the perineum—that it is not simply a visible tear of the soft parts, but actual separation of the muscular fibres and fascia of the pelvic floor. Every subsequent operation of permanent value has been based on this sound anatomical principle. Any man who watches the arrest of the head at the lower third of the parturient canal must admit this, even if it had not been confirmed by careful dissections and studies of frozen sections. Earlier and more skilful application of the forceps has done much to prevent this lesion, while, as regards vesico-vaginal fistula—due to neglected labor—this has become literally a *rara avis* since the days when I was an interne in the Woman's Hospital, where Sims won his spurs for his successful treatment of this hitherto common and hopeless condition.

The classical cervix operation, once so common (and so abused as to apparently justify the sneer of foreign surgeons, that "one set of American gynecologists incised the cervix and another sewed it up") has given place to Schroeder's amputation. We hear little nowadays about subinvolution and "reflex neuroses" due to laceration. Dr Emmet himself admits that amputation is now the most useful operation to prevent the subsequent develop-

ment of carcinoma. I share in the enthusiasm of your distinguished Fellow, Dr. A. Laphorn Smith, that the general recognition of this fact has led to a notable diminution in the number of cases of epithelioma of the portio vaginalis, though I cannot agree entirely with him in view of the fact that the insidious disease, adenocarcinoma of the cervical canal, is still as prevalent as ever, and is unfortunately seldom recognized until the parametria have been invaded.

When I was a student and young practitioner the most experienced diagnostician had no eye, or sentient finger, except for coarse lesions. We rested long under the magic spell of Sims, the burden of whose song (as has been that of the French school) was the cure of sterility by operations on the uterus. His influence is still felt, and we continue to dilate and curette, regardless of the old dictum of Gross, that in a considerable proportion of our cases the husband, not the wife, is at fault. Various patent stems and sure cures have had their day. "*Donnez moi des chiffres, et je vous prouverai tout*" must be written on most tables of statistics. If we only had sufficient patience to wait for the results of collective investigation, instead of rushing into print with our own scanty experiences! We are so prone to jump at conclusions based on imperfect and ill-digested material!

Sterility is, and ever will be, the burning question in gynecology. I cannot pretend, in this short hour, to discuss it, and would only call attention to the fact that certain difficult problems, psychical as well as physical, are still unsolved. My own observations in the post-mortem room and at the operating-table have convinced me that in closure of the abdominal ostia of the tubes (whether due to simple or to mild specific inflammation) lies the solution of many of these cases which baffle the clinician because he can discover no palpable lesion, or history of former trouble.

A word in this connection as to the results of so-called conservative surgery of the adnexa for the cure of sterility. I never remove both ovaries and tubes in women of the child-bearing age unless they are hopelessly diseased, not because I have had such brilliant results as used to be reported, but because I believe that the retention of the function of ovulation and menstruation preserves the patient from much future misery. Under certain limited indications, I am ready to open the abdomen (with the full understanding on the part of the patient that the operation is more or less empirical) where I suspect occlusion of the tubes, and have been gratified to find that my inferences have sometimes been justified; but I am not yet prepared to advocate this as a regular procedure in doubtful cases.

Dysmenorrhea, its etiology and cure—how much do we really *know* about this common symptom, a favorite question with the examiner, which is answered glibly enough by the student? Why do a familiar type of neurotic young women suffer atrociously every month when, with all our experience, we can find no satisfactory cause for it? We may dilate, curette, remove cystic ovaries, or a “suspicious” appendix, fix a mobile kidney, suspend a retroverted uterus, but the pain still persists. Here is an essential difference between the old and new gynecology. We are just beginning to realize the importance of the psychological element in these cases, that the border-line between normal and abnormal menstruation is ill-defined, and that the rythmical, painless, uterine contractions which have been proved to exist during the menstrual flow in every healthy woman may easily become exaggerated under the influence of nervous disturbances, even though no lesions can be found, either gross or microscopical. No man can boast that he thoroughly understands a woman. Dr. Oliver Wendell Holmes was right when he described the successful doctor of the old school as one who studied the currents and counter-currents of the soul, as well as of the body. And then, too, the interesting question of intestinal toxæmia in its relation to pelvic disorders—how little attention the gynecologist, as well as the surgeon, has paid to this important subject! I sometimes feel as if, in the ancient phrase, “*Propter ovarium mulier est,*” we should substitute “*intestinum*” for “*ovarium.*”

We have only begun to touch upon the more obscure causes of amenorrhea, especially in young women who increase rapidly in adipose. The question of the internal secretion of the ovaries, and its bearing on metabolism, has always been a fascinating one to me. There is something deeper than mere anatomical changes in the uterus and ovaries, for under proper treatment the long-absent function of menstruation may return. Yet every day men dilate and curette to relieve this condition—true homœopathic treatment.

Curettement—its use and abuse—would fill a volume. Too often we resort to it because we don't know what else to do—a lame confession enough! Heed the warning of the elder Flint, in all therapeutics to remember first the injunction, “*Non nocere.*”

I have found in the trite subject of uterine displacements a great deal that still remains to be explained. Surgery has accomplished much for the relief of this condition, especially the ingenious Alexander-Adams operation, though its indications are now recognized as so limited that I question if there are many of us with sufficient experience to attempt it with the same confidence

as of yore. The most ardent advocate of extensive shortening of the round ligaments now numbers his operations by the scores instead of by the hundreds.

I am old-fashioned enough to believe in pessaries, because, in proper cases, and when we take the trouble to adjust them properly, they are valuable makeshifts. Most men nowadays do not bother to select their cases, and become easily discouraged if immediate relief is not obtained. Pessaries used to be legion, and a weird lot they were, almost as great curiosities to the present generation as the instruments unearthed at Pompeii. The prevailing idea that every retroverted uterus causes symptoms has long been disproved. You all have patients who would not know that their uteri were displaced if you did not tell them. If you examine women as a routine practice, four or six weeks after delivery, you will be surprised to find how often the heavy uterus sags backward, to resume its normal position under simple postural treatment after involution is complete.

I do not, of course, refer to those cases of adherent retro-displacement in which, after palliative treatment has proved unsuccessful, ventro-suspension or internal shortening is clearly indicated. While much time was lost, and patients were exposed to unnecessary suffering during the long course of tamponade to which they were formerly subjected, it must be admitted that shortening of the round ligaments—both extra- and intra-peritoneal—is often followed by an anatomical rather than by a symptomatic cure. What does a woman care how “successful” an operation is if she *feels* no better?

Uterine hemorrhage is another familiar theme. This symptom was once so easily explained. There was always a local cause to be found and removed by the surgeon, while most practitioners were content to try ergot—the *bête noir* of the scientific mind. What teacher of obstetrics and gynecology sees a case of hemorrhage in consultation, or reads an examination-book, without hearing a wearisome reference to this ancient remedy? We shudder at the remembrance of those barbarous subcutaneous injections employed for the “cure” of uterine fibroids, and have all had experience with the supposed “hour-glass contraction” of the parturient uterus, due to its baleful action, when given before the placenta is expelled. And as for its blind administration in cases of unrecognized uterine cancer—I do not care to dwell upon them. Ergot has done almost as much to cover up our mistakes in diagnosis as the undertaker—only nobody knows it. A patient with fibroids said to me only two days ago: “Why, doctor, I have

been taking big doses of ergot right along, and I flow worse than ever." Of course she did. The irregular, spasmodic contractions of the arterioles were naturally followed by increased vaso-dilation. I do not propose to touch upon the elementary points known to all, only to emphasize certain facts overlooked by our predecessors, but now generally recognized, that metrorrhagia is a most important symptom, which at once leads us to infer the possible existence of incomplete abortion, ectopic or carcinoma, and that menorrhagia means increased pelvic congestion due to the presence of either uterine or adnexal disease—always the possibility of climacteric influences. In brief, when there is bleeding, explore the uterus inside and out, and don't waste time with medication, hot astringent douches or tampons.

But these cases are not always as simple as they appear. It is a common experience with every gynecologist to encounter cases in which repeated curetting, with or without local cauterization, even atmocausis, so vaunted by the Germans (I do not speak of that fanciful procedure, ligation of the uterine arteries), all fail to arrest the flow, and it becomes necessary to extirpate the uterus in order to save the patient's life. The most careful microscopical study of serial sections of the organ fails to explain the phenomenon. We may talk of "hemorrhagic endometritis," "endarteritis" and other vague pathological conditions, but we are often obliged to acknowledge our utter ignorance of the *causa ultima*.

To properly review the progress that has been made in the treatment of uterine neoplasms, both benign and malignant, would require a separate monograph, but what we really know about the etiology and pathology of fibro-myoma and carcinoma could be condensed within a page. When I recall the frightful mortality of hysterectomy for fibroids with the extra-peritoneal clamp, and the boldness of those surgeons who first ventured to drop the stump back into the cavity, knowing the imminent risks of hemorrhage and sepsis, and think of our present technic, I feel justly proud of gynecology. But let us not forget that it was a general surgeon (Dr. Lewis A. Stimson, of New York) who first paved the way to successful supravaginal amputation by advocating previous ligation of the uterine arteries.

What more curious historical fact in medicine than the widespread enthusiasm over Apostoli's method of intrauterine galvanization, which led Keith to abandon hysterectomy for fibroids at the height of his success? How much was claimed for it, and how little was really accomplished!

With the remarkable diminution of the death-rate under the influence of modern asepsis came that mischievous tendency to

remove every fibroid of any size, merely because it was a neoplasm. I have thrown what little influence I may possess strongly against operative intervention in the case of small tumors without clear indications, and I am happy to see that a reaction is already setting in against indiscriminate resort to the unnecessary mutilation of poor women, who have troubles enough of their own without our suggesting new ones that had not occurred to them.

As to the true etiology of fibroids, we are still at sea. Personally, I believe that it will eventually be found that they are mainly of inflammatory or irritative origin (endarteritis?), but we have not yet sufficient evidence upon which to generalize.

I hesitate to approach the burning question of cancer of the uterus, because it is impossible to do justice to it in a few minutes. Perhaps I ought not to consider it at all, being an avowed pessimist with regard to the surgery of malignant disease of the viscera, and consequently a prejudiced witness. Statistics at the best are so imperfect and misleading. I never use the word "cure" in advising a radical operation for cancer of the uterus, nor do I believe that we can assign any limit of time after which we can confidently affirm that the dread disease may not recur. I have been bitterly disappointed after ten, yes, fifteen, years of waiting and hoping. The cardinal rule, to operate early and thoroughly, can only be followed when a case is absolutely favorable, and how few are such, in comparison with the vast army of the inoperable! It is a curious fact that while the general profession has learned to recognize promptly acute appendicitis and ruptured ectopic, thereby saving many lives, in spite of all the teaching and the flood of literature on the subject, the initial symptoms of cancer of the uterus are generally overlooked. It is the slight irregular bleeding which should at once arrest our attention, not the pain, foul discharge and cachexia, which in themselves usually denote that the disease has progressed beyond the sphere of surgery. We cannot expect our results to bear any comparison with those of the Germans until the general practitioner has learned (here, as he has abroad) to diagnose cancer in the initial stage. As to the choice of methods of operating, unquestionably the abdominal route appeals to the surgeon as the more thorough and scientific, though the mortality is still high, and the ultimate results are not what was anticipated. But in my early days less than ten per cent. recovered after the imperfect hysterectomy, then called "Freund's operation," while vaginal extirpation carried a heavy death-rate and early recurrence. We have much to encourage us, but let us not forget, when we speak of "radical" operations, that the con-

ditions in the pelvis and in the mammary region and axilla are so essentially different that no comparison is justifiable. As a matter of fact, no operator can confidently affirm that he has removed *all* the outlying foci of disease, even in the axilla, let alone in the pelvis.

Since such a large proportion of our cases of uterine cancer are susceptible only of palliative treatment, it is gratifying to note the greater attention now paid to the relief of inoperable cases, as compared with former days, when they were regarded as a sort of *noli me tangere*. It is one of the sad proofs of how soon really beneficent work is forgotten when we try to recall to a younger generation the remarkable results obtained by the late Dr. John Byrne, of Brooklyn, with the galvano-cautery. His papers, buried in the Transactions of the American Gynecological Society, are almost forgotten, except by those who knew that fine type of the old Irish gentleman, whose work was absolutely reliable, and was founded on what we now know as a sound pathological basis. I can only refer you to his original papers, and testify to the absolute accuracy of his statements.

The etiology and treatment of cancer is a subject of absorbing interest. Not more earnestly have the telescopes of the astronomical world been focussed on our rare celestial visitor than are the minds of patient observers in research-laboratories concentrated upon the problem of cancer—one so elusive, yet at times apparently almost within our grasp. I firmly believe that its cause and cure will be discovered, though hardly in this generation, and that serum-therapy, not surgery, will solve the problem. Now "we see only in part," and our brilliant operations must remain at the best largely empirical. We must learn to look beyond the operating-room, or our vision will become dim and contracted.

Much has been written of late about the utility of the radical removal of thrombosed veins in puerperal septicemia. I am ready to go as far as any man, but I confess to the same feeling of limitation in these conditions that exists in the case of cancer—a lack of definite knowledge as to the extent of the disease. Recent experiments at Bellevue Hospital in a series of desperate cases of general septic infection (confirmed by careful blood examinations) have inclined me to again give a fair trial to intra-venous injections of our new antistreptococcus serum, without any other treatment, since it has seemed in twenty per cent. of the cases that we were able to arrest and eventually eliminate infection admitted to be beyond the reach of surgery.

I have purposely avoided any discussion of the much-vexed question of the abdominal versus the pelvic route, since I believe

that each has its advantages. I have seen too many disasters follow a blind adherence to vaginal hysterectomy in complicated cases to desire to practise that method except in certain cases of sepsis and malignant disease. Now that the fierce controversies have ceased, it must be apparent to the candid observer that surgeons in general prefer to work with the aid of the eye, as well as the fingers, with the patient in Trendelenburg's posture, and the intestines carefully walled off with gauze. The question of the propriety of removing the appendix in every abdominal operation as a routine measure has always found favor with me (of course, under proper conditions), and I have had no untoward result in upwards of five hundred cases.

The questions of flushing the pelvic or abdominal cavity and drainage have been the battleground of abdominal surgeons during the past twenty-five years. Thanks to our present knowledge of phagocytosis and the wonderful absorptive power of the healthy peritoneum, we have learned that irrigation (except perhaps in desperate cases of diffuse septic peritonitis, or visceral wounds, with the escape of stomach or intestinal contents) is likely to do more harm than good, and we have reversed the former dictum: "When in doubt, drain." Our old teachers would turn in their graves to see the apparent recklessness with which we simply mop out pus and close the wound without drainage. It seems strange that the natural method of drainage per vaginam was not adopted earlier, though I know personally that Marion Sims tried it when I was a student. When he advocated laparotomy for gunshot wounds at the time of President Garfield's assassination he was regarded as a dreamer, but I remember the night in the old Chambers Street Hospital when William T. Bull—then a young and rising surgeon—had the courage to carry out this suggestion with brilliant success, and, like Byron, "awoke the next morning to find himself famous." Our modern methods are, after all, not new discoveries, but simply accretions of knowledge.

We can cast no reliable horoscope of the obstetrics and gynecology of the future which does not take into consideration the problem of medical education. When we recall the pompous lecturers of the old days, the dramatic surgical clinics, with their "gallery-plays" (and "cleaning up" behind the scenes), we can only compare them with the spectacular warfare of the Napoleonic era as contrasted with the cold, business-like, long-range annihilation of thousands which will mark future wars.

The substitution of recitations and demonstrations for formal didactic lectures, personal instruction of small sections of stu-

dents in the wards and operating rooms instead of in public clinics, where only a few can actually see and hear the teacher—that is the plan which is going to make the trained medical man of the future. But this is only a small part of our work, to fit the young practitioner to hold his own in the fierce competition of modern life. Let us try to inspire him with a love of knowledge for its own sake, not that he may merely coin it into filthy lucre. Let us fire him with an ambition to become an original investigator. Never before has the world had greater need of *men*, of men who set the honors which await scientific achievements above money. This is the age of reason in religion and in medicine. “He did the *deed*, why need he talk?” is the virile creed of your foremost apostle of English manhood. It is a hopeful sign in this outwardly flippant, pessimistic age, that beneath it all runs a deep current of serious, earnest thought, a sense of personal responsibility. After all, is not this the sum and substance of what we call education? As youth and its fair dreams recede, the realities appeal to us more. To those whose attentive ears can catch faint echoes of the waves of that shoreless sea on which we must soon embark, the opinions of men count less and less.

“What I gave, I have;
What I kept, I lost,”

is a quaint old epitaph on the tomb of an English knight whose name is long forgotten. Let us give ourselves more earnestly to the search after truth, and, having caught glimpses of that glorious vision, let us show it to those who succeed us, and to whom it will be revealed more clearly.

What of the gynecology of the future? I predict that the surgical side will become less prominent, that greater attention will be paid to accurate diagnosis and medical treatment. Not that operative technic has yet become crystallized into a permanent form as some believe. There is still room for many improvements. The gynecologist will recognize the propriety of restricting his work more closely to his legitimate field, and will not aspire to absorb the whole of visceral surgery, because no man has the right to perform at the expense of his patient an operation which he can not do well. And by the same token, the half-fledged specialist will be succeeded by the trained mind and hand of the mature man, who has devoted himself to one branch only, after having served a long, severe apprenticeship in general medicine and surgery. Prophylaxis will be the

key-note of future medicine, and the general practitioner will cease to be only the purveyor for the specialist. Doubtless further study of the functions of the ductless glands will throw new light on the physiology and pathology of the organs peculiar to women, and advance organo-therapy beyond the empirical stage. All the various isms are bound to result in some permanent good, as they have in the past. When we understand woman's complex nature better we shall be able to treat more intelligently her protean ailments of mind and body. Gynecology will cease to be regarded as an isolated specialty, but will be an integral part of the whole field of physical and psychical research.

I believe that some of us will live to see the realization of what the laity regard as a chimera, state control of marriage, so that it will no longer be said that we exercise less forethought in the breeding and upbringing of human bodies and immortal souls than we do in the care of our stock farms. This is not a visionary scheme, but it is being worked out even now. Darwin's theory is just as true as it ever was. There *must* be a survival of the fittest, and it is for us to make them fit.

If there is one thought above all others that tends to lower our conceit when we think that we have accomplished something of permanent value, it is the sure knowledge that it must be approved by the judgment of future generations, long after our ephemeral work has been merged in the Everlasting Whole. I know no more pathetic words than those written at the end of his autobiography by that mighty thinker, Herbert Spencer, who, looking back over a life in which he had deliberately sacrificed everything to pure science, asks: "What if there exist no comprehension anywhere?" We remember our own "great cloud of witnesses," the men whom we knew and revered so many years ago. Alas! to the younger generation they are mere names. "There were giants in those days," but with what incredulity do our students hear us speak of the pre-aseptic times, when (as Sir Astley Cooper said) a surgeon needed to have "the heart of a lion." As we compare their limited advantages with ours, their crude pathology, and the uncertainty attending every operation, we question if we would have dared what they dared, and would have accomplished what they did.

Twenty-five years hence our methods will undoubtedly have been long outgrown, our theories forgotten, our conclusions disproved. Be it so. Let us be content to add our little increment of knowledge and experience to the universal sum, toiling like the unconscious polyp in the ocean-depths, until upon countless out-

worn shells a fair isle "lifts its froned palms in air." It matters little what is our faith or creed, if we have learned the lesson of *service*, or when it is all over.

"Rest after toil, port after stormy seas,
Death after life, doth greatly please."

Friends and brothers, what better epitaph can we desire than the simple, manly leave-taking of your beloved King: "I have done my bit"?

A CASE OF RENAL CALCULUS WITH NEPHRECTOMY.*

BY W. WARNER JONES, F.R.C.S., TORONTO.

Mr. Chairman and Gentlemen:

My reason for reading this paper before you was that I thought it might serve to bring up some points for discussion relative to the diagnosis and treatment of renal calculus. In the majority of cases the diagnosis of renal calculus is fairly easy. In a suspected case with a history of pain in the loin and renal colic the patient is sent to be X-rayed, and the diagnosis is usually confirmed. In the vast majority of cases the X-ray plate or photo will show the stone—will tell its probable character and give its relative position in the kidney. But this is not always the case. Some calculi offer less resistance to the rays than other calculi—and the shadow is correspondingly faint. It goes without saying that the more expert the radiographer the more accurate will be the radiogram.

But, notwithstanding the greatest care, an expert will occasionally fail to reveal the stone, and one has several times seen an operation performed and a stone removed when the radiogram failed to show it. However, an occasional exception only proves the rule that "it is fairly safe to rely on the radiogram."

But X-rays are not everywhere available, and the physical signs must be carefully considered. The cardinal symptoms of pain in the loin and renal colic do not always mean stone—for sometimes extension of tuberculous disease to the ureter from a tuberculous kidney—where the wall of the ureter is thickened and its lumen narrowed—will give rise to renal colic. Here it is due to masses of

*Read before Canadian Medical Association, June 3, 1910.

debris—caseous material or blood clot—being obstructed by the narrowed lumen.

And, of course, one must remember that phosphatic stone is sometimes deposited in cases of tuberculous kidney. Here the examination of the urine for tubercle bacilli and the use of the cystoscope will help to clear the difficulty.

Several other conditions give rise to symptoms of renal stone and may cause difficulty in diagnosis. Neuralgia of the kidney is often present when the organ is movable, and one must remember that in movable kidney it is possible to get torsion of the pedicle, which will likely give rise to both pain and haematuria. Moreover, the fact that a kidney is movable or misplaced does not exclude it from either disease or calculus. Intermittent hydronephrosis and appendicular colic may both be mistaken for renal colic. New growth in the kidney is usually distinguished by the fact that the haematuria is not only very profuse but is apparently causeless and not improved by rest.

Paroxysmal pain of unknown origin may closely simulate the pain of renal stone, and the kidney has frequently been explored for this condition and nothing found. Renal embolism from heart disease and thrombosis of the renal artery occasionally but very rarely occur and cause difficulty in diagnosis.

The most valuable aid to diagnosis is the X-rays.

Having made the diagnosis of renal stone, two courses are open to the surgeon:

1. Extraction of the stone, or nephro lithotomy, and occasionally secondary nephrectomy may have to be done after nephro lithotomy.
2. Removal of the K. with the stone or nephrectomy.

The operation should not be delayed in the hope that the stone may be passed or dissolved by drugs.

Before proceeding to operate in a case of renal calculus, it is advisable to know the condition of the other kidney. This is important, because it occasionally happens that the kidney is found to be so badly diagnosed that nephrectomy is obviously indicated, and if the condition of the other kidney is known to be satisfactory one would proceed to perform primary nephrectomy and thus avoid the difficulties and dangers of a secondary nephrectomy. To investigate the condition of the other kidney, either the segregator or urethral catheterization may be used; of the two I think the urethral catheter is the more accurate.

Should the condition of the other kidney be unsatisfactory, it would not contraindicate the performance of nephro lithotomy, but rather would it urge one to advise immediate removal of the stone

so as to minimize the damage to the kidney containing the calculus. At the same time it would put one on one's guard not to do more than was absolutely necessary.

Occasionally one may meet with a case in which it is impossible to use the cystoscope because of stricture or abnormality of the urethra; then the patient must take his chance, and if the kidney is found to be so badly disorganized that nephrectomy is necessary the probability is that the other kidney is working all right or the patient would not be living.

I shall now proceed as briefly as possible to give a short account of a case.

Patient, a male, age 37. Had a perineal fistula six years ago. A year ago was operated on for perineal fistula, due to periurethral abscess. Never had any symptoms of kidney trouble until last Christmas, when he had pain in the loin, accompanied with formation of a swelling, evidently a perinephritic abscess. This was opened in two or three days, and at the same time nephrotomy was performed, and the pelvis of the kidney and ureter were explored and no stone was found. The kidney was found to be badly damaged and a drainage tube was inserted. The patient improved. Four months later Dr. Harvey Todd X-rayed the patient and found that the kidney contained numerous calculi embedded in its substance, and he was sent into the General Hospital under my care.

I cystoscoped him, and with the examination cystoscope saw that the right ureter was discharging pus freely and that the left was pumping clear urine. The patient had a stricture and several false passages, and I was unable to use the catheter cystoscope because of the stricture. There was a large tumor in the loin and a fistula from the previous operation.

Examination of the urine (24 hour specimen) gave 1.5% urea. No tubercle bacilli present. The left kidney was X-rayed also and found to be apparently normal.

Operation.—The lumbo-ilio-inguinal incision was used, and with the greatest difficulty, because of perinephritic inflammation, the kidney was freed. But the pedicle was greatly shrunken and it could not be delivered onto the loin.

Exploration of the kidney through a wound along the convex border revealed numerous stones embedded in the kidney substance and the kidney so badly damaged that nephrectomy must be done.

The ureter was isolated, ligatured and divided. The pedicle was transfixed and ligatured in situ with No. 4 silk and the kidney cut away.

A wound in the peritoneum was closed, and after placing a large drainage tube in the loin the wound was closed with interrupted silkworm gut sutures. The patient made an uninterrupted recovery.

One would draw attention to the total destruction of the kidney without symptoms until the development of perinephritic abscess.

Pathological examination after removal showed that the kidney had been almost entirely converted into fibrotic tissue. Numerous stones were imbedded in the calices and substance of the kidney. These would account for the slow fibrotic change, and the fact that they were fixed in the calices and not loose in the pelvis might explain the absence of symptoms.

A stone loose in the pelvis usually causes well-marked symptoms, and if "nosed" so as to block the ureter usually causes distension of the pelvis and calices, with destruction of kidney substance, and eventually pyornephrrosis.

The microscope showed chronic inflammation and the kidney parenchyma replaced by fibrous tissue.

APPENDICITIS IN CHILDREN.*

BY ISAAC WOOD, M.D., KINGSTON, ONT.

We know of no other subject in the range of medical science that requires more careful consideration from both the physician and surgeon than "Appendicitis in Children." The term "children" in this paper shall include all under fifteen.

For more than a century the ablest men of our profession have been devoting earnest thought and effort to the diagnosis and treatment of this disease, and yet it is to-day responsible for more deaths than any other acute abdominal lesion.

The history dates back almost a century. In 1812, Parkinson, a London physician, reported the first case of death from perforation of the appendix in a boy five years old. Villermay, in 1824, reported two deaths in children, after a brief illness, and in each case the autopsy showed a gangrenous appendix. In 1837, Bohr reported a case of perforated appendix in a boy ten years old, and Burne, in 1839, recorded a similar condition in a child of fourteen years.

*Read at Canadian Medical Association, Toronto, June 1-4, 1910.

About this time, Melier, a French physician, collected five cases, all of which occurred within a short period, and in his report of these he suggested:

1st. These conditions may not be so rare as they are supposed to be.

2nd. The appendix-*ceci* may be the primary seat of the disease.

3rd. Chronic suppurative tumors in the right iliac fossa may result from a primary lesion and perforation of the appendix.

4th. The possibility of surgical interference for these conditions may some day be conceived.

Melier's conclusions deserved greater recognition than was accorded them. He was evidently living in advance of his generation.

An important contribution to our knowledge of the subject was made by Goldbeck and Albers, who, after careful investigation of the origin and location of these inflammations, in the right iliac fossa, introduced the terms Typhlitis, Peri-Typhlitis, Cecitis, etc., to distinguish the several types of the disease. Up to this time the treatment of these chronic inflammations of the appendix-*cæci* was incision and drainage, but not before fluctuation appeared. In 1848, Hancock, an English surgeon, diagnosed inflammation of the appendix, and incised the mass without waiting for fluctuation, and to him must be accorded the honor of introducing the modern method of treating a diseased appendix.

Dr. Willard Parker, a well-known surgeon, of New York, was the next to report a series of four cases, treated by incision and drainage, one, at least, before fluctuation appeared. From his observation of these cases he concluded:

1st. That nature endeavored to throw a protective wall around the abscess.

2nd. That there was danger of this wall being ruptured by ulceration or over-distension.

3rd. That "a timely incision should be made, neither too early nor too late—not before adhesions had fully formed, nor after a short period before the maximum formation of pus had been reached—that is, from the fifth to the twelfth day." He further remarked that "gangrene and perforation were much more frequent in children than in adults, and were more dangerous because of the more rapid progress of the disease in children."

Parker's paper, published in 1867, marked a great advance in the evolution of our knowledge of the true nature of disease of the appendix, its pathology and treatment. The Willard Parker operation came into general use, and the treatment became more and

more a question of surgery. Up to this time, the writers were no doubt earnest seekers after the truth. They made careful and accurate observations, but they did not seem able to interpret or correlate the facts they observed. Their knowledge of typhlitis, peri-typhlitis and cecitis was vague and indefinite, and their conceptions of the origin, the pathology and the location of these conditions were in the suggestive rather than the positive stage. It remained for Reginald Heber Fitz, of Boston, to dispel the mists, clear away the misconceptions and bring order out of confusion. The essential features brought out in this paper (*Amer. Jour. Med. Sci.*, 1886, vol. 92, p. 32) were:

1st. That all these obscure conditions, known as typhlitis, peri-typhlitis, cecitis, etc., were only different stages of a morbid process beginning in the vermiform appendix, and that the word "appendicitis," used for the first time in this paper, was "coined" by him to call attention to the inflammation of the appendix as the primary lesion.

2nd. That an early diagnosis was imperative.

3rd. That an operation should immediately follow diagnosis.

4th. That the diseased appendix should be excised.

This paper, published twenty years later than Parker's, introduced a new and progressive era in the history of our subject. The literature of appendicitis has increased rapidly, and our knowledge has been wonderfully enriched. More than 3,000 journal articles, besides books and monographs, have been indexed in the Surgeon-General's Library at Washington since 1896.

In the study of this literature, one cannot but note the almost complete absence of any special reference to appendicitis in children. With few exceptions, recent writers have treated "appendicitis" as a disease common to all ages. Books written by Morris, Fowler, Deaver, Ochsener and others are replete with information on other aspects of the disease, but not a page or possibly even a paragraph is found to differentiate appendicitis, as it occurs in children and in adults. Among the exceptions, I may mention that Howard A. Kelley has given, in his 1909 edition of "Appendicitis and Diseases of the Vermiform Appendix," an excellent chapter on appendicitis in children, and for many of the facts in this paper I am indebted to this valuable work.

If we turn our attention to those special features which differentiate appendicitis in children and in adults, *Anatomically*, we find:

1st. That the appendix in the child is relatively larger and longer.

- 2nd. The walls are thinner; the meso-appendix is shorter, often less than half the length of the tube. This tends to kink or bend the appendix, and to limit the blood supply, especially to the distal half.
- 3rd. The entrance from the cæcum is funnel-shaped; the lumen is larger; the mucous membrane smoother and the valve of Gerlach often absent or ineffective; hence foreign bodies or morbid materials more readily find their way into the tube.
- 4th. The lymphoid tissue in the appendix of the child is more abundant and the blood supply is poor; hence destructive processes go on more rapidly, and the liability to gangrene and perforation is greater.
- 5th. The omentum is relatively smaller and less effective in walling off a gangrenous or perforated appendix.

Pathologically, we note:

- 1st. These inflammations of the appendix induce a greater effusion of serum in children than in adults.
- 2nd. That this effusion quickly becomes purulent.
- 3rd. The occurrence of gangrene and early perforation is more frequent in the child.
- 4th. That abscesses are more likely to form and to rupture in children than in adults.
- 5th. That there is greater tendency to spreading peritonitis. (Sprengel found 46.8 per cent. among his cases.)
- 6th. That intoxication of the system is more rapid and intense in children.

Clinically:

These differential features assume more than ordinary interest and importance. We have not time to discuss them in detail. We simply mention some of the general principles:

- 1st. That appendicitis in the child is more sudden in its onset, rapid in its progress and intense in its symptoms than in the adult.
- 2nd. That the unstable conditions of the nervous system (peculiar to children) may lead to confusion or error, and may delay or prevent a positive diagnosis.
- 3rd. That abnormal conditions are frequently met with in children which render the clinical phenomena vague and misleading; for example, right-sided pleurisy or pneumonia may simulate appendicitis, the pain, tenderness and rigidity being located in the right iliac fossa. Or

in abnormal positions of the appendix (common in children), the pain and other symptoms may be found on the left side of the abdomen, in the epigastric region or under the costal arch.

We feel that a due appreciation of the anatomical, pathological and clinical features already noted should enable us to not only differentiate appendicitis in children from the same disease in adults, but to set it apart as a subject for special and separate consideration in its diagnosis, its prognosis and treatment.

We are told by eminent authorities that "the diagnosis of appendicitis is generally easy." This may be true in adults; it is not true in children. The recognition of appendicitis in the early stages—when operation would be successful—is extremely difficult. The cardinal symptoms of appendicitis—sudden acute pain in the right iliac fossa, tenderness over McBurney's point, rigidity of the right rectus muscle, vomiting, elevation of temperature, acceleration of pulse, etc.,—which are quite constant in the adult, are irregular, uncertain, and have little diagnostic value in the child.

The prognosis of appendicitis in the child ought to be good. Compared with the prognosis in the adult, it is bad, very bad. In 1907, the average mortality for children in six large clinics was 19.23 per cent.; for adults it was 2.9 per cent.

Dr. J. B. Murphy says: "We should have no deaths from appendicitis"; but we have them. What are we going to do about it? Where does the responsibility rest for this terrible mortality, this veritable "slaughter of the innocents"?

From a careful review of the literature of appendicitis, and from observation, we have come to the following conclusions:

1st. That the occurrence of appendicitis in children is much more frequent than it is generally supposed to be. Selter found that appendicitis was seven times more frequent before the age of fifteen than it was from fifteen to thirty.

2nd. A large percentage of cases that occur are not diagnosed.

3rd. A large percentage of cases are diagnosed too late for successful treatment.

4th. That the current literature of appendicitis should be revised, and those features of the disease peculiar to children should be clearly set forth and strongly emphasized.

5th. Our "diagnostic senses" should be awakened and trained to recognize the earliest, the initial symptoms of the disease.

6th. Physicians and surgeons should be made to realize that an early diagnosis is imperative in the case of children.

7th. That diagnosis should be followed immediately by operation.

Reviews

Operative Surgery. W. I. DEC. WHEELER, M.D. London: Bailliere, Tindall & Cox.

This, the second volume of the work, is modeled after Treves' small operative surgery.

It contains some three hundred pages of well-written matter, and is very well illustrated.

Some new features are introduced, such as the modern method of doing Syme's amputation by dissecting from the front and using the foot as a lever instead of the tedious plan of freeing the heel flap. The author still advocates the V-shaped incision for epithelioma of the lip, a procedure which is responsible for the frequent recurrences. The author seems to have a mistaken idea as to the significance of the seat of election in leg amputation—that being applicable to the old bucket stump.

The book, while not intended for surgeons, should be welcomed by students, for whom it is well adapted.

G. E.

Disorders of Metabolism and Nutrition. VON NOORDEN. Part VIII. Inanition and Fattening Cures. Part IX. Technique of Reduction Cures and Gout. Authorized American Editions. Edited and translated under the supervision of Alfred C. Croftan, M.D., Chicago. Price, each, \$1.50. New York: E. B. Treat & Co.

Carl Von Noorden speaks with authority upon these studies. The two monographs are the substance of four lectures delivered in a post-graduate course to Vienna physicians in May, 1908. Based upon sound physiologic reasoning, they are limited to theoretical and clinical experience, and are, therefore, of value in actual practice. The lectures are on: Inanition and Undernutrition; Fattening Cures; Technique of Reduction Cures; Gout, Nephrolithiasis Urica and their Treatment. They are eminently a justly scientific deliverance upon these subjects.

The Pathology of the Living and Other Essays. By B. G. A. MOYNIHAN, M.S. (London), F.R.C.S., Honorary Surgeon to Leeds General Infirmary; Professor of Clinical Surgery at the University of Leeds, England. 12mo. of 260 pages. Philadelphia and London: W. B. Saunders Company. 1910. Cloth, \$2.00 net. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

This is a very readable, entertaining and instructive book of 260 pages. It is a volume of essays or addresses, which have previously been published in various medical journals, and now collected within covers. It goes without saying they will be read and admired,

not alone by surgeons, but by internists and general practitioners, with much profit. From the well-known proclivities of the author, almost every essay embodies much of thought and moment of the biliary apparatus. Probably the most interesting essay from the standpoint of the internist is the one dealing with "Inaugural Symptoms."

Practical Suggestions in Border Land Surgery. For the use of students and practitioners. By GUSTAVUS M. BLECH, M.D., Chicago. Philadelphia: Professional Publishing Company.

This little book is brimful of common sense, and may be read with much profit by all, especially the man who is youthful in surgery. Described as a big-little book, it is always concise, pointed, and possesses many original features.

International Clinics. Vol. II. Twentieth Series. 1910. Philadelphia, London and Montreal: J. B. Lippincott Company.

In this issue there are many good articles on Diagnosis and Treatment; Medicine; Surgery; Obstetrics; Dermatology; Paediatrics, Neurology; and amongst the miscellaneous topics is a very interesting article on physicians' "hobbies." Benedict writes a comprehensive review of the progress of therapeutics during the past twenty years, and James J. Walsh one on the progress of medicine in the same period. John G. Clark has a series of clinical lectures, which were delivered after Easter—home-coming week of the University of Pennsylvania. John B. Denver contributes clinical reports. Standing in a class by itself, *International Clinics* is a periodical every progressive practitioner would profit by having, as it covers the entire field of medicine.

A Text-Book of Medical Jurisprudence and Toxicology. By JOHN GLAISTER, M.D., D.P.H. (Camb.), F.R.S.E., Professor of Forensic Medicine and Public Health in the University of Glasgow, etc., etc. With 130 illustrations. Edinburgh: E. & S. Livingstone.

Everywhere cases in legal medicine and poisoning cases are frequently popping up, and the live medical man must needs in these have the latest and best productions on these subjects. This, the second edition of a work which was exceedingly well received in 1902, will be found brimful of the best in these lines. The present edition, owing to the comprehensive scope of the work, including medical jurisprudence, toxicology and public health matters, is being issued in two volumes. The text of this volume embraces 764 pages and deals with medical jurisprudence and toxicology. When complete the work will be a splendid exposition of these subjects, and will be found of the best benefit to students and practitioners of both medical and legal professions.

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COMMENT FROM MONTH TO MONTH.

Medical Education in the United States and Canada is the subject of Bulletin No. IV. of the Carnegie Foundation for the Advancement of Teaching. It is a rather bulky volume of 346 pages, and has been met with varying criticism at the hands of the medical profession, the medical press and universities, and medical schools and colleges: this, too, in spite of the fact that the President of the Foundation, Dr. Henry S. Pritchett, clearly states in his introduction the studies were taken to serve a constructive and not a critical purpose.

The report is indited by Mr. Abraham Flexner, brother of Dr. Simon Flexner, of the Rockefeller Institute, and—the President to the contrary notwithstanding—is a foreible and exhaustive criticism of medical educational methods and some medical schools and colleges in both countries.

Coming as the second of two thorough investigations—the first being by the American Medical Association—in the past five or

six years, it profits by the experience of the former, and savors somewhat of "the last word being said on the subject."

To Canadians, so far as medical education and existing institutions in this country are concerned, there is nothing very much new. The conditions here have long been evident, the defects apparent, and the short-comings quite well known. It is new, however, to us that even one of our medical schools is rated or berated as being as bad as anything in the United States, that country so prolific of educational institutions, where, if not now, then in the past, degrees and even "sheepskins" have been sold in the open market. We have no sectarian schools here in medicine, as the report says, so one in Canada cannot possibly be as bad as what obtains across the border. All our medical schools provide clinical and laboratory instruction, be it never so meagre; it is not apparently so in the United States. Surely not one of our schools is as bad as some of the eclectics, the homoeopathic, the physiomed; or yet the osteopathic.

The self-appointed critic seems to have some doubt anent the future of Queen's. We may tell him there is no doubt about it in this country. It has long been considered here one of our best institutions.

Withal we believe the report in general will serve a good purpose. It will stimulate to higher qualifications and much better instruction in every form, for in no one or two forms of teaching is to be found the best method, but in all combined.

That part of the report which deals with the sectarians the osteopaths, we commend for diligent reading and earnest digest to the powers that be, who may contemplate here in this or any other province of Canada, the enactment of legislation in the interests of those who in the pursuit of pure commercialism, would seek to set aside proper qualifications for those who are charged with the prevention and treatment of the ills flesh is heir to.

Ontario Medical Council.—That the medical editorial is of importance and exerts an influence of its own has surely been proven quite recently in Toronto. In the *Canadian Journal of*

Medicine and Surgery, the Managing Editor, Dr. W. A. Young, for several issues, has been calling in question the business methods of the Medical Council of the College of Physicians and Surgeons of Ontario. Taking his cue from the printed announcement of 1909, Dr. Young penned a series of irritating editorial articles, which attracted wide attention, not only amongst the medical faculty of the province and the medical press, but invaded even the public mediums. The climax came at the forty-fifth annual meeting of the Council in Toronto on the 6th, 7th, 8th, and 9th of June. Denied, repeatedly, statements of the finances of the Council in detail, Dr. Young carried the war into Africa, and during the actual sitting of the Council, wrote demanding that, as a member in good standing, he be given a detailed statement of the receipts and disbursements of the Council for the past three years. The weather at the time was exceedingly warm, and the Council Chamber occasionally superheated. Dr. Young gained his point partially, in that he was permitted, for his delectation and profit, to examine the books, to con and collate for himself.

President E. A. P. Hardy, of Toronto, opening the annual session, delivered the annual presidential address and set the ball rolling. He stated, in referring to the editorials in question, that he had refused, as President, to order the Treasurer to allow access to the books at the instance of Dr. Young, a member of the College, but not connected with the Council in any way, and, therefore, not responsible to any one. He was not to be dragooned by the irresponsible editor of a "flamboyant" medical journal. The proper place to discuss matters of this character was at the Council meetings, and not in the public press—Dr. Young's editorials were reproduced in the public press. This, we opine, is a level-headed sentiment, but does not well dove-tail with the freedom of access the lay reporter enjoys during the time of the Council meetings. Altogether there has been too much, far too much, publicity in this particular matter, if not, indeed, in all matters connected with the governance of the profession of Ontario through the medium of the Medical Council.

There are many eminent medical men of the Province of Ontario having seats in the Ontario Medical Council. Indeed, it

would be a difficult matter to get together a better body of representative men of the profession; but, somehow or other, the present Council does not appear to be able to conduct the financial affairs of that body successfully—hence the criticisms. Expenses are increasing; funds are diminishing. In 1909, when the receipts were the largest of any year in its history, the balance to the credit of the Council was \$48,359.41. By the date of the annual meeting this amount had declined to \$41,168.27. As there has been a gradual diminution in capital, it is little wonder that Dr. Young, or even someone else, has pointed out that a continuance of this state of affairs would in the end lead to bankruptcy. Numerous were the suggestions to save. One member would cut out the per diem allowance to members; another would appoint men on committees who would not have far to travel; still another would do away with examinations at other places than Toronto; a fourth would close out the additional examination in the fall; a fifth saw a remedy in the appointment of a chartered accountant as auditor, and so on, even to reducing the number of territorial representatives, the university representation, and the homoeopathic representation. If decided action had been taken on all these suggestions, we trow, the Council would have come pretty nearly to squaring itself with the electorate.

So far as the representation on the Council goes—it numbers 32—it would have been wise for the present Council, even though it is a moribund body and next elections take place in December of the present year, and this, therefore, being the last session of the Council, for it to have placed itself on record as favoring a reduction in the representation. Dr. J. S. Hart, of Toronto, who proposed this resolution, must have been chagrined when his resolution was characterized “an electioneering dodge.” It is one of the best possible reforms which could emanate from within the body, as there are, unfortunately according to law, men sitting, who represent, if they can represent, defunct institutions; nor need one pass any comment upon the necessity of a speedy reform of the homoeopathic representation, five sitting and voting upon the conduct of the profession throughout Ontario (numbering over 3,000), sitting

there, speaking, directing, voting and representing a paltry "pocket borough" constituency of thirty odd. It is the principle which is wrong, not the men.

Toronto University sent a deputation from its medical faculty, consisting of Professor McPhedran, Professor Irving H. Cameron and Professor Alexander Primrose, asking that the annual examination period be postponed until after the month of May. Dr. McPhedran was the chief spokesman. He called the attention of the Council to the fact that their requirements called for an eight months' session, but it was made impossible for the University to carry that out, as the Council examinations were held too early. Owing to the enormous amount of work the medical student has to get over now to what he had to do ten years ago, the deputation asked that the time be extended to give the student some time for private thinking and private reading. The present tendency, according to Dr. McPhedran, was for the student to get information without knowledge, and so not be able to apply what he learns. Dr. Primrose, in supporting Dr. McPhedran, said they could not begin the term earlier than October, as that had been tried at McGill and had to be abandoned. Mr. Cameron gave his moral support to the requests. The Council promised consideration.

Medical Health Officer for Toronto.—The deadlock in connection with the appointment of medical health officer for Toronto has been broken by the reappointment of Dr. Charles Sheard to that position. Some months ago Dr. Sheard resigned after a service of some seventeen years; and during this period the Board of Control of Toronto has been struggling with the appointment of a successor. Dr. Charles Hodgetts, Toronto, was offered the position, but declined. Dr. Hodgetts has recently resigned from the secretaryship of the Ontario Board of Health to accept the position of medical director of the Canadian Conservation Commission. Dr. John Amyot, bacteriologist of the Ontario Board of Health, was strongly favored by the Toronto profession for the position, but he, as well as Dr. C. J. C. O. Hastings, could not muster the required number of votes in Council for appointment,

so Dr. Sheard was reappointed. Either would have made excellent officials. Dr. Amyot has recently succeeded to the chair of hygiene in the University of Toronto, vacated through the resignation of Dr. William Oldright.

The Extermination of the Fly is becoming an important feature of sanitation. How to deal with the fly nuisance is the title of a card issued by the Department of Agriculture, which might well be hung in every kitchen, restaurant and other places where these pests abound. Any physician can secure cards by addressing the Entomological Division, Central Experimental Farm, Ottawa.

News Items

FROM BULLETIN No. IV.—CARNEGIE FOUNDATION.

In the United States and Canada there are 3,533 professors and 4,828 instructors, teaching 23,927 medical students. The annual income from fees is \$2,896,744.

Canada, with an estimated population of 6,945,228, has 6,736 physicians, a ratio of 1 to 1,030.

In the United States there are 32 sectarian medical schools: fifteen are homoeopathic, eight eclectic, one physiomedical, eight osteopathic. In Canada there is none.

One osteopathic school in the United States has a student body of five hundred.

Medical students are distributed in the different Canadian institutions as follows: Winnipeg, 115; Halifax, 63; Kingston (Queen's), 208; London (Western), 104; McGill, 328; Laval, Montreal, 217; Laval, Quebec, 92; Toronto, 592. Total, 1,719.

Winnipeg General Hospital has 400 beds; Victoria General Hospital, Halifax, 200 beds; Kingston General Hospital, 80 beds. Toronto General Hospital, 500 beds; Montreal General and Royal Victoria about 500 beds; about 250 beds in Notre Dame and Hotel Dieu. These are available for clinical purposes.

The number of women medical students in Canada and the United States in 1909 was 921, and the number of women graduates, 162. These numbers seem to be diminishing, now that they have free access to the medical profession. In 1904 the number of students was 1,129 and the graduates 254.

The increase in Canada's population last year was 239,516, requiring 160 new physicians; losses by death are estimated at 90 (too many). At this rate, 250 doctors are required each year in Canada. According to the report, these could be sent out by McGill, Toronto, Laval at Quebec and Manitoba.

Manitoba Medical College collects \$14,000 annually in fees; Halifax, \$5,000, and \$1,200 from the Provincial Government;

Queen's, \$19,978; Western, \$11,590; Toronto, \$64,500; McGill, \$43,750, and in addition an endowment of \$350,000, making its budget reach \$77,000.

The teaching staff of Manitoba is 22 professors and 19 of other grade; Halifax, 16 professors and 17 others; Queen's, 16 professors, 22 others; Western, 8 professors, 12 of other grade; Toronto, 27 professors, 41 of other grade; McGill, 19 professors, 80 of other grade; Laval, Montreal, teaching staff eight; Laval, Quebec, teaching staff, 22.

The United States has a negro population of ten millions and seven medical schools for negroes.

There are three women's medical colleges in the United States; combined schools, 94; co-educational medical schools, 91.

The eight osteopathic schools in the United States now enroll over thirteen hundred students, who pay some \$200,000 annually in fees.

There are 13 post-graduate medical schools in the United States.

In New York State, homoeopaths, eclectic and osteopaths making together but a negligible proportion of the practising physicians of the State, have together a majority on the State Examining Board.

In Germany there are twenty-two medical schools; in the United States, 155.

While the population of the United States increased 5,000,000 from 1904 to 1909, the medical student-body decreased from 28,142 to 22,145.

The average annual production of doctors in the United States from 1900 to 1909 was 5,222. In June of 1909 the number had dropped to 4,442.

ACCOMPANYING his annual letter, in which he asks the readers of THE DOMINION MEDICAL MONTHLY to send him the names and post-office addresses of any boys or girls, known to them, whose eyesight is so defective that they cannot attend the Public Schools with advantage, Principal Gardiner, of the Ontario Institution for the Education of the Blind, at Brantford, sends us a card on which

he has printed, without ink, the letters used by the blind in their reading. These letters are composed of raised dots or points, arranged in two horizontal rows, and the combinations of points that have been contrived to represent the various literary, numeral and musical characters are most ingenious. Point letters are much easier to read with the fingers than line letters, and blind children soon learn to read and write words, figures and music signs, the writing being done with a steel stylus and a brass frame which they call a slate. The School for the Blind is maintained by the Ontario Government as a part of our free school system, under the supervision of the Minister of Education, and the Principal will promptly answer any letter of inquiry concerning the school and its work.

ESTEVAN, Sask., is building a cottage hospital.

DR. T. G. RODDICK, Montreal, has sailed for England.

VICTORIA, B.C., will raise \$45,000 for an Isolation Hospital.

EDMONTON, Alta., has voted \$175,000 for hospital construction.

DR. A. J. FRALEIGH, Toronto, has been on a visit to the Pacific Coast.

DR. J. M. ROGERS, Ingersoll, Ont., has been visiting in California.

DR. DENMAN ROSS, Harvard University, is visiting in Vancouver.

DR. H. G. MCKID, Calgary, has been on a visit to Toronto and Montreal.

DR. D. MCGILLIVRAY, Toronto, has been visiting Western Canada.

DR. GRAHAM CHAMBERS, Toronto, is spending July and August in Maine.

THE Victoria Hospital at Fredericton, N.B., is to be greatly enlarged.

DR. JOHN B. MURPHY, Chicago, is the President-elect of the American Medical Association.

DR. E. E. KING, Toronto, is spending August at his summer home in Hastings County, Ontario.

DR. CHAS. F. MARTIN, Montreal, has been elected President of the Montreal Medico-Chirurgical Society.

DR. ALEXANDER HUGH FERGUSON, Chicago, has been elected President of the Chicago Medical Society.

DR. D. FULLER MCKINLEY, Preston, Ont., has retired from practice and will become a missionary to China.

DR. P. H. BRYCE, chief medical officer for the Department of the Interior, has returned from a trip to England.

OVER fifty cases of smallpox are in Brantford, and the authorities are considering ordering a general vaccination.

DR. J. D. MCKAY, Marion, Indiana, Trinity, '95, has been visiting in Toronto and his old home town, Whitby, Ont.

DR. A. H. BEATON, Superintendent of the Provincial Hospital at Orillia, has resigned after thirty-four years' service.

THE management of the Toronto Isolation Hospital is to be made the subject of a judicial enquiry in the near future.

THE Nova Scotia Medical Society has elected Dr. James Ross, Halifax, President, and Dr. J. R. Corston has been re-elected Secretary.

THE Daughters of the Empire, Vancouver, will erect a hospital for convalescents and incurables, which will be a memorial to King Edward VII.

DR. CHARLES DOHERTY, Superintendent of the New Westminster Hospital for the Insane, has been visiting similar institutions in Eastern Canada.

DRS. F. N. G. STARR, Helen MacMurchy and R. A. Reeve, Toronto, are in England, attending the annual meeting of the British Medical Association.

DR. BRYDENE-JACK, Vancouver, is in charge of the work of medical inspection of schools in that city. He personally examines about 10,000 children.

DR. W. H. B. ATKINS, Toronto, has bought 130 Bloor Street West, is making extensive alterations, and will remove there from College Street in the fall.

THE new wing for the Toronto Isolation Hospital is now under

construction, and will be ready for occupation about June 1st, 1911. It is to cost \$102,000.

DR. J. GEORGE ADAMI, McGill University, will represent the Canadian Association for the Prevention of Tuberculosis at the Tuberculosis Conference in Rome.

DR. MACKENZIE, Winnipeg, has been appointed surgeon to the Canadian Northern Railway from Fort William to Vancouver. He will reside in future in Victoria, B.C.

By the spring of 1912 it is expected that the out-patient and emergency departments of the Toronto General Hospital will be completed on their new site on College Street.

TYPHOID fever in Montreal last year claimed 212 deaths out of 1,892 cases. So far this year there have been 700 cases, with 150 deaths. The Montreal hospitals are again turning away cases.

DR. J. W. S. McCULLOUGH, Alliston, Ont., a member of the Ontario Board of Health for the past four years, has been appointed Secretary of the Board in succession to Dr. Charles A. Hodgetts.

THE Canadian Medical Protective Association now has a membership of about 700. The Society has nearly \$7,000 on deposit, and in 1909 only had to defend two cases, one of which was successfully defended, and the other still before the courts.

THE annual meeting of the Toronto Academy of Medicine was held on the 3rd of May. The books in the library now number 5,375, not counting duplicates. During the past year 292 Fellows paid \$10 each; 9 Fellows paid half-yearly fees, and 30 non-resident Fellows paid \$5 each.

THE Dominion Government will require three surgeons for the Canadian Navy. They must not be over thirty years of age, will receive \$4 per day for three years, and after that \$5 per day up to five years. At the completion of service, they will each be given gratuities of \$1,000 to \$1,500.

THE Maritime Medical Association has elected the following officers: President, Dr. E. A. Kirkpatrick, Halifax; Vice-President for Nova Scotia, Dr. G. E. Dewitt, Wolfville; Vice-President for P.E.I., Dr. H. E. McEwen, O'Leary; Vice-President for N.B., Dr. G. G. Melvin, St. John; Secretary, Dr. G. G. Corbett, St. John; Treasurer, Dr. D. C. T. Watson, Halifax. At the recent annual

meeting, in St. John, on the 21st and 22nd of July, Dr. Edward Archibald, Montreal, General Secretary of the Canadian Medical Association, made an address urging Maritime medical men to become permanent members of the Canadian Medical Association.

AMERICAN PUBLIC HEALTH ASSOCIATION TO MEET IN MILWAUKEE.—The American Public Health Association will hold its 38th annual meeting in Milwaukee, Wisconsin, September 5th to 9th next. Representatives from many of the national organizations working in the interest of public health have been invited to be present and to discuss methods for the correlation of the work of such organizations, and for co-operation, with a view to increasing efficiency and economy. Sanitary engineering will occupy a conspicuous place on the programme. This Association is the oldest national sanitary organization in the United States. Its membership extends over the United States, the Dominion of Canada, Mexico, and Cuba. Information concerning it can be obtained by addressing Dr. Wm. C. Woodward, Secretary, Washington, D.C.

THE Seventh International Congress of Dermatology and Syphilography will be held in Rome, September, 1911. Dr. Graham Chambers, Toronto, has been appointed Secretary for Canada.

Publishers' Department

A LONG-FELT NEED SUPPLIED.—The need for an abdominal supporter that will *do the work* is constantly being borne in upon the minds of the medical profession everywhere.

By the introduction of the Storm Supporter, this need is fully met. Invented by a physician, whose practice had taught her the great need of a perfect support in cases of abdominal weakness, it is made so that it can be adapted to any and every condition to which an abdominal supporter can be applied.

Its comfort and efficiency equally recommend it to those who use it. Sole Agent in Canada, Miss Trevorrow, 192 Jarvis Street, Toronto.

Dr. Hamill, Medical Broker, who conducts the Canadian Medical Exchange, 75 Yonge St., Toronto, for the purchase and sale of medical practices and properties, desires us to state that the inhabitants of several different villages throughout Ontario without a doctor have written him to try and induce some physician to locate therein. The population and area should warrant a practice of at least from two to three thousand yearly, cash. He will be pleased to furnish the names of those villages to any who think the opening would suit them. At the same time, to those wishing to buy a practice, he has a list of over twenty to offer, thus offering a short-cut to those in need.

COLONIC FLUSHING.—The supplementary treatment of intestinal disorders of children by irrigation of the colon is a method of treatment long used and invariably successful, if the proper technique is used and details carefully adhered to. These details include a properly medicated solution, a proper temperature and its introduction into the bowel by a suitable tube.

Since using Glyco-Thymoline, I have continued with that medicament, as I have found its use invariably followed with success. The temperature should be about 70° or 80° F. Ice-cold solutions I do not approve of as, in feeble children, serious collapse has often followed their use. Where the case is more acute, temperature

high, and patient's vitality little impaired, cold solutions may not cause such serious symptoms; but the warmer solution of Glyco-Thymoline fluid will, I am assured, reduce the temperature sooner by removing the bacterial factors more effectually.

The child, whose clothing must be removed, is placed on a table, on which may be laid a quilt covered by a rubber sheet, the buttocks raised slightly and body inclined and supported towards the right side. The receptacle for the solution, a glass irrigating outfit or fountain syringe, is suspended about three and a half feet above patient. A soft rubber catheter of the largest size is secured to the tubing of the irrigator. About seven and a half to eight inches from the catheter's distal end, a cotton bandage, whose edges are frayed, is wound around till a diameter of three and a half inches is reached. This permits a firm pressure around the anal orifice, and produces no discomfort to the child.

The catheter, well lubricated, is now carefully introduced, and the Glyco-Thymoline solution permitted to flow in advance of the tube, thus inflating the bowel and permitting an easy introduction. As the fluid is passing onwards the contour of the bowel may be seen, and a careful manipulation of abdomen will assist its advance. The amount necessary to fill the colon, as the ileo-cecal valve is the limit of irrigation, will be, for a child of six to eight months, from fourteen to sixteen ounces; a child of one and a half to two years, thirty to thirty-six ounces. The amount specified must be present in the bowel before the Glyco-Thymoline is permitted to run out. The flushing must be continued until three and a half quarts are used. If properly done, more than one irrigation in twenty-four hours in acute cases, or two in the same period of time for chronic conditions, will not be necessary.—T. D. LYONS, M.D., New York City.

THE ANEMIA OF THE NEPHRITIC PATIENT, like that of any organic disease or constitutional infection, is secondary in nature and is caused by, or is dependent upon, the original lesion or infection. There is, however, another element to be considered in this connection, *i.e.*, the influence of an iron-poor milk diet in increasing the degree of anemia from which the patient suffers. It is pretty generally conceded by authorities and clinicians of experience that a bland milk diet is best suited to the needs of the nephritic invalid, as the damaged kidneys are thus spared the irritation which results from the excretion of the products of the metabolic changes of the

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Blaud Arsenic and Nux Vomica

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Arsenical solution..... = 1 min.
Ext. Nux Vomica..... ¼ gr.
- No. 60 { Blaud..... = 10 grs.
Arsenical solution..... = 2 mins.
Ext. Nux Vomica..... ¼ gr.

Blaud Arsenic and Strychnine

- No. 61 { Blaud..... = 5 grs.
Arsenical solution..... = 2 mins.
Strychnine..... 1-50 gr.
- No. 62 { Blaud..... = 10 grs.
Arsenical solution..... = 2 mins.
Strychnine..... 1-50 gr.

Blaud Tonic Laxative

- No. 65 { Blaud..... = 10 grs.
Arsenical solution..... = 2 mins.
Ext. Nux Vomica..... ¼ gr.
Phenolphthalein..... ½ gr.

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meat proteids, etc. It is well known, however, that milk contains but an infinitesimal proportion of iron, and the patient who subsists entirely upon this fluid for any length of time is deprived of the food-iron that is normally supplied to the blood to maintain its hematin and hœmoglobin. This deficiency can be readily made good by administering *Perr'o-Mangan* (Gude) both during and after the milk diet period. This palatable, organic, ferruginous compound is entirely free from irritant action upon the kidney, and it does not disturb the digestion or cause constipation. The essential iron is supplied in tolerable and promptly assimilable form and the use of the remedy does not, in any way, interfere with such other treatment as the physician may see fit to adopt.

THE DOSE OF CODEINE.

Frænkel (*Munich. Med. Woch.*) claims that codeine must be given in larger doses than is generally used, in order that the full effect may be obtained, as codeine is from ten to twenty times less powerful than morphine. The proper dose should be two-thirds or three-fourths grain, and this amount may be given three or four times a day without any evidence of habit formation. The single maximum dose permissible is one and one-half grains, and maximum daily dose is four and one-half grains. For children the daily dose may be as follows:

4 years of age.....	1-6 grain
6 years of age.....	1-3 grain
8 years of age.....	2-3 grain
12 years of age.....	1½ grains

—*Meyer Brothers Druggist, July, 1910.*

HENRY WAMPOLE EXCURSION.—The first annual excursion of the employees of Henry K. Wampole & Co., Limited, where the whole laboratory took part, was held Saturday, July 23rd. The St. Louis and Arrah Wannah were chartered for the day and the trip was made up the Rideau Lake to the Rocky Narrows. About 120 of the employees, accompanied by a limited number of their most intimate friends, took part, and from the time the boats left Perth until their return it was a continual round of pleasure. In



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fact, it was, without doubt, the most successful and thoroughly enjoyable excursion that has been held in this vicinity. A substantial lunch was spread at the Rocky Narrows and was thoroughly appreciated by all. A programme of sports was arranged and very successfully carried out. After the sports a very enjoyable trip was made to the Ferry, supper being spread on tables on the lawn in front of the Coutts House. Much credit is due Mr. King for the excellent table which he placed before the assembled guests. After supper, the prizes were distributed to the successful winners in the different events of the sports. The entertainment programme was given from the St. Louis, and it was a surprise to many to find such talent contained in the laboratory. An early boat was scheduled to leave for Perth at 7.45, about thirty taking advantage of an early return home, while the majority remaining took a moonlight up the lake, returning to the Ferry in time for a dance. A delightful trip home brought to a close a day of good wholesome enjoyment, and great credit is due to the committee who made such splendid arrangements whereby the proceedings were put through to the satisfaction of every individual person who took part in the excursion. This is the first excursion in which all the employees participated, and it is the wish of all that there will be many more to follow. The following is a list of the prize-winners in the several events: 100-yard dash for men—1st, Dalton Affleck, a fishing rod; 2nd, Robt. Carr, pair cuff links. 50-yard dash for girls—1st, Miss Margaret Davis, silver thimble; 2nd, Miss Helen Hartney, silver cuff links. Needle race—1st, bonbon dish and watch fob, won by Miss Ivie King and Mr. John Lyon; 2nd, cream jug and pocket knife, won by Miss Litang and Benson Roche. 100-yard dash for men over 32—1st, pearl-handled knife, won by R. Leach; 2nd, half-dozen handkerchiefs, won by John Lyon. Potato race—1st, pair cuff links, won by Miss Helen Hartney; 2nd, cream jug, won by Miss Katie McCarthy. 50-yard dash for married women—1st, silver salt cellar, won by Mrs. Chaplin; 2nd, silver cuff links, won by Mrs. Hutchinson. Three-legged race—Pocket knife and neckties, won by R. Carr and D. Affleck. Running hop, step and jump—1st, pair cuff links, won by J. Hartney; 2nd, necktie, won by R. Leach. Putting the shot—1st, pocket knife, won by W. Pennett; 2nd, troll, won by Joe Steacy. Throwing the baseball, girls—1st, half-dozen silver spoons, won by Miss M. Conlon; 2nd, brooch, won by Miss J. Dodds. 100-yard dash for all girls wishing to be married—(Heavy entries)—1st, a new greenback, won by ———; 2nd, a silver piece, won by ———. 50-yard dash for old maids—No entries.

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It is used mixed with fresh new milk, and forms a delicate and nutritive cream, which is enjoyed and assimilated when other foods disagree. It is entirely free from rough and indigestible particles which produce irritation in delicate stomachs.

The *Lancet* describes it as "Mr. Benger's admirable preparation." Mothers and interested persons are requested to write for Booklet "Benger's Food and How to Use it." This contains a "Concise Guide to the Rearing of Infants," and practical information on the care of Invalids, Convalescents, and the Aged. Post free on application to Benger's Food Ltd., Otter Works, Manchester, England.

Benger's Food is sold in tins by Druggists, etc., everywhere.

CUTANEOUS SYPHILIS.—A. Ravogli, Cincinnati (*Journal A. M. A.*, January 1), publishes the results of his studies, microscopic and otherwise, of the proliferating growths of syphilis. He remarks that in a short article on elephantiasis (*Jour. Cutan. Dis.*, 1906), presented to the American Dermatological Association, he had maintained the luetic origin of this condition when occurring in the genitals, in many instances. He also held that all cases of elephantiasis are started by the presence of infectious germs or of parasites causing irritation and lymph stasis. He goes at length into showing how the germ of syphilis acts in producing vegetating papillary growths, etc. His microscopic findings are illustrated, and he comes to the conclusion that the proliferating masses of the tertiary syphilitic ulcers show no special characteristics, but have common characters with the proliferations of other morbid processes. The imbibition of the tissues from the lymph stasis, the hypernutrition of the connective tissue corpuscles, cause their division and their proliferation. The normally limiting elastic fibres are gradually lost, and the collagenous elements are left free to proliferate without restraint. That the spirochete is a starting-point cannot be doubted, as they are shown in the secondary vegetating patches. In the tertiary, they were not found, but this does not disprove the above assertion. It is possible they are not so readily stained, or may be concealed in the deeper tissues. As regards treatment, it is not difficult to cure the secondary proliferated patches by internal constitutional treatment with external application of calomel or solution of mercurial chloride, one to five hundred. In some cases strong caustics may be necessary. In some cases other measures, like the use of iodide, local bathing with bichloride solution, one to one thousand, and local applications of mercurial plasters have been satisfactory, while in others, extensive curetting was required.

It is but just that I should attest my satisfaction with the use of Resinol Ointment. It is a marvel of efficiency in pruritus ani. Also in relief of soreness due to the irritation of the discharge from acute nasal coryza, it acts like a charm.—J. H. Thompson, M.D., Goshen, N.Y.