Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- ☐ Coloured covers / Couverture de couleur
- ☐ Covers damaged / Couverture endommagée
- ☐ Covers restored and/or laminated / Couverture restaurée et/ou pelliculée
- ☐ Cover title missing / Le titre de couverture manque
- ☐ Coloured maps / Cartes géographiques en couleur
- ☐ Coloured ink (i.e. other than blue or black) / Encre de couleur (i.e. autre que bleue ou noire)
- ☐ Coloured plates and/or illustrations / Planches et/ou illustrations en couleur
- ☐ Bound with other material / Relié avec d'autres documents
- ☐ Only edition available / Seule édition disponible
- ☐ Tight binding may cause shadows or distortion along interior margin / La reliure serrée peut causer de l'ombre ou de la distorsion le long de la marge intérieure.
- ☐ Additional comments / Commentaires supplémentaires:

- ☐ Coloured pages / Pages de couleur
- ☐ Pages damaged / Pages endommagées
- ☐ Pages restored and/or laminated / Pages restaurées et/ou pelliculées
- ☑ Pages discoloured, stained or foxed/ Pages décolorées, tachetées ou piquées
- ☐ Pages detached / Pages détachées
- ☑ Showthrough / Transparence
- ☑ Quality of print varies / Qualité inégale de l'impression
- ☐ Includes supplementary materials / Comprend du matériel supplémentaire
- ☐ Blank leaves added during restorations may appear within the text. Whenever possible, these have been omitted from scanning / Il se peut que certaines pages blanches ajoutées lors d'une restauration apparaissent dans le texte, mais, lorsque cela était possible, ces pages n'ont pas été numérisées.

THE

Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XVI. HALIFAX, NOVA SCOTIA, JANUARY, 1904. No. 1

PRINTED BY T. C. ALLEN & CO., 124 GRANVILLE STREET, HALIFAX, N. S.

McGILL UNIVERSITY, Montreal.

Faculty of Medicine, Seventy-Second Session, 1903-1904.

OFFICERS AND MEMBERS OF THE FACULTY.

WILLIAM PETERSON, M. A., LL. D., Principal.
C. E. MOYSE, B. A., LL. D., Vice-Principal.
T. G. RODDICK, M. D., LL. D., Dean.

J. G. ADAMI, M. A., M.D., Director of Museum.
F. G. FINLEY, M. B., Lond, Librarian.
E. M. VON EBERTS, M. D., Registrar.

EMERITUS PROFESSORS.

WILLIAM WRIGHT, M. D. L. R. C. S. | DUNCAN C. MacCALLUM, M. D., M. R. C. S. Eng..

G. P. GIRDWOOD, M. D., M. R. C. S., Eng.

PROFESSORS

Thos. G. RODDICK, M. D., Professor of Surgery.
WILLIAM GARDNER, M. D., Professor of Gynæcology.
FRANCIS J. SHEPHERD, M. D., M. R. C. S., Eng. Professor of Anatomy.
F. BULLER, M. D., M. R. C. S., Eng., Professor of Ophthalmology and Otology.
JAMES STEWART, M. D., Prof. of Medicine and Clinical Medicine.
GEORGE WILKINS, M. D., M. R. C. S., Professor of Medical Jurisprudence and Lecturer on Histology.
D. P. PENHALLOW, B. Sc., Professor of Botany.
WESLEY MILLS, M. A., M. D., L. R. C. P. Professor of Physiology.
JAS. C. CAMERON, M. D., M. R. C. P. I., Professor of Midwifery and Diseases of Infancy.
ALEXANDER D. BLACKADER, B. A. M. D., Professor of Pharmacology and Therapeutics.
R. F. RUTTAN, B. A., M. D., Prof. of Chemistry.
JAS. BELL, M. D., Prof. of Clinical Surgery.
J. G. ADAMI, M. A., M. D., Cantab. Prof of Pathology.
F. G. FINLEY, M. B., London, McGill, Assistant Professor of Medicine and Associate Professor of Clinical Medicine.
HENRY A. LAFLEUR, B. A., M. D., Assistant Professor of Medicine and Associate Professor of Clinical Medicine.
GEORGE E. ARMSTRONG, M. D., Associate Prof. of Clinical Surgery.
H. S. BIRKETT, M. D., Prof. of Laryngology.
T. J. W. BURGESS, M. D., Prof. of Mental Diseases.
C. F. MARTIN, B. A., M. D., Assistant Professor of Clinical Medicine.
E. W. McBRIDE, M. A., D. Sc., Prof. of Zoology.
T. A. STARKEY, M. B., (Lond.) D. P. H., Prof. of Hygiene.
JOHN M. ELDER, M. D., Assistant Prof. of Surgery.
J. G. McCarthy, M. D., Assistant Prof. in Anatomy.
J. T. Halsey, M. D., (Columbia) Assistant Professor of Pharmacology.

LECTURERS.

W. S. MORROW, M. D., Lecturer in Physiology.
J. J. GARDNER, M. D, Lecturer in Ophthalmology.
J. A. SPRINGLE, M. D., Lecturer in Applied Anatomy.
F. A. L. LOCKHART, M. B., (Edin) Lecturer in Gynæcology.
A. E. GARROW, M. D., Lecturer in Surgery and Clinical Surgery.
G. GORDON CAMPBELL, B. Sc, M. D., Lecturer in Clinical Medicine.
W. F. HAMILTON M. D., Lecturer in Clinical Medicine.
D. J. EVANS, M. D., Lecturer in Obstetrics.
N. D. GUNN, M. D., Lecturer in Histology.
J. W. STIRLING, M. B., (Edin). F. R. C. S., Lecturer in Ophthalmology.
J. ALEX HUTCHINSON, M. D, Lecturer in Clinical Surgery.
A. G. NICHOLS, M. A., M. D, Lecturer in Pathology.
W. W. CHIPMAN, B. A., M. D., F. R. C. S., (Edin.), Lecturer in Gynæcology.
R. A KERRY, M. D., Lecturer in Pharmacology.
S. RIDLEY MacKENZIE, M. D., Lecturer in Clinical Medicine.
JOHN McCRAE, B.A., M.D, Lecturer in Pathology.
D. A. SHERRS, M. D., Lect. in Neuro-Pathology.
D. D. MacTAGGART, M. D., Lect. in Medico.legal Pathology

FELLOWS.

W. THOMAS, M D. and L. Loeb, M.D., Fellows in Pathology. | G A CHARLTON, M. D, Fellow of Rockfeller Institute.

THERE ARE IN ADDITION TO THE ABOVE THIRTY-SEVEN DEMONSTRATORS AND ASSISTANT DEMONSTRATORS.

The College Course of the Faculty of Medicine of McGill University begins in 1903, on September 23rd, and wil continue until the beginning of June, 1904

The Faculty provides a Reading Room for Students in connection with the Medical Library which contains over 25,000 volumes—the largest Medical Library in connection with any University in America.

MATRICULATION.—The matriculation examinations for entrance to Arts and Medicine are held in June and September of each year.

The entrance examinations of the various Canadian Medical Boards are accepted.

FEES—The total fees, including laboratory fees examination and dissecting material, $125 per session.

Courses.—The REGULAR COURSE for the Degree of M. D. C. M. is four sessions of about nine months each.

DOUBLE COURSES leading to the Degrees of B. A. or B. Sc., and M. D., of six years have been arranged.

ADVANCED COURSES are given to graduates and others desiring to pursue special or research work in the Laboratories of the University, and in the Clinical and Pathological Laboratories of the Royal Victoria and Montreal General Hospitals.

A POST-GRADUATE COURSE is given for Practitioners during May and June of each year. This course consists of daily lectures and clinics as well as demonstrations in the recent advances in Medicine and Surgery and laboratory courses in Clinical Bacteriology, Clinical Chemistry, Microscopy, etc.

DIPLOMAS OF PUBLIC HEALTH —A course open to graduates in Medicine and Public Health Officers of from six to twelve months' duration. The course is entirely practical, and includes in addition to Bacteriology and Sanitary Chemistry, a course on Practical Sanitation.

HOSPITALS.—The Royal Victoria, the Montreal General, and the Montreal Maternity Hospitals are utilized for the purposes of Clinical instruction. The physicians and surgeons connected with these are the clinical professors of the University.

These two genpral hospitals have a capacity of 250 beds each, and upwards of 30,000 patients received treatment in the department of the Montreal General Hospital alone last year.

For information and the Annual Announcement, apply to—

T. G. RODDICK, M.D., DEAN. E. M. VON EBERTS, M.D., REGISTRAR,
McGILL MEDICAL FACULTY

HALIFAX MEDICAL COLLEGE,

HALIFAX, NOVA SCOTIA.

Thirty-Fifth Session, 1903-1904.

THE MEDICAL FACULTY.

ALEX. P. REID, M. D., C. M. ; L. R. C. S., Edin.; L. C. P; & S. Can. Emeritus Professor of Medicine.
JOHN F. BLACK, M. D., Coll Phys. and Surg., N. Y , Emeritus Professor of Surgery and Clinical Surgery
H. McD. HENRY, Justice Supreme Court; Emeritus Professor of Medical Jurisprudence.
GEORGE L. SINCLAIR, M. D., Coll. Phys.; and Surg., N. Y. ; M. D., Univ. Hal. ; Emeritus Professor of Medicine.
DONALD A. CAMPBEL, M. D., C. M.; Dal. ; Professor of Medicine and Clinical Medicine.
A. W. H. LINDSAY, M. D., C. M.; Dal. ; M. B , C. M.; Edin.; Professor of Anatomy.
F. W. GOODWIN, M. D., C. M., Hal. Med. Col.; L. R. C. P.; Lond ; M. R. C. S., Eng.; Professor of P armacology and Therapeutics
M. A. CURRY, M. D., Univ. N. Y. ; L. M., Dub.; Professor of Obstetrics and Gynæcology and of Clinical Medicine.
MURDOCH CHISHOLM, M. D. C. M. McGill; L. R. C. P., Lond.; Professor of Surgery and of Clinical Surgery
NORMAN F. CUNNINGHAM, M D. Bell. Hosp., Med. Col.; Professor of Medicine.
G. CARLETON JONES, M. D C M., Vind; M. R , C. S., Eng ; Prof. of Diseases of Children.
LOUIS M. SILVER, M. B., C. M., Edin.; Professor of Physiology and of Clinical Medicine.
JOHN STEWART, M. B C. M., Edin.; Emeritus Professor of Surgery.
C. DICKIE MURRAY, M. B , C. M., Edin.; Professor of Clinical Medicine.
GEO. M CAMPBELL, M., D., C. M , Bell Hosp. Med. Coll. ; Professor of Histology and Pathology.
F. U. ANDERSON, L. R. C. S., and L. R. C. P., Ed.; M. R C S, Eng.; Adjunct Professor of Anatomy.
W. H. HATTIE, M. D. C. M., McGill.; Professor of Medicine.
N. E. MCKAY, M. D., C. M. Hal. Med. Col. ; M. B., Hal. ; M. R. C. S., Eng.; Professor of Surgery, Clinical Surgery and Operative Surgery.
M. A. B. SMITH, M.D., Univ. N. Y.; M. D., C. M., Vind., Professor of Applied Therapentics, Class Instructor in Practical Medicine.
C. E. PUTTNER, PH. M., Hal Med. Coll.; Lecturer on Practical Materia Medica.
HOS. W. WALSH, M. D., Bell. Hosp. Med. Coll.; Adjunct Professor of Obstetrics.
A. I. MADER, M. D., C. M., Class Instructor in Practical Surgery.
H. S. JACQUES, M. D., Univ. N. Y., Lecturer on Medical Jurisprudence and Hygiene.
E. A. KIRKPATRICK, M. D., C. M., McGill. Lecturer on Ophthalmology, Otology, Etc.
E. H. LOWERISON, M. D., Lecturer on Ophthalmology, Otology, Etc.
H. D. WEAVER, M. D., C. M., Trin. Med. Coll., Demonstrator of Histology.
JOHN MCKINNON, LL. B.; Legal Lecturer on Medical Jurisprudence.
THOMAS TRENAMAN, M. D., Col. P. & S., N. Y., Lecturer on Practical Obstetrics.
E. V. HOGAN, M. D., C. M., McGill ; L. R. C. P. & M. R. C. S. (Eng.) Demonstrator of Anatomy.
J. A. MCKENZIE, M. D., C. P. S., Boston ; Demonstrator of Anatomy.
T. J. F. MURPHY, M. D., Bellevue Hospital Med. School. Lecturer on Applied Anatomy.
L. M. MURRAY, M. D., C. M., McGill ; Demonstratory of Pathology, and Lecturer on Bacteriology.
W. D. FORREST, B. Sc., M. D., C. M., Dal. ; M. R. S. C., Eng.: L. R. C. P., Lond.; Junior Demonstrato o Anatomy.
D. J. G. CAMPBELL, M. D., C. M., Dal.; Demonstrator of Histology.

EXTRA MURAL LECTURERS.

E. MACKAY, PH. D., etc., Professor of Chemistry and Botany at Dalhousie College.
————————, Lecturer on Botany at Dalhousie College.
———— ——, Lecturer on Zoology at Dalhousie College.
JAMES ROSS. M. D., C. M., McGill, Lecturer on Skin and Genito-Urinary Diseases.
S. M. DIXON, M. A.; Prof. of Physics at Dalhousie College.

The Thirty-Fifth Session will open on Thursday, August 27th, 1903, and continue for the eight months following.

The College building is admirably suited for the purpose of medical teaching, and is in close proximity to the Victoria General Hospital, the City Alms House and Dalhousie College.

The recent enlargement and improvements at the Victoria General Hospital, have increased the clinical facilities, which are now unsurpassed, every student has ample opportunities for practical work.

The course has been carefully graded, so that the student's time is not wasted.

The following will be the curriculum for M. D., C. M. degrees:

1ST YEAR.—Inorganic Chemistry, Anatomy, Practical Anatomy, Biology, Histology, Medical Physics
(Pass in Inorganic Chemistry, Biology, Histology and Junior Anatomy.)

2ND YEAR.—Organic Chemistry, Anatomy, Practical Anatomy, Materia Medica, Physiology, Embryology, Pathological Histology, Practical Chemistry, Dispensary, Practical Materia Medica.
(Pass Primary M. D., C. M. examination).

3RD YEAR.—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics.
(Pass in Medical Jurisprudence, Pathology, Therapetics.)

4TH YEAR.—Surgery, Medicine, Gynæcology and Diseases of Children, Ophthalmology, Clinical Medcine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination, Applied Aanatomy.
(Pass Final M. D., C. M. Exam.)

Fees may now be paid as follows;

One payment of	$300 00
Two of	155 00
Three of	110 00

Instead of by class fees. Students may, however, still pay by class fees.
For further information and annual announcement, apply to—

L. M. SILVER, M. B,
REGISTRAR HALIFAX MEDICAL COLLEGE,
63 HOLLIS ST., HALIFAX.

The Addition of Cow's Milk to Wampole's Milk Food

In no wise improves its eficacy, inasmuch as it already has the right amount of milk in it; besides, cow's milk contains an excess of casein, which the baby cannot digest.

By our process this excess of casein is removed, as well as the acid and other impurities which make cow's milk unsuitable for infants. Logically speaking, the baby can no more thrive on cow's milk than a calf at the breast of a woman.

Wampole's Milk Food

Can be prepared in a moment and at any time—anywhere—in the kitchen, in the bedroom, on the cars, by the roadside, or any place where water can be obtained.

It is sterilized in process of manufacture, is thoroughly cooked, and ready for use at any time of night or day by simply adding warm water.

Marketed only in glass containers which are securely sealed.

Samples cheerfully furnished without charge. Correspondence on the subject of artificial foods solicited, which will receive prompt and courteous attention.

MADE BY

HENRY K. WAMPOLE & CO.,

Specialists in Progressive Pharmacy,

Originators and Sole Manufacturers of "Wampole's Perfected and Tasteless Preparation of the Extract of Cod Liver Oil."

Main Offices and Laboratories, PHILADELPHIA, U. S. A.

Branch Office and Laboratory, TORONTO, CANADA.

THE GREASE OF A COD FISH'S LIVER

Is of no more value than any other grease. The virtue of Cod Liver Oil lies in the fact that it contains curative principles that are not grease nor greasy.

Only these active principles are contained in **WAMPOLE'S PERFECTED AND TASTELESS PREPARATION OF THE EXTRACT OF COD LIVER OIL,** which in solution are combined with equal quantities of Liquid Extract of Malt, the Compound Syrup of Hypophosphites, and Fluid Extract of Wild Cherry.

It is as palatable as Curaca, a delight and relish to patients—not an abhorrence as crude Cod Liver Oil or its emulsions.

Command us to send samples—the only expense to you will be the energy and time to try same.

HENRY K. WAMPOLE & CO.,

Specialists in Progressive Pharmacy,

Main Offices and Laboratories,

PHILADELPHIA, U. S. A.

Branch Office and Laboratory,
TORONTO, CANADA.

Antiphlogistine

PROPERLY APPLIED, IS UNQUESTIONABLY THE STRONGEST THERAPEUTIC FORCE IN SUCCESSFULLY WAGING THE MUCH TALKED OF

CRUSADE AGAINST PNEUMONIA.

ANTIPHLOGISTINE IS A SCIENTIFIC PREPARATION HAVING A DEFINITE PHYSIOLOGICAL ACTION, AND THAT ITS REMEDIAL VALUE MAY BE FULLY REALIZED, IT SHOULD BE USED WITH CAREFUL ATTENTION TO DETAIL.

ANTIPHLOGISTINE

APPLIED WARM AND THICK TO THE ENTIRE THORACIC WALLS, FRONT, SIDES AND BACK, AND COVERED WITH A CHEESE-CLOTH COTTON-LINED JACKET

Produces Immediate Results

BY INDUCTION OF CUTANEOUS HYPERÆMIA (FLUSHING THE SUPERFICIAL CAPILLARIES), IT BLEEDS BUT SAVES THE BLOOD. THUS, ALL THE DISTRESSING SYMPTOMS ARE AMELIORATED. THE OVERWORKED HEART, THE CONGESTION, THE PAIN, THE DYSPNŒA, THE RAPID AND DIFFICULT BREATHING ARE PROMPTLY RELIEVED. THE PULSE IMPROVES, THE TEMPERATURE DECLINES, AND REFRESHING REST AND SLEEP ARE INVITED.

THE PATIENT RECEIVES ANTIPHLOGISTINE IN PERFECT CONDITION WHEN THE PHYSICIAN PRESCRIBES ORIGINAL PACKAGES.

MARKETED ONLY IN FOUR SIZES—
SMALL, MEDIUM, LARGE AND HOSPITAL—
NEVER IN BULK.

THE DENVER CHEMICAL MFG. CO.

DENVER. LONDON. NEW YORK.

Blood Nourishment During Lactation.

At the time when a mother must share her food supply with her child the liability to systemic depletion is great. If the quality of the blood in the mother is allowed to fall below normal, the food of the child will not be of proper life-forming quality.

Pepto-Mangan ("Gude")

restores depleted conditions of the blood by feeding it with manganese and iron. It builds rich, red blood and is a nutrient and general reconstructive tonic.

Pepto-Mangan ("Gude") is ready for quick absorption and rapid infusion into the circulating fluid and is consequently of marked and certain value in all forms of

ANÆMIA, CHLOROSIS, BRIGHT'S DISEASE, RACHITIS, NEURASTHENIA, Etc.

To assure proper filling of prescriptions, order Pepto-Mangan ("Gude") in original bottles containing ℥ xi. *IT'S NEVER SOLD IN BULK.*

SAMPLES AND LITERATURE UPON APPLICATION.

M. J. BREITENBACH COMPANY,

Laboratory, Leipzig, Germany.

53 Warren Street, NEW YORK.

LEEMING, MILES & CO., Montreal, Selling Agents for Canada

THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

Communications on matters of general and local professional interest will be gladly received from our friends everywhere.

Manuscript for publication should be legibly written in ink on one side only on white paper.

All manuscript and business correspondence to be addressed to

DR. JAMES ROSS,
59 Hollis Street, Halifax.

CONTENTS FOR JANUARY, 1904.

ORIGINAL COMMUNICATIONS.

Further Notes on Mastoiditis, with Cases—W. G. Putnam..... 1
Strangulated Hernia with Unusual Sequelæ—D. Murray..... 8
Notes on some Drugs—Geo. G. Corbet 13
Practical Lessons from an Experience of more than One Hundred Cases of Eclampsia—Barton Cooke Hirst... 18
Douches—Vaginal and Uterine—N. S. Fraser 29

EDITORIAL.

Medical Witness Fees..... 32

SOCIETY MEETINGS.

Nova Scotia Branch British Medical Association. 34
Personals..... 36
Programme of N. S. Branch British Medical Association..... 36
Therapeutic Suggestions..... 37
Books Reviews.. 39
New Books Published..... 39
Notes..... 40

The Subscription Rate for the Maritime Medical News is $1.00 per annum.
Advertising Rates may be had upon application to DR. JAMES ROSS, 59 Hollis St

THE
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVI. HALIFAX, N. S., JANUARY, 1904. No. 1

Original Communications.

FURTHER NOTES ON MASTOIDITIS, WITH CASES.*

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

An experience of fifteen cases of mastoiditis in little more than three years is my excuse for bringing this subject once more before the Association. I will not bore you with a recital of my cases in detail, but will try to give a general analysis of them.

The age of these patients varied from one year to fifty-seven years. Of the fifteen cases, ten required the mastoid operation.

Causes.—In six of the cases, a severe cold may be ascribed as the cause, since there was apparently nothing else to which to ascribe it. In five the patients had sharp attacks of lagrippe. Three cases followed old-standing discharge from the ear, and one was due to improper use of the nasal douche. Just here let me condemn the custom of "sniffing up" irritating solutions into the nose, as many cases of acute middle ear inflammation are caused thereby.

Symptoms.—These have varied considerably, especially in the early stages. In those following O. M. P. C., all have been the same—a gradual lessening of the amount of the aural discharge, and a gradually increasing pain referred to the mastoid region. Then a swelling appeared behind the ear, which either "broke" or was opened.

In the other cases, all at first complained of earache more or less severe. Then pain was referred to the back of the ear, and the mastoid became tender to pressure. In all cases where the drum ruptured spontaneously, there was immediate relief so far as the earache was concerned, while the pain back of the ear was little changed.

*Read at meeting of Medical Society of Nova Scotia, Antigonish, July 2nd, 1903.

In those cases not seen early and proper treatment applied, redness and swelling over the mastoid occurred, and in four cases there was fluctuation at the time of operation.

Temperature and pulse vary. In one of my cases there was no disturbance of either, although operation showed a serious condition of affairs in the whole mastoid process. In all other cases there was some elevation of temperature and rise in pulse rate, but in no case was this of great amount.

Appearances—The external appearances varied from normal to marked swelling over the mastoid region, and some of the cases had old sinuses. In the canal, there was almost the same amount of variation. The cases of O. M. P. C. showed little or no drum membrane left, and in one there was a large polypus. In one case the membrana vibrans was practially normal while Shrapnel's membrane was bulging. In all the other cases, the drum as a whole was inflamed, and perforation had occurred in several. In every case which came to operation there was "sagging" of the postero-superior canal wall, and in two of the others it was present in a lesser degree.

The diagnostic points common to all cases were, pain back of the ear, and tenderness on firm pressure over some part of the mastoid process, together with inflammatory redness of some portion of the drum head and the "sagging" of the canal wall referred to before. I saw a case in the N. Y. Eye and Ear Infirmary in December last, in which the canal conditions were apparently normal. There was pronounced pain over the posterior part of the mastoid and marked tenderness on pressure, both of which persisted in spite of local treatment. The patient was kept in the Infirmary for a week and then operated on, when a large cell full of pus was found just under the tender point, and almost communicating with the sinus. The antrum contained only granulation tissue.

Treatment.—Three of the cases required immediate operation when seen. Seven others had free discharge from the ear when firs seen. These were ordered ice cold applications over the mastoid. Two recovered completely under this treatment. The other five had either a very scanty discharge or the drum was imperforate and in all a very free incision was made in the drum, more than one fourth of its circumference in its postero-superior aspect being freely opened, and the sagging canal wall was also split. Three of the cases recovered without further operative treatment, the ice bag being used

locally. All these five cases were seen early and treated at once. This result turns one's mind to the ear conditions in scarlet fever, diphtheria, etc. where so many chronic suppurations of the ear have their origin. The drum should be inspected regularly in the course of these diseases, and if there be any ear-ache, the indications for so doing are stronger still. Should the drum be found inflamed a *free incision* through the lower part of the drum is indicated, rather than waiting for perforation by ulceration.

Appropriate local treatment should follow, not waiting for the child to "outgrow" the discharge. Remember that a chronic discharge from the ear in an adult bars him from many kinds of life insurance in good companies. The ice-bag should be applied for twenty-four hours in all cases where its use is indicated. If at the end of that time the symptoms are worse, proceed to operate. If no worse or better, wait another twenty-four hours and then decide.

Operation.—The patient is prepared by shaving the head well away from the field of operation. Syringe the canal with 1-4000 bichloride solution, and cleanse the parts as thoroughly as possible. The canal is then plugged with a strip of gauze, and sterilized towels cover the head and chest. The incision is made from the mastoid tip to a point above the meatus just behind and parallel to the retro-auricular fold. It should go right through the periosteum on the first cut. It is then enlarged up and down with scissors, if necessary, and some of the fibres of the sterno-cleido-mastoid are cut away. The periosteum is then retracted and bleeding points caught up with forceps. Should the space for operating seem too small, an incision can be carried backwards at the level of the meatus as far as is needed. If there be a perforation in the cortex, as there was in four of my cases, that can be taken as a guide, and enlarged by curette and rongeurs. If not, the small suprameatal spine is taken as a guide, and with a gouge and mallet the bone is cut towards the mastoid tip, exploring with a fine probe every cavity opened, for the sinus may be anywhere. It makes the operation easier to remove most of the tip before attempting to find the antrum, which always exists. Once it is opened, the further steps of the operation depend on the amount of necrosed bone. In chronic cases, it is better to do the radical operation, that is, to take away the posterior canal wall, throwing the canal, middle ear and antrum into one large cavity. The main danger in the radical operation is that of injuring the facial

nerve, as its canal may be opened into while breaking down the posterior canal wall. In another operation, it is time well spent to remove every particle of suspicious bone or unhealthy granulation tissue, and make the cavity in the bone as smooth as possible, since the healing process is much accelerated by so doing.

The cavity is then syringed with 1-4000 bichloride or sterilized normal salt solution, as is the canal. It is then packed with strips of iodoform gauze, and some is put in the canal. Then strips of plain gauze, and finally abundance of absorbent cotton and a bandage. The outer dressing should be removed whenever there is any sign of staining, and the fifth day the packing is taken out. Thereafter, it is better to pack very loosely, and plain sterile gauze seems to give better results than iodoform, in a clean wound, at least. It should be dressed every second or third day, as indicated. If granulations are troublesome, solid silver nitrate will keep them in check. The patient should be kept in bed for a week, when, if the temperature is normal, he may be allowed up. At the end of three weeks one can usually dispense with the large dressings and use a small pad behind the ear.

Cases.

Case 6.—M. P., 16 years old. Seen first June 14, 1901. Earache for a week, free discharge from the ear two days. Pain and tenderness on pressure over antrum; some swelling. Ordered ice bag locally. No change for better in two days. Operation June 17, 1901. Pus in antrum, and other cells full of unhealthy granulations. Wound healed in two months.

Case 7.—W. D., 36 years. Seen first August 24, 1901. Recovering from lagrippe; had earache for three days, then discharge from ear for a week. Complained of pain behind ear. Discharge scanty; pain and tenderness on pressure over whole mastoid. Free incision under nitrous oxide anæsthesia; ordered ice locally. Slight improvement for two days and then worse. Operation August 23, 1901. Whole mastoid cells riddled with pus. Wound healed in nine weeks.

Case 8.—M. H., 10 years old. Seen October 21, 1901. Had a very severe cold, and then developed earache. Had most profuse discharge from ear when seen, and some swelling over mastoid. Ordered ice locally, and irrigation of canal. Swelling got steadily worse. No fluctuation. Discharge very free. Operation November 23, 1901. No pus in antrum, but lots of unhealthy granulations. Wound healed in seven weeks.

Case 9.—R. P., 56 years. Seen October 11, 1901, in consultation. Earache and pain on pressure over antrum. Advised free incision of drum and ice locally. Some improvement for a time, then got worse. Operation October 14, 1901, at which I assisted. This was type of sclerosed mastoid, and made operation difficult. Antrum contained much pus. Wound healed in about two months.

Case 10.—W. D. 37 yrs. the same patient as case 7. Seen June 14 1902 for ear-ache following use of salt water snuffed up nose, prescribed by some kind neighbour for nasal catarrh. Advised hot irrigation of canal, as congestion of drum did not look severe. Next day ear was discharging, pain gone, June 28/02 the pain returned and some pain in, and tenderness on pressure over antrum. Discharge from ear still free. Ordered ice locally. Operation June 30/02, some swelling over mastoid and much tenderness on pressure. Found antrum full of pus, Wound healed in six weeks.

Case 11.—W. A., 42 yrs. Seen January 12/03. Had been sick with lagrippe, and on improving had ear-ache, which steadily got got worse. Found pain in and tenderness on pressure over antrum. No discharge from canal, but marked bulging of drum. Incised drum freely under nitrous oxide anaesthesia. Ordered ice locally. Immediate improvement. [Discharge from ear ceased completely in ten days.

Case 12.—G. H. 8 yrs. Had occasional attacks of ear-ache and discharge from the ear for several years. Had adenoids and tonsils removed about December 15/01. Had another attack of ear-ache about a week later, and early in January was seen by Dr. Hallett, of Weymouth, who found a large fluctuating swelling behind the ear. This he opened and much relief was experienced. Operation January 19/03. Found sinus behind ear and free discharge. Had to expose sinus for 3/8 inch, since it was covered by granulations Wound healed in two months.

Case 13.—A. P. 19 yrs. Seen January 31/03. He had a severe attack of lagrippe and ear-ache. Was discharging freely. Had pain behind the ear, but little tenderness on pressure. Canal conditions usual to O. M. P. A. Ordered ice locally. Well in a week. Possibly not mastoiditis.

Case 14.—D. W. 4 yrs. Seen March 7/03. Had been in house with a cold for a week. Seen by her physician first on March 5/03. Had had ear-ache for five days and on that day there was some dis-

charge from the ear. On March 7/03, the auricle seemed to be standing out somewhat. Ordered ice locally and irrigation of canal since discharge was quite free. Operated March 9/03, when there was distinct fluctuation over mastoid. Found pus under periosteum. Considerable pus in antrum. Wound was healed in seven weeks. This case demonstrates how much damage can occur in a short time as nine days from first appearance of ear-ache.

Case 15.—A. J. P., 44 years. Seen April 26, 1903. Severe attack of lagrippe, with much prostration. Earache and tenderness on pressure over top of mastoid. Ordered ice locally. Next morning found tenderness more marked. Drumhead almost normal, but with marked bulging of Shrapnell's membrane. Made a free incision under chloroform. The discharge from ear was very profuse and watery. Two days later the pain reappeared, but probing of canal and freshening edges of incision caused it to disappear. Ice bag removed two days later, and on May 13th discharge from ear ceased.

The following three cases were seen since the paper was read:—

Case 16.—L. P. 14 yrs. Seen June 2/03. Had been under observation by her physician for several days with furunculosis of canal. Swelling over mastoid appeared two days before I saw her. This was incised, but no pus. Canal was very narrow, so inspection was difficult. Considerable swelling over mastoid with pain and tenderness on pressure Operation same day. Antrum was full of unhealthy granulations, while the surrounding bone was soft. Doing well at present, June 29/03.

Case 17.—M. H. 4 yrs. Seen first June 20/03. History of lagrippe and bronchitis four weeks ago. Ear-ache for ten days. Swelling behind ear two days. No discharge. Pain and tenderness on pressure. Canal conditions not clearly seen. Did a free incision under chloroform and ordered ice locally. Seemed to do well for three days. Then swelling behind ear got worse. Operation June 25/03. Fluctuation present, found pus under periosteum and cortical perforation. Antrum had no pus, but full of broken down granulation tissue.

Case 18.—G. J., 14 years. Seen August 4, 1903. First seen by Dr. Woodland the previous day. History of discharge from right ear for three years. Had swelling behind ear, and hardly able to open mouth for a week. Also had chills for nearly a week. Patient lived eighteen miles in the country, and I went up prepared to operate

from history given by Dr. W. Found symptoms as described. Swelling over, behind and below tip of mastoid. Very tender on pressure. Made usual incision. Found pus immediately under cortex in every cell. Antrum full of pus, foul smelling. Exposed sinus for nearly an inch. Found it bathed in pus, but pulsating. Cleared away all dead bone, packed wound, etc. No chills for two days, but came on next day. Wound dressed on August 8, 1903. Much foul pus, some coming from around sinus, which still pulsated. Next day I saw patient and dressed wound. Discharge very foul, temperature high. Some bloody sputum; septic pneumonia or general pyæmia. Died on August 14th. Probably a case of tubercular mastoiditis, with infection, which had become general before operation.

STRANGULATED HERNIA WITH UNUSUAL SEQUELÆ.*

By D. Murray, M. D., Logan's Tannery, N. S.

When our indefatigable secretary wrote me, asking me if I could not contribute something for the meeting bearing on a case which occurred in my practice, and of which he had certain knowledge, I said I would try, and on his further writing and asking me to put it in the form of a paper, and not a mere case report, I, in a moment of weakness, again said yes. It was, on my part, a clear case of not sitting down first and counting the cost, for on my looking into the matter more fully, I saw that all that I could contribute relative to the case would be a mere statement of some of the facts occurring in connection therewith.

It would, from the very nature of things, be a difficult matter for even a more capable mind to write a paper relative to this case, at the same time hoping for, much less expecting, an audience, for the only subject one could treat upon would be asepsis vs. sepsis in operative surgery, a thing which has been decided and finally settled long before the writer of this knew aught of the healing art.

What I have to say is simply setting forth what nature can accomplish in a fight for our preservation, even though the odds are mightily against her, provided that the scene be laid in a locality naturally removed from the conditions favorable for the growth and development of the pyogenic micro-organisms, at the same time showing you a case where it was debatable whether or not to establish an artificial anus, giving you our own decision, and further showing you how that, when at a late date nature did so, she also effected what may be termed a spontaneous closure of a fecal fistula, and not forgetting the primary cause of all this trouble, did also a radical cure for the hernia, and, as I said, all this against tremendous odds, favoured only by a healthy country atmosphere.

On the 24th day of December last I was in off the road to see a patient, a man 86 years of age, a farmer, living in a house through which, in order to get a condition anything like sanitary, nothing less

*Read at meeting of Medical Society of Nova Scotia, Antigonish, July 2nd, 1903.

than the River of Styx would have to be turned in all its volume. The house was dirty beyond compare, but situated in the beautiful and healthful West River Valley, in Pictou County.

The patient in question complained of vomiting, abdominal pains and absolute constipation, notwithstanding, as he said, repeated doses of salts and injections. He had been treated for seven days for these conditions by an M. D. who at one time would have done much better, but upon whom Father Time has wrought havoc. He had given the man up, leaving him a tonic to be a comfort to him in his last hours, and had gone home. At this juncture I was passing, and was called in.

I was just getting home from a serious case, and was cold, wet and tired. The man gave a history of chronic constipation. The symptoms were not very severe. His general condition was only moderately bad.

I made a hurried examination, and decided to change his drastic treatment, give an opiate to rest the tired-out bowel and system generally, go home, and when in better condition return in three or four hours. I did this.

On my return, a more careful examination revealed the presence of a strangulated hernia of the femoral type, hard as a stone, although not large. The patient was now anæsthetized, and some attempts made at reduction, but to no purpose—it would not be persuaded.

What were we now to do? A man 86 years of age, vomiting everything ingested since seven days; an unsavoury house; no nursing staff, and no hope of any being secured. Patient was resolute, however, saying he was willing to put the price of a cow into the operation, but would die rather than go in debt.

All this said coolly and collectively. We decided to operate, and Dr. J. W. McKay, of New Glasgow, was sent for.

Dr. McKay arrived that evening on what was the eighth day of the strangulation, and found affairs presenting a gruesome spectacle. After giving a bad prognosis to the family and instituting what sterilization was practicable, proceeded to operate.

The skin over the tumor was dusky and œdematous, and on an incision being made, the deeper tissues appeared soft and almost emphysematous to the touch. The odor was very bad. The patient taking the anæsthetic badly.

The operation was proceeded with, however, and on the bowel being reached we found that the hernia was femoral, as we had diagnosed, but of the Richte-type, only part of the lumen being shut off, although the obstruction was absolute. I had felt rather small over missing my diagnosis when I first called. Now, however, my feelings were somewhat mollified, as the books say that this type of hernia often offers difficulty in diagnosis.

We also found that the strangulated gut was very dark, if not black, in color. The remainder of the cross section was in quite good condition.

Now what was to be done? Dr. McKay was doing the operation, but the case being mine, wished to do as I desired. The anæsthetist called our attention to the fact that the patient was doing badly. A council of war was quickly held. We were not prepared for a reaction. All conditions were unfavorable. We decided that we would have less to account for if we returned the bowel. He would certainly not stand a reaction.

The bowel was returned and stimulation applied to patient. The condition of surroundings would not permit even an attempt at an operation for radical cure. Suture would not hold. We firmly believed that ere forty-eight hours elapsed the cure would be radical enough for all practical purposes.

The patient was now put to bed and warmth and other means used to stimulate and support. Strict orders were given to the attendant regarding diet, quietness and cleanliness. Next-day we called and found that the father was feeling quite well. Had been sitting up a little, eating a little, smoking a little, and evacuating his bowels a little, but had gone back to bed; where we would find him.

Ones feelings and language under these conditions can be better imagined than described.

Yes, gentlemen, and each day following for nine or ten days, this man took his regular food. Took his proverbial salts and cream of tartar regularly. Had three or four stools, and each time, until he got too weak, he got out on his night stool to do so.

I may say that my brother, a fourth year medical student, did the dressings for me, during this time, and we both know all these thing to be true and the half has not been told.

You will ask why was this allowed to go on? You would need to be on the ground in order to understand.

We operated on the 26th of December, and up until January 6th all went well as far as the reparative process was concerned. My brother did his last dressing on the sixth or seventh day of January, when he handed the case over to me, he having to go back to College. On that date I received a telephone asking me to come at once as something has gone wrong with Mr. Mc., his water was coming out through his side. I remember thinking then that I would like to know at what time things had gone right at Mr. Mc's. I went at once to the place and sure enough his water was coming through his side, not urinary water, but the watery product of fecal masses and magnes. sulph. These had burst through the field of operation and were now coursing is streams over his abdomen and flanks. A flow could at any time be produced by putting a finger into opening. He was now the picture of despair. His first expression was "sonny surely I wont live long". I sat by his side and rehearsed gently his conduct, telling him in effect that he had all through tried to thwart our plans which were for the saving of his life, and that now his efforts were likely to be crowned with success. I angered him thus; and he replied "I'll not die if I can help it".

I felt sure that if he did not die at once as he looked like now, he would soon become exhausted, as he could not now raise his head, although yet stubborn.

What next was to be done? He was freely physicked, all discharge being caught in bed. He had no nurses and few friends.

I tried to constipate him in order to get his excoriations healed. Plaster had been used to keep dressings in situ, and considerable irritation had been produced. To this was now added the irritation of watery fecal discharges. My efforts at constipating him were not meeting with must success. That bag of grocery-store salts and cream of tartar was more powerful than opium and its congeners which were not willingly taken, and the patient eight miles away from me. I may say that his son who was nurse, is an imbecile.

This condition of affairs persisted for four or five days, when I was able to secure nursing upon which I could depend. The son was honorably discharged from duty. Now I was able to lock up bowels for a few days, and institute ordinary cleanliness, with the result that small puny granulations risked an appearance. These I carefully nurtured, although I hardly knew why, expecting any day a return of former things. Each day these grew and multiplied, became

more vigorous and healthful. When the bowels moved, as they must, I had discharges looked after as well as possible, and the door again locked. In 16 days I had the opening in bowel reduced to a narrow slit, which was not now for three or four days showing much improvement, although patient's general condition was much improved.

Now I thought no harm could come from a little interference. So next day I took along a suture and with a perineal needle, put in four or five stitches after first freshening edges of wound and causing them to bleed freely. If you ask me what tissue I included in stitches I will reply, "where ignorance is bliss 'tis folly to be wise." I do not know what I caught, simply closed the opening.

I applied a light bandage over a light dressing, and again constipated him, keeping him thus for six days, feeding him light all the while.

At the end of the time I opened the dressing and found it apparently healed, but union looked weak. I considered it a delusion.

His stomach was failing and generally likewise. So decided to give divided doses of calomel, and when a desire to stool occurred, I threw up in bowel a pint of olive oil.

The result was a movement of immense size, the first for twenty-four days "*per viam naturalis*," the patient exclaiming, "Isn't it natural to be doing it again the old way."

From this on not an untoward symptom occurred, except patient's temper, which grew with his returning strength.

To bring this already too long article to a close, I have to say that in forty-nine days from the date on which I first saw him he was able to be up, and with my consent. He is 86 years old. How long ought he yet to live?

Now a word for nature's crowning glory. The arch must have its keystone. The rupture which had made regular descents for four years does so no more. She has done for the old man a radical cure, which we could not dare to attempt. The cure has now lasted six months.

Should we have established an artificial anus at first? Is it worth your discussing?

NOTES ON SOME DRUGS.*

By Geo. G. Corbet, M. D., Fairville, N. B.

In the paper which I have the honor of presenting to you this evening, I hope to draw your attention to a few drugs which I consider worthy of a more extended use in the treatment of disease.

First I will draw your attention to an old drug as a new external treatment for rheumatism.

Carbon Bisulphide, CS_2.—My attention was first called to its use in the external treatment of sciatica and rheumatism, about three years ago, by reading an article by Dr. Cline, in a medical journal. I did not at once commence using it, until I had a case of sciatica that baffled the usual treatment, and as my patient was suffering and could get no relief, I decided to try carbon bisulphide, and did so, and my patient got immediate relief from the pain. This gave me a chance to wait for the action of the drugs, as to a permanent cure, by internal medication.

I can do no better that quote Dr. Cline's article, "I suffered from sciatica and rheumatism, the torments of hell for six weeks cured in less than three minutes, by rubbing from hip to heel, half ounce of carbon bisulphide.

"Give it to suffering humanity.

"A gentleman from Canada called to see me, saw my intense suffering and told me a wealthy man spent a large fortune in trying to get cured of rheumatism, and ten cents worth of the above cured him.

"Like drowning man catching at a straw, I tried it, and was well before I was dressed. Did you ever hear of it being used in that way?"

W. S. Cline, M. D.

Woodstock, Va.,

* Read at meeting of St. John Medical Society, Nov. 4th, 1903.

I will briefly tell you of a few cases in my own practice.

Case One.—Miss ——, a young lady about 23 years old, suffered for six months off and on with sciatica. I was called to see her last spring and found her in bed, suffering from sciatica. She had been treated by one of our city physicians all winter without results although she was not confined to her bed.

I tried the usual internal and external treatments without avail I then remembered reading about carbon bisulphide, and at once procured some, and applied about two drams, rubbing in over painful part of hip, also up to the spine; pain relieved in less than three minutes. This was repeated about three times in all, when patient got up and went to work.

Case Two.—Boy, about 11 years old, suffering from acute articular rheumatism of left knee. When I was called he could not bear to put his foot to the floor, let alone walk. I gave his knee a good rubbing with about three drams of carbon bisulphide, and inside of five minutes he could walk anywhere in the room; pain had disappeared. I left instructions to rub his knee again in four hours, and repeat if needed. Pain did not return after first rubbing. I gave him internally sodii salicyl. grs. xv. every two, hours. About two weeks ago the same boy came to my office, and asked me for the recipe for carbon bisulphide, as his brother, who is a policeman, had an attack of rheumatism. I gave him the recipe, and his brother was better after the first rubbing This boy has not had any more attacks of rheumatism six months since treatment.

Case Three.—Mrs. ——, colored woman, about 45 years old suffering from rheumatism in both hands. One of our physicians had treated her for several weeks without curing her. A few rubbings with carbon bisulphide, and alkaline treatment internally and in a short time, three days, she was cured, and remains so five months after.

Case Four.—Mrs. ——, about 50 years old, came to my office. She could not move her left arm, as it pained her at the shoulder. One rubbing of carbon bisulphide to her shoulder, and inside of three minutes pain disappeared, before she could get her waist on she could use her arm. She repeated the rubbing twice within

twelve hours, and pain has not appeared. This is four months ago. No internal treatment.

I could mention about one hundred cases in all, but the above cases will do for illustration.

When you first use carbon bisulphide, you will take notice of a very unpleasant odor, as of rotten eggs. So I always apply it to a patient in an unoccupied room. Do not use it in any of your living rooms, unless your close the doors, and after applying carbon bisulphide, come out of the room, opening the windows, and as it is very volatile, the odor disappears in a few minutes, and also is not perceptible on you or your patient.

When you first use carbon bisulphide on the skin, (except exposed parts, as the hands,) the sensation is one of intense coldness, followed by intense heat. This disappears inside of three minutes, and pain is gone or greatly relieved.

I have used it successfully to relieve the pain of acute abscess. It is good in treating enlarged glands, also in neuralgia. I have found it good for relieving pain in many acute inflammatory conditions.

I wish some of you would give the drug a fair trial and report to the Society.

I can fairly endorse Dr. Cline's statement, and I believe it acts as a local anæsthetic. It has the advantage of being cheap and *very rapid* in its action. You can relieve or perhaps cure the pain in from three to five minutes in acute rheumatism, and give immediate relief to your patient. First be sure of your diagnosis, then go ahead, and at the same time you can give your favorite internal treatment as the case demands.

If we made our patients attend to the organs of elimination and assimilation, we would have less rheumatism.

Have you tried *Apocynum Cannabinum* internally for rheumatism? I have with good results. I am using it alone, but I think it could be combined with pot. iodid. or sodii salicyl. with advantage. Try it. Its action in large doses is emetic and cathartic, in moderate dose antiseptic, expectorant and diuretic.

This is Canadian hemp, and I think it would be better for us if we understood more about it. Do not confound it with cannabis Indica or Indian hemp.

For the treatment of tuberculosis, may I call your attention to some drugs beside creosote and its compounds, or cod liver oil?

IODOFORM AND QUININE.—I have used with good results. I give it in capsule, commencing with a half grain of each, and increasing the dose, watching my patient as to the action of both drugs, but it is to the following drug I wish to draw your attention more especially.

FLUOROFORMOL, $CHFl_3$.—I use a water solution of the gas Fluoroform, CHFl. My attention was drawn to this drug in the treatment of tuberculosis by reading an article written by Dr. Loewenthal, 615 Carrol St., Brooklyn, N. Y.

It is not to be used in cases where cavity formation exists, but in the early stages of tuberculosis.

It is *odorless, tasteless and non-toxic.* I have tried it with good results, as in Case One. Married woman, age 32. Complained of loss of weight, shortness of breath, cough, slight fever towards evening. Physical examination showed signs of beginning tuberculosis in apex of left lung. No microscopical examination of sputum made. Had been treated for nine months for run down system and bronchitis by another physician. There is a family history of tuberculosis. She was unable to work, hardly walk from weakness. I put her on aqua fluoroform for six months. At the end of first three months there was a slight improvement in general health, four months the general health greatly improved and cough nearly disappeared. At the end of six months she was discharged cured She has none of the complaints she had when I first saw her. Physicil examination negative, she was in perfect health when discharged. My treatment was fluoroform for six months, and Pil. Blaud Co, Laxative, g. c., gr. iii, during the last month. I did not give her any cough remedies after first two weeks.

Case Two.—Man aged 50. All physical signs of tuberculosis. Dr. Addy made a microscopical examination of sputum and reported bacilli present. Patient took fluoroform for three months, and improved in general health. He gained in weight, cough disappeared and appetite improved. When he came to me he could hardly lift 50 lbs, and inside of three months he could lift 200 lbs. I am sorry to say that like many more patients he stopped treatment before he was cured, intending to get fluoroform, but kept putting it off from day to day.

My experience with creosote and its compounds, also cod liver oil, in the treatment of tuberculosis has been poor, as both drugs (in most patients) disturb the stomach. Have any of you cured tuberculosis with either of these drugs?

Now, gentlemen, I will not take up any more of your time, but draw these few notes to a close, and hope that you will be very gentle with your criticisms, as what I have given you has been from my own clinical experience, and that when you meet a patient suffering the pains of rheumatism, or as Dr. Cline says the "torments of hell," you will first think of, and then use externally carbon bisulphide and not morphine to relieve the pain.

PRACTICAL LESSONS FROM AN EXPERIENCE OF MORE THAN ONE HUNDRED CASES OF ECLAMPSIA.*

By Barton Cooke Hirst, M. D., Philadelphia.

In the University Maternity we have the records of fifty-four cases of eclampsia. In ten years' service in the Maternity Hospital, in seventeen years' service in the Philadelphia Hospital, in private and consulting practice, I have seen an equal or greater number. Certain facts stand out from this experience which should be emphasized at present, I think, in view of the prevalence of theories not reconcilable with clinical observation nor with the best treatment of the patient.

There are three phases of the subject on which clinical experience throws a valuable light: etiology, the premonitory signs, the preventive and the curative treatment.

It is not the purpose of this brief communication to enter the maze of theories about the etiology of eclampsia: whether the disease depends upon an embolism of placental cells; upon cytolysis of the syncytium, the consequent production of a toxin, and the failure of the organism to produce an antitoxin; upon deficient work on the part of the liver in the reduction of the products of metabolism, and of excess nitrogeneous food to urea; upon hyperactivity of the suprarenals or deficient activity of the thyroid; upon resorption of toxins due to microbic infection, is not yet demonstrated. There is no theory yet advanced which has the same basis of common sense and is in such accord with clinical observation as the long-accepted view that the products of fetal metabolism discharged into the maternal blood and eventually eliminated by the maternal kidneys are the chief predisposing cause of eclampsia, and that insufficient elimination by the maternal kidneys is the chief exciting cause. Dienst, one of the latest investigators† of the subject, has come back to this view

* Read before the Philadelphia County Medical Society, December 9th, 1903.

† Herzfeld, from an experience of 81 autopsies on eclamptic subjects unqualifiedly declares that insufficient renal excretion, due to a diseased condition of the epithelium, is the cause of eclampsia. *Centralbl. f. Gyn.*, 1901, No. 40. Bar found the kidneys badly diseased in every one of the cases he examined. *L'Obstretique*, 1903.

and says, with scientific circumlocution, what the clinician has been saying for a generation. Anything which throws extra work on the kidneys, as a heavy nitrogeneous diet and deficient activity of the skin and bowels; anything which impairs the functional activity of the kidneys, as the congestion of an acute nephritis or pressure upon the ureters, is well known to determine an eclamptic attack. As a rule, eclampsia is a disease only of late pregnancy with a living fetus, and is about ten times more frequent in twin than in single pregnancies, showing the probability, at least, of the fetal origin of the toxins of the disease. It is true that rare exceptions to this general rule are observed. Eclampsia has occurred as early as the second month of gestation and as late as six weeks after delivery. But it is open to question whether these cases were not ordinary uremic convulsions. I have a patient in the Maternity at present who has had convulsions in two successive pregnancies at the third and at the fourth month, but she has advanced nephritis and her convulsions are such as might occur in any nephritic subject, whether she is pregnant or not. No doubt the irritability of the cortical cells in the brain, characteristic of pregnancy, has already developed in the woman and determined the convulsive rather than the comatose form of uremia in her. An argument often advanced against the responsibility of the maternal kidneys for eclampsia is the alleged fact that women with nephritis are not liable to eclampsia. One set of German statistics is frequently quoted to the effect that only 5 per cent. of nephritic subjects in pregnancy develop eclampsia. The way in which these statistics are exploited by the supporters of some of the newer theories to account for eclampsia would, it seems to me, lead the inexperienced to believe that disease or impaired functional activity of the kidneys in pregnancy may be regarded with entire indifference. No view could be more incorrect or more harmful to our patients. It is not true that women with nephritis are not disposed to eclampsia. The reasons why a comparatively small percentage of them actually arrive at the convulsive stage of the disease are that abortion, miscarriage and permature death of the fetus is the rule in the nephritis of gravid women; that the signs of toxemia appear so early and are so marked as often to call for the artificial termination of pregnancy; that such patients are subjected to an unusually careful dietetic and other treatment and that a long-continued imperfect elimination has made the organism tolerant to toxins. It has been my experience that

pregnant women with nephritis or with a predisposition to nephritis by heredity almost invariably demand active treatment to combat a gestational toxemia, and usually require a premature termination of pregnancy. There is nothing, therefore, in the clinical observation of nephritis in pregnancy to shake our belief in insufficient renal activity as a cause of eclampsia, and we should hold fast to the lesson taught by many a bitter experience that nephritis in pregnancy is one of the gravest complications, demanding constant care and never to be regarded with indifference.

Among the premonitory signs of eclampsia there is nothing comparable in value to the experienced physician, with albumin in considerable and increasing quantities in the filtered urine. It is true that a certain proportion of cases occur without precedent albuminuria, but their proportion is not nearly so large as one would infer from the report of sporadic cases with which recent medical literature is filled. In all my cases there were only two in which albumin was absent. In one of these the postmortem examination showed a chronic nephritis dating from an attack of scarlet fever five years before. In a recent report of 322 cases of eclampsia from the *Charité* in Berlin albumin was absent in only six. There is no other symptom of a gestational toxemia and threatened eclampsia so constant and characteristic as this. The urea excretion is valueless in comparison. Pregnant women excrete anywhere from three to over thirty grams a day, but usually less than the normal twenty to twenty-four grams. I have repeatedly seen a very low output without the slightest disturbance of health, and occasionally a rapid increasing toxemia with an excretion of more than thirty grams. Any one who is ill advised or inexperienced enough to attach much importance to urea elimination as a sign of gestational toxemia or threatened eclampsia will be constantly making blunders in diagnosis and treatment.

Cases, other than hyaline, should of course be looked for, but their quantity cannot be measured; they usually accompany albuminuria, increasing with the increase of albumin and disappearing with its decrease, so that their presence and number do not give the clinician as valuable a guide to the requisite therapeutic measures as the quantity and increase of albumin. It is a clinical rule with few exceptions that albuminuria precedes the other signs of gestational toxemia, that the gravity of the women's condition can be measured by the steady increase in the amount of albumin in spite of treatment,

and that a steady and rapid increase of albumin is the most certain and constant premonitory sign of eclampsia that we possess at present. A disregard to this clinical rule is apt to be disastrous to the patient and detrimental to the physician's reputation; yet the impression created by much of the recent literature on the subject, it seems to me, is that albuminuria is unimportant as a danger signal in pregnancy —a view largely theoretical and speculative that cannot be based on sufficient clinical experience. One factor contributing to this view is the use lately of a delicate and unreliable test for albuminuria. Potassium ferrocyanide gives a reaction with albumin, with albumoses, etc., giving the impression that albuminuria is much more common in pregnancy and less serious than is really the case.

The preventive treatment is based by every one, I think, on the theory of kidney inadequacy, whether the individual authority accepts that theory or not. It consists, as we all know, of a milk diet, diaphoresis, diuresis and catharsis, with extra precautions against chilling the skin. The use of thyroid extract as proposed by Nicholson is still on trial. I propose to make a study of it in the Maternity.

The curative treatment is too large a subject to be treated *in extenso.* Certain disputed points, however, are opened to discussion, and on no division of the whole subject is clincial experience so safe a guide. The most important therapeutic measure on which there is still a difference of opinion is the obstetrical treatment of eclampsia in pregnancy and labor. The views as to the necessity of a rapid evacuation of the uterus are widely divergent. It is easy to understand the feeling which prompts a resort to *accouchement forcé* in eclampsia. The fetus *in utero* seems to be the cause of the eclampsia; the intra-abdominal pressure of advanced pregnancy is an embarrassment to the kidneys; as demonstrated by Herzfeld, a large proportion of the cases is due to pressure on the ureters; there is a general belief that eclampsia is less dangerous after delivery than before, and there are numerous clinical records of convulsions ceasing with delivery and not returning. I entered on practice firmly convinced that the rapid evacuation of the uterus was the proper treatment, and I have twice reverted to this view, but increasing experience forces me to the conclusion that it is erroneous. The operative procedures necessary, even with the aid of such an excellent instrument as Bossi's dilator, are often followed by injury and shock which an eclamptic patient cannot well endure. I have seen deaths from this cause that might perhaps have been

averted by a more conservative treatment. Moreover, recent statistics show that postpartum eclampsia is very little less dangerous than antepartum or intrapartum convulsions, and that the proportion of cases in which convulsions cease after labor is smaller than is generally supposed. After an extended and repeated trial of both plans, I am better satisfied with the treatment directed solely to the eclampsia without regard to the uterine contents, until such a degree of dilation of the os is secured spontaneously that delivery can easily be secured without violence. In antepartum eclampsia evacuation of the uterus is only indicated if, after the eclampsia is controlled, the patient's urine is persistently albuminous and filled with casts, or if other symptoms of gestational toxemia continue to a degree that excites anxiety. In such a case it is better, if possible, to induce labor slowly by bougies or the Voorhees bags rather than to resort to a forced delivery. Meanwhile the eliminative treatment by diuresis, catharsis and diaphoresis should be actively employed. It necessarily follows that anyone holding these views cannot approve of Cesarean section for eclampsia. There is no treatment of the disease with such a high mortality except the pilocarpine treatment. One has a mortality of over 40, the other of over 60 per cent.

As to the treatment of the convulsions, it is well understood that we must employ two sets of remedies: one to eliminate the poison, the other to quiet nervous irritability and muscular activity. It is generally agreed that normal salt injections, sweats and purgation are the most reliable measures under the first heading. Diuretics during eclampsia are of no use, because the kidneys during the attack are practically nonexistent as excretory organs. There is usually anuria or a scanty quantity of bloody, albuminous urine, in which, by the way, the percentage of area is often normal for a pregnant woman. Venesection should be classed among the eliminative measures; but after resorting to it almost routinely at first, I now rarely do so. Among the sedatives, chloral and opium dispute the field. I confess to a prejudice against the latter, because it antagonizes the eliminative treatment and there is, it would seem, danger of fatal poisoning from the large doses required, in view of the inactivity of the kidneys. The experience of my colleague, Dr. Tyson, who saw fatal poisoning in a nephritic subject from a dram of paregoric, is always present in my mind. For the relief of the arterial tension and spasmodic contraction of the arterioles we have always used veratrum viride. An

experience of twenty years with it confirms the good impression originally conceived. Nicholson's arguments in favor of thyroid extract in five or ten-grain doses for the same purpose are plausible, and I intend to give it a trial; but there are cases in which the ingestion by the mouth of five-grain tablets would be difficult or impossible.

Finally, I would urge the advantages of treating eclampsia in a well-appointed hospital. Nothing is more disheartening than the inadequacy of this treatment observed, in consulting practice in private houses. If cases of eclampsia were transported in an ambulance without delay to a hospital well appointed for their treatment and with a staff thoroughly drilled in the management of such cases, the mortality could be kept at or under 13 per cent., which is less than half what it is in private practice. In other words, a patient would have more than double the chance of recovery than she has in her own home.

Discussion.

Dr. James Tyson said that many years ago he had gone carefully over this subject and had come to the conclusion that a large majority of cases of puerperal eclampsia was due to nephritis, and that he had never had any occasion to change his views, although his practice in eclampsia due to pregnancy had ceased. He considers one of the strongest evidences in favor of the theory that the eclamptic attack is due to a toxic condition, the result of imperfect elimination, and in turn due to nephritis, is that women having Bright's disease previous to marriage are almost invariably taken with eclampsia at the birth of the first child. He had recently been surprised to learn of the change of view regarding the etiology. He had recently discussed the question with one of the adherents of the later views who had favored him with a paper on this subject, and it seemed to Dr. Tyson that the very cases reported tended rather to confirm his original view that in the majority of cases eclampsia is due to nephritis, the result of toxic absorption, probably from the fetus, and defective elimination from the blood of the mother with the usual consequences of this condition.

Dr. M. Howard Fussell referred to a case of eclampsia early in pregnancy which he saw in Dr. Tyson's ward at the University Hospital. The woman was three months pregnant; she had nephritis

with albuminuria and casts; she did not have eclampsia, because abortion occurred, and she entirely recovered. It seemed to him that in this case the nephritis was due to the toxemia of pregnancy, because immediately after delivery of the fetus all toxic symptoms disappeared. He called attention to the absolute necessity of frequent examinationa of the urine late in pregnancy. He said that he had just gone through a trying case impressing this upon his mind. Regular monthly examinations of the urine of the patient had been made during the spring and summer until Dr. Fussell had gone away in September. Another examination was made on November 5. The patient's limbs were swollen, but her urine was normal. She was directed to go to bed, because it was feared that the edema was due to toxemia. Examination of the urine on the following day showed it to be normal. He did not see the patient again until November 18, when he received a summons to attend her for a bad cold. When he reached the house she was in convulsions. He believes that had he continued the examinations of the urine between November 4th and 18th the toxic condition would have been discovered. Another case impressing this point was of a normal pregnancy developing slight albuminuria. An examination 3 or 4 days later showed a slightly increased amount of albumin. The woman was ordered to bed, but instead she had gone to town and shopped all day. On the evening of the same day she was in convulsions and died. He is distressed to hear that immediate delivery is not considered by Dr Hirst to be the proper thing, because he thought he was following Dr. Hirst's views when he employed this treatment. In his own personal experence immediate delivery has always been extremely satisfactory. He would like to ask Dr. Hirst what he would do if he were called in the middle of the night to a woman for whom he had been sent for the first time, and found her absolutely unconscious with eclamptic convulsions occurring every few minutes?

Dr. R. C. Norris said that at the Preston Retreat patients are received sufficiently early to frequently avoid this complication. Of 2,000 consecutive deliveries of patients under his own care there were only 19 of grave toxemia arising in the pregnant women. He believes that a patient with a slight amount of albumin and a few hyaline casts, but without any constitutional symptoms of toxemia, under the action of free purgation and restriction of diet will become normal in a week or 10 days. In the 19 grave cases there were 8 eclampsias

with no mortality. This he believes bears out Dr. Hirst's statement regarding the advantages of treating those cases in hospitals. His record of 5 years of consultation practice and his experience at the Retreat show 29 cases of eclampsia with 7 deaths, a mortality of 24%; 10 cases of grave toxemia in which he induced labor, with a mortality of 10%; and 6 cases were tided over the critical period by the aid of medicines alone, with 1 one death from uremia without convulsions, a mortality of 17%. Altogether there were 45 cases of grave toxemia, with 9 deaths, a mortality of 20%. These facts Dr. Norris believes shows, in the first place, that while albumin in increasing quantity is a most valuable sign, albumin in conjuction with increasing systemic symptoms is a condition especially to be studied, and he is sorry that Dr. Hirst did not lay more stress upon the study of the constitutional evidences of toxemia. Every man of wide experience, he said, has seen large quantities of albumin in the urine of pregnant women unaccompanied by signs of toxemia elsewhere, and such cases will frequently go through pregnancy without trouble. These cases seen once in a while by the general practitioner erroneously lead him to have faith that albumin alone is not dangerous. The toxemia is sometimes shown by attacks of neuralgia, hebetude, headache, nausea and vomiting, after the period when physiological nausea and vomiting should cease; at other times the nervous system is especially affected, as shown by irritation of the peripheral or central nervous systems, ptyalism, pruritus, incorrigible vomiting, insomnia, even neuritis, melancholia and mania. Sometimes the skin may bear the brunt of the toxemia, as in herpes and bronzing. He lays special stress upon the importance of a study of the woman's cardiovascular system. He has reported 3 cases in which it had seemed to him that the toxemic outburst was manifested upon the heart and circulation rather than upon the kidneys. While experience teaches that the kidneys show the first failure of elimination, it must be borne in mind that the liver is frequently at fault. This organ is one of incalculable advantage to the pregnant woman. Its function properly performed will prevent the formation of and destroy toxins, whose excretion finally overtaxes the kidneys. In the prophylactic treatment of eclampsia, therefore, the study of the liver goes hand in hand with that of the kidneys. He has noticed that in toxemia not associated with advanced Bright's disease the prognosis for the induction of labor or for the result of medical treatment is very much better than in the presence of toxemia

associated with advanced kidney changes. In some cases he has induced labor when the condition became alarming from toxemic symptoms with advanced kidney disease. While the patient has been spared the eclamptic outbreak she has died subsequently from the condition of uremia without convulsions. Exanination of the urine in the early months of pregnancy he regards as important as in the later months, to detect if possible the slow and steady oncoming of the storm of toxemia which otherwise apparently will suddenly burst out in eclampsia when the doctor is least expecting it. In other words, he regards the slow accumulation of toxins as more dangerous and less reponsive to prophylactic treatment than their rapid formation. Regarding the obstetric treatment of eclampsia he is glad to hear Dr. Hirst return to that which he had taught at the time when Dr. Norris was a quiz-master; noninterference obstetrically until the os is sufficiently dilated to do a speedy forceps delivery. The advantages of immediate delivery when *it could be done without violence to the patient* he has seen many times; and, in this he thinks Dr. Fussell did not rightly understand Dr. Hirst's paper. None of the 8 so treated at the Preston Retreat have died. His plan of treatment is to treat from a medical standpoint and, and as soon as the os is sufficiently dilated, to deliver by forceps or by version. He tried rapid dilation of the cervix by Bossi's method last winter, but the 3 women died. At Blockley in a women overwhelmed with the poison and with a dead child he had incised the cervix and delivered by craniotomy in a very few minutes and that woman had died. Two years ago at Blockley, in the case of a colored woman with contracted pelvis, he did a rapid Cesarean section and she also died. He is convinced that in cases in which the patient seems to be overwhelmed with the poison, in which she has been neglected, and in which the attack comes to her like a burst of lightning out of a clear sky, no matter how speedy the delivery, she is very often doomed. He advocates the use of veratrum viride, but not in every case, and says that the same rule should guide the profession as gave their forefathers their success from bleeding. The plethoric cases with the full bounding pulse have, in his experience, responded most happily; while in some cases he thinks veratrum viride would have killed, cases in which digitalin and strychnin even had to be employed. In his personal experience the administration of Epsom salts has aided most in the elimination of the toxins. He has yet to see a patient die in whom he can secure from ten to twelve

liquid stools in twenty-four hours. The blood-vessels should, in such cases, be kept filled with salt solution. When a patient is so overwhelmed that no purgative is of avail, not even croton oil, that patient is very likely doomed. After free purgation he has seen patients come out of their toxæmia and edema of the lungs disappear when it has seemed they must die. Chloral he believes of undoubted value.

Dr ALEXANDER HERON DAVISSON said that Dr. Hirst had taken away one of his main supports in the treatment of eclampsia, for he confesses to a belief in the utility of bleeding. It seems to him that when the patient is so loaded with poison, having one convulsion after another, and it takes so long to eliminate this poison by catharsis and diaphoresis that bleeding is a very satisfactory treatment. While not having had a large experience with eclamptic patients, he has had cases in which he has bled with good result. The blood, usually so dark and thick, with so little coming from the parturient tract in the subject of eclampsia, would seem to make it desirable to have some elimination of this poisoned blood. Its loss can easily be supplied by the injection of saline solutions. He asked Dr Hirst's opinion about the use of morphine in the treatment of eclampsia. The inhalation of chloroform will control the convulsion, but during that time he feels that the woman is absorbing more poison and, in addition, having her oxygen shut off; so he asked if under the circumstances it would be dangerous to give a hypodermic of morphine.

Dr. J. MADISON TAYLOR asked Dr. Hirst what he would expect in a case of cyclic albuminuria in the event of marriage and possible pregnancy. He feels that such cases puzzle the general practitioner considerably.

Dr. HIRST, in closing, said he had presented his brief communication for the purpose of combating theories advanced by specialists in this line of work which he felt were likely to do harm. Naturally he had gone into the whole subject of eclampsia, which was too large to consider in the time allotted. He was glad, therefore, that Dr. Norris had supplemented what he had said by his extremely valuable remarks. He would emphasize, from his own experience and from observation of the work of others, the statement of Dr. Norris that there is a great deal more to consider than the mere action of the kidneys. He is of the opinion, however, that the kidneys are the main organs to consider and that the profession would make a mistake in departing from that view. Answering Dr. Fussell, being called to

such a patient in private practice, he would wrap up in crash towels half a dozen bricks, heated on the kitchen fire, saturate them with about a quart of alcohol, put them about the patient and cover her with as many blankets as he could find; then, if he could procure the materials for hypodermoclysis, he would employ that. If the woman was slow to respond he would give her Epsom salts and, if necessary, croton oil. If the convulsions continued he would give chloroform and, as soon as the os was sufficiently dilated to permit delivery without too much violence, he would deliver the fetus. Veratrum veride, he believed, can be given in the majority of cases. Venesection may be resorted to, but the kind of cases seen in the city he feels do not call for it. As Dr. Norris suggested, he feels that digitalis and strychnine are required in some cases rather than veratrum viride and venesection. He confessed to a prejudice against the use of morphine, and has never used it. He cannot help remembering what Dr. Tyson has said about opium in kidney failure, and it seems to him that there is great risk of poisoning the patient and of combating the eliminative treatment, which is the most important feature. Answering Dr. Taylor, he would say that a woman with cyclic albuminuria who becomes pregnant needs greater care than the ordinary patient He referred to such a case. He believes that when a woman who is predisposed to kidney disturbance of any kind becomes pregnant, she is in a more precarious condition than the average pregnant woman.

DOUCHES—VAGINAL AND UTERINE.

By N. S. Fraser, M. B., St. John's, Newfoundland.

The value of douching after labour has been very differently estimated by different observers from time to time, and whereas but ten or fifteen years ago great things were expected from douching after labour, the present-day tendency is to go to the other extreme, and condemn it as useless or even harmful. The result is that some of us are not quite sure where we are in this matter. Some stick to the old practice, more particularly when any fever arises; others, again, set their faces against the douche altogether.

Exact scientific observation is gradually putting us on a firm basis, and in all matters relating to the puerperal patient our efforts are now directed to the *exclusion* of germs—prophylaxis of puerperal fever—rather than to the *destruction* of germs. We can no longer put a couple of tablets of perchloride of mercury into a douche-bag and believe that with the douche we have destroyed all the germs which our carelessness has allowed to enter. The experiments of Doderlein and others have proved that the vagina is not only aseptic, but that its secretions are actually antiseptic. The vaginal douche lessens this antiseptic power, and so renders the patient more susceptible to infection.

S. Marx, of New York, has recently made known the result of a series of experiments on the bacteriology of the uterus (*Amer. Jour Obs.*, Sep., 1903), in which he proves that the uterus is normally aseptic. When the contents of the uterus are found to be septic, we, as accouchers, have allowed the entrance of the infecting agent. The conclusion to be drawn from this is that to douche a uterus after manual interference is really unnecessary, if we have been conscientious in our aseptic technique, and to use the douche is an acknowledgment of want of confidence in ourselves.

Neither the vaginal nor the uterine douche is therefore required as a routine practice in obstetrics; and they are contra-indicated: first,

from the danger of conveying infection on the nozzle, if not absolutely sterile; and second, from the fact that the bactericidal power of the vaginal discharges is lessened thereby.

Remembering these facts I desire to point out that the douche is still not without its value. We can all remember cases of high temperature, following delivery, where a single douche has been followed by a drop to normal in the temperature, but the action in this case is, of course, not germicidal—simply mechanical. Personally, I think the vaginal douche is of great service in some cases of obstetrics—particularly where a torn perineum has been sutured, provided that we are careful to have an aseptic syringe and an aseptic fluid for irrigation. The normal saline, prepared with sterilized water, is probably the best, as we desire the mechanical action—removing the nidus that would favor the growth of germs.

The puerperal patient lies mostly upon her back, her perineum has been carefully sutured, and the result is a *cul-de-sac* in which the lochia lodges and only the overflow drains away. What could be more favorable than this pool of lochia for the cultivation of germs of putrefaction! It is not necessary to commence to douche until the end of forty-eight hours, but after that a daily douche for the next five days is grateful to the patient and prophylactic to infection. The following case is an example of what may occur when these precautions are neglected.

Mrs. S., primipara, attended in her confinement by one of the most careful practitioners of the maritime provinces; had also the advantage of a hospital-trained nurse. The confinement was normal in every respect, no assistance being given, and all precautions taken against infection. The perineum was torn, but repaired immediately, and the needle and suture used were boiled just before use. The puerperium was normal, save that after the fifth or sixth day the patient complained of the close smell in her room, and noticed that it came from the diapers. She spoke of it to the doctor, and even suggested the advisability of a douche, but he told her that douching was an antiquated practice, and not good.

The patient was slow to regain her strength, and was unable to leave her bed until her baby was four weeks old. On getting up she was seized with a pain in the left side, and, although various remedies

were tried, the pain continued to interfere with her getting about for another three months. At the end of that time I saw her. She was pale, had lost flesh, and complained of the constant pain in the left inguinal region.

On examination the lower abdomen was tender, the muscles rather rigid. The perineum was soundly healed—a most excellent result—but on examining the uterus it was subinvoluted, and there was also an endometritis. From the history the latter must have resulted from a spread of the infection from the stagnant pool of lochia in the vagina, which might easily have been relieved by simple douching with sterile water, or, better still, sterile salt solution. Under an anæsthetic I examined the tube and ovary, but they were not diseased and a curettement followed by the application of pure carbolic acid relieved the pain, having cured the condition.

While, therefore, strong in condemnation of the old method of using one fountain syringe for all cases, without any attempt at sterilization, and while also condemning the practice of putting in a few perchloride of mercury tablets, thinking that they make everything safe, I hold that the carefully-prepared aseptic vaginal, and, in some cases, uterine douche, is still of great value in obstetrics.

THE
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVI. HALIFAX, N. S., JANUARY, 1904. No. 1

Editorial.

MEDICAL WITNESS FEES.

The Medical Society of Nova Scotia was organized and sustained for the purpose of safeguarding the rights and caring for the material interests of the profession as well as for the promotion of scientific knowledge.

For many years after the formation of the Society sanitary legislation, vital statistics, medical ethics, protection against quackery, adequate remuneration for services rendered to public authorities and corporations, medical education, etc., etc., received careful consideration, and important concessions were secured.

During recent years practically the whole time of the annual sessions of the Society have been devoted to scientific work, and the welfare of the profession ignored, notwithstanding the fact that, owing to social and economic changes, the points of contact between medical men and public authorities have multiplied.

Attempts to interest the Society in questions affecting their rights have been made from time to time, but were usually side-tracked by reference to committees which never reported.

At the New Glasgow meeting in 1902, Dr. Henry P. Clay, of Pugwash, in a very pointed and spicy paper, called attention to a number of grievances affecting the profession, more particularly in the rural districts. The discussion which followed emphasized his statements, and the matter finally ended in the appointment of a committee on legislation, to which, unfortunately, no very specific duties were assigned; consequently no report was submitted at the Antigonish meeting last year. Several matters came up at the Antigonish meeting, a new committee being appointed on legislation, and specific work was assigned to them.

One subject referred to by Dr. Clay, concerning which there is no difference of opinion among medical men, calls for prompt and united action. That is the very inadequate remuneration allowed for testimony in courts of law.

The Nova Scotia law only makes provision for evidence before a coroner's court. For this a fee of $5.00 is fixed by statute, but nothing is allowed for a post-mortem examination, provided it is called for. Formerly $5.00 was paid for an autopsy, but this fee was struck off without any protest from the profession. For testimony in the higher courts, whether ordinary or skilled, there is no allowance but ordinary witness fees, sixty cents a day, and five cents a mile for travelling expenses, which bears very hard on rural practitioners who may be called away from practice for several days. In short, medical witnesses' fees are lower in Nova Scotia than in any other province of Canada.

In Ontario, Manitoba and British Columbia, physicians and surgeons, when called upon to give evidence of any professional service rendered by them, or give a professional opinion, are allowed $4.00 per diem, exclusive of mileage fees; in all of the courts of justice these allowances are somewhat lower than those provided in Great Britain, but are greatly in excess of those which obtain in Nova Scotia.

Last year the Provincial Medical Board was requested by resolution of the Cumberland County Medical Society to obtain legislation for an increase of medical witness fees. Dr. McIntosh, of Pugwash, strongly supported the resolution, and urged immediate action. Though not empowered to deal with subjects other than those provided for by law, the Board agreed to appoint a committee to report upon the subject, and to defray any legal expenses which might be incurred in the investigation. At a later meeting the report of the committee was adopted, and they were authorized to co-operate with the committee of the Society.

All the necessary information has been obtained. The preparation of a bill is a simple matter, but to secure its acceptance by the legislature will require the united exertions of the whole profession.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

December 9th, 1903. Meeting held in the Council Chamber of the City Hall, Dr. Goodwin, President, in the chair.

Dr. Birt, of Berwick, was called upon, and read his paper on the relationship between visceral syphilis and pulmonary tuberculosis. The paper was chiefly the report of a case that came under Dr. Birt's observation in his practice. The patient came to him complaining of cough, pain in right side of chest, loss of weight, sweats, and an evening rise of temperature to 101.5° F., or thereabouts. He had a hypertrophic rhinitis, and there was considerable enlargement of both liver and spleen. There was some retraction of right apex, with a limited expansion, and also some dulness on this side. Repeated examinations of the sputum gave a negative result. He was placed on appropriate treatment, and carefully watched. During the following summer he improved somewhat, gained in weight, etc. The following winter, however, saw the patient in much the same position as described above. The liver was still markedly enlarged and tender. About this time a history of syphilis was obtained. This had previously been stoutly denied. K. I., along with grey powder, was then administered, and the result was a complete disappearance of all the symptoms. The apparent improvement afore mentioned was due to potassium iodide, which was given him by a throat specialist for his nose. Dr. Birt then read extracts from a clinical report of a very similar case by Dr. Janeway, of New York.

Dr. Birt referred to anomalies of the shoulder girdle and muscles about it that may mislead one when examining the chest. His patient was a left-handed man, and was much better developed on this side than on the right; hence the retraction of the apex and flatness present. The patient's slight anatomical difference was sufficient to account for his chest condition. The pain was due to pressure from the liver. The doctor dealt with the possibility of the two conditions, namely, phthisis and syphilitic liver trouble coexisting. He did not now think there was any pulmonary trouble. Auscultation had shown nothing abnormal beyond slight prolongation of the expiratory sound on the right side.

Dr. Chisholm referred to a case that came under his observation with a diagnosis of tubercular arthritis of the knee. The patient had a suspicious mark on his forehead, which suggested syphilis. The knee rapidly improved on potassium iodide. Dr. Chisholm thought in all obscure cases the possibility of syphilis should be considered.

Dr. Clay, of Pugwash, referred to some cases he had cured by potassium iodide.

A vote of thanks to Dr. Birt for his interesting and instructive paper was moved by Dr. Trenaman and seconded by Dr. Ross.

January 6th. Meeting was held at the Nova Scotia Hospital, Dartmouth, the President, Dr. Goodwin, in the chair.

Dr. Lawlor read a short paper on "The Stigmata of Degeneration." He also presented the following cases illustrating his paper:—(1) a patient with cleft palate, no angle to jaw, and very shrivelled-up ears; (2) patient with very high arched palate; (3) patient with very small ears in proportion to size of body; (4) a man 26 years of age, whose general appearance would indicate that he was much younger, no hair on any part of his body but head; (5) a want of similarity between the two sides of the face; (6) a difference in length of the two humeri. Dr. Lawlor pointed out that it was the rarest of things to find a perfectly-formed man. Everybody has some stigma more or less severe. It is only when taken in conjunction with some other conditions that they are of importance. In the insane they were always looked for.

Dr. MacKenzie's paper was on "Paretic Dementia." He dealt with the part played in the causation by syphilis and alcohol. He referred to the more frequent occurrence of the disease in men. Dr. MacKenzie said that in making a diagnosis it should be remembered that many cases do not exhibit exalted ideas—are, in fact, often melancholic throughout.

Dr. Hattie's paper was on "The Prevention of Insanity."

He spoke of the influence of heredity and alcoholism in the production of insanity. Dr. Hattie thought that legislation was necessary to restrict marriage among people of neurotic temperament. The children of such marriages generally showed a tendency to nervous weakness, and were more or less predisposed to insanity. Consanguinity is not looked upon now as an important factor in the causation of insanity, particularly if both parents are healthy.

Dr. Hattie thought that the question of education was most important, and should receive more attention than it does at present.

The discussion following the reading of these papers was participated in by Drs. Stewart, Trenaman, C. D. Murray and Chisholm.

The members then adjourned to the dining-room where they enjoyed the good things provided by Dr. and Mrs. Hattie.

Personals.

Dr. Smith L. Walker has returned to Truro after practising some years in Los Angeles, California.

Drs. J. G. McDougall, of Amherst, and James McLeod, of Wallace, have gone to London, to carry on post graduate study for some months.

N. S. BRANCH OF BRITISH MEDICAL ASSOCIATION PROGRAMME.

The following is the plan of the agenda for the remainder of the session:

Feb. 3rd—Paper by Dr. T. D. Walker, St. John, N. B. Subject to be announced.

Feb. 17th—Pathological Meeting at Halifax Medical College.

March 2nd—Paper on "Iritis," by Dr. W. G. Putnam, of Yarmouth, N. S. Discussion by Dr. Kirkpatrick and others.

March 16th—Paper by Dr. John Stewart, "Carbolic Acid in Surgery;" also paper by Dr. M. Chisholm.

March 30th—Paper by Dr. H. K. McDonald, Lunenburg, N. S. Subject to be announced.

April 13th—"History of Medical Society in Halifax." Paper by Dr. D. A. Campbell.
Discussion on "Diseases of the Prostate Gland," by Drs, Murphy, Ross and others.

Additions and changes to the above programme may be made as occasion arises. Members and all visiting practitioners from all parts are welcome. Any medical gentleman willing to contribute a paper will kindly communicate with the Secretary, Wm. D. Forrest, M. D., Pleasant street, Halifax.

Therapeutic Suggestions.

CYSTITIS.—There is an advantage, according to the *Jour. de Med. de Paris*, in prescribing salol internally in the form of an emulsion instead of powder form in the treatment of cystitis. The following formula is recommended:

R.	Salol.....gr. xxx-dr. i	2-4	
	Pulv. tragacanthae.....gr. ii		12
	Pulv. acaciae.....gr. xxx	2	
	Tinc. simp.....oz. ss	15	
	Aq. distil. q. s. ad.....oz. ii	60	

M. Sig.: Ft. emulsio. Sig.: One teaspoonful before each meal.

The following combinations are recommended by *Merck's Archives* in the treatment of cystitis:

To relieve the pain:

R.	Ext. opii.....gr. vi		40
	Ext. hyoscyami.....gr. v.		30
	Olei theobrom. q. s.		

M. Ft. suppos. No. vi. Sig.: One to be introduced into the rectum at night; or:

R.	Pulv. opii.....gr. xii.		75
	Camphorae.....dr. ss	2	
	Ext. belladonnae.....gr. iii		20
	Olei theobrom. q. s.		

M. Ft. suppos. No. vi. Sig.: One to be inserted at bedtime.

As an antiseptic and to relieve the irritation the following is of service:

R.	Ext. belladonnae fl.....gtt. xx	1	30
	Sodii boratis.....dr. ii	8	
	Acid benzoici.....gr. xx		30
	Tinc. opii camph.....oz. iss	45	
	Olei gaultheriae.....gtt. xii		75
	Syrupi.....oz. ii	60	
	Aq. destil.....oz. xii	120	

M. Sig.: One dessertspoonful in water four times a day.

—*Los Angeles Medical Journal.*

OPACITY OF THE CORNEA.—Mazel of Marseilles recommends a solution of benzoate of lithium (5 to 15 grs. in drams ii. p. aqua) to be instilled into the eye t. i. d.—He reports several patients successfully treated with this solution.—*Medical Press.*

FETID BREATH:—

R.	Inf. sage	250.0
	Glycerin, pure	30.0
	Tinct. myrrh	
	Tinct. lavender	āā 12.0
	Laborraque's solution	30.0

M. et S. Mouth wash, as required.

When due to gastric fermentation, wood charcoal in dose of ten grains every three hours.—*Campbell.*

PRURITUS ANI:—

R.	Ext. conii	drams ii
	Ungt. stramonii	
	Lanolini	āā oz. i

M. Sig.: Apply at bedtime and before stools.

—*Tuttle.*

PHOSPHORUS FOR HOARSENESS.—A very valuable drug for chronic hoarseness and loss of voice, is phosphorus in small, frequently repeated doses.—*Pennsylvania Medical Journal.*

FOR HABITUAL EPISTAXIS.—In habitual epistaxis, without regard to the cause, the frequency of the attacks, or their severity, Woodward says (Med. Summary) ammonium carbonate is an absolute specific. Two grains every ten minutes will stop the flow quickly during the attack. To correct the tendency and overcome the habit, two grains should be given from three to six times each day. He has depended upon it for twenty-five years without a single failure, and obtained the suggestion from a physician who had used it for nearly as long a time before him.

Book Reviews.

"PLAIN HINTS FOR BUSY MOTHERS."—By Marianna Wheeler, Superintendent of the Babies' Hospital, New York, and author of "The Baby." Price 35 cents. Published by E. B. Treat & Co, New York.

As the author indicates, this booklet is to give practical suggestions to the busy mother who must care for her own baby and at the same time attend to the household. The information given will be found of great advantage, while the illustrations are excellent and easily followed The book deals with such subjects as "The Bath," "Dressing the Baby," "Clothing," "Fresh Air," "Food," "Emergencies" and "Receipts," which contain much valuable information. The chapter on "Dont's" is especially worthy of attention, and it would be well for practitioners to distribute this booklet among the many families requiring the knowledge contained in its pages.

New Books Published.

The following published by E. B. Treat & Co., New York:

"THE BLUES, (Splanchnic Neurasthenia) CAUSES AND CURE."—This form of nervous weakness is so common as to render this volume of more than theoretic interest. By Albert Abrams, M. D., F. R. M. S. 8vo. 230 pages illustrated, $1.25.

"DISEASES OF METABOLISM AND NUTRITION; Part IV., AUTOINTOXICATION."—By Prof. Dr. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfort-on-Main, and Dr. Mohr. Authorized American edition. Edited by Boardman Reed, M. D. Small 8 vo. 80 pages, 50 cents.

"TREATMENT OF DISEASE BY PHYSICAL METHODS."—Lectures on Electricity, Massage, Baths and Exercise. By Thomas Stretch Dowse, M. D., (abd.) F. P. C. P. (Ed.) 4th Ed., small 8 vo., 454 pages, illustrated, $2.75.

"DISEASES OF METABOLISM AND NUTRITION."—A series of Monographs. By Prof. Dr. Carl von Noorden, Physician-in-Chief to the City Hospital, Frankfort-on-Main, and assistants. Authorized American edition. Edited by Boardman Reed, M. D., Philadelphia. 1. Obesity, small 8 vo., 50 pages, cloth, 50 cents; 2. Nephritis, small 8 vo., 112 pages, cloth, $1; 3. Colitis, small 8 vo, 40 pages, cloth, 50 cents.

"MEDICAL AND SURGICAL ELECTRICITY."—Including X Ray, Vibratory Therapeutics, Finsen Light and High Frequency Currents. By A D. Rockwell, A. M., A. D. New and enlarged edition, Royal Octavo, 672 pages, illustrated, half Mor., $6; cloth, $5.

The following published by W. B. Saunders & Co., Philadelphia:—

"THE TREATMENT OF FRACTURES" with notes upon a "Few Common Dislocations," by Dr. Chas. L. Scudder, Surgeon of the Massachusetts General Hospital. 4th edition. Thoroughly revised, enlarged and reset. Octave volume of 534 pages, with nearly 700 original illustrations; 1903. Price, Polished Buckram, $5, net; Sheep or one-half Morocco, $6, net.

"A TEXT-BOOK OF LEGAL MEDICINE AND TOXICOLOGY," Vol. 2, edited by Drs. Frederick Peterson, Chief of Clinic Nervous Department of the College of Physicians and Surgeons, New York, and Walter S. Haines, Professor of Chemistry, Pharmacy, and Toxicology, Rush Medical College, Chicago. Two imperial octavo volumes of about 750 pages each, fully illustreted. Price per volume, cloth, $5 net; sheep or half morocco, $6 net.

Notes.

"Many a man is to-day worrying over a case or two of pneumonia, pleurisy or capillary bronchitis, whose troubles would flit away like mist did he but know enough to put his patient into a jacket of Antiphlogistine."—*Medical Summary*, Nov., 1902.

THE TREATMENT OF NASAL CATARRH.—Mannon (*Cincinnati Lancet-Clinic*) finds no danger whatever from the use of the nasal douche provided ordinary care is taken and a proper solution is employed. The charge that post-nasal douching is prone to excite inflammation of the middle ear he does not find sustained. All leading specialists employ this method of treatment in the posterior as well as the anterior nares with equally good results. The doctor has had chronic nasal catarrh of many months duration yield to douching when heroically employed. Listerine, to which a small quantity of bicarbonate of soda has been added, is his main stand-by. If hemorrhage is a controlling feature he uses instead a saturated solution of tannic acid to each ounce of which ten grains of carbolic acid has been added. When the tendency to bleed ceases he returns to the listerine solution. Treated in this way the most pronounced cases yield in three or four weeks and are not prolonged by complications or sequelæ.

RHEUMATIC PAIN AND FEVER.—In *The Medical and Surgical Bulletin* we find the following under the caption of "Acute Articular Rheumatism" by Dr. E. G. Evans: "Salol is the best intestinal antiseptic we have, and antikamnia as a pain reliever is, without doubt, unsurpassed; therefore, the combination of these two remedies in the form of the well known 'Antikamnia and Salol Tablets' afford us the ideal medicament for pain and fever in rheumatic conditions. Patients appreciate the fact that when administering antikamnia, you relieve the pain without giving them morphia, while the salol acts as a germicide and antiseptic, tending to ameliorate generally, the symptoms of the disease. Antikamnia and Salol Tablets (each tablet contains 2½ grains antikamnia and 2½ grains salol) are best given in doses of two tablets every three hours until ten or twelve tablets are taken during twenty-four hours. The patient's bowels must be kept open and the diet should be light. Alcohol is contra-indicated and water should be freely and frequently given The bed covering should not be too heavy, but warm. Cold water packs, as well as hot fomentations, are very beneficial."

Gude's Pepto-Mangan, if we look over the field of preparations launched upon the market, claiming to be "just as good," "just the same," etc., and now relegated into oblivion, we will find their name is legion. Since its introduction to the medical profession of America, many manufacturers, through their representatives, have heralded competing products as possessing wonderful medicinal properties. They were tried, found wanting, withdrawn from the market, and to-day find a resting place in some upper loft labeled, Deadstock. "Gude's" has stood the test of clinical investigation in both private and hospital practice; moreover, it has been before the profession during the last 12 years, and during this period has steadily grown in favor.—Editorial *Medical Examiner and Practitioner*, Dec., 1903.

Dr. Colin Campbell, Southport, Eng., L. C. P. R., M. C. R. S., writes in the *Medical Press and Circular*, London, Eng., Oct. 7, 1903:—

PLEURISY.—Dr. B. was under my care last winter suffering from a pulmonary cavity. He had had previously two or three intercurrent attacks of pleurisy, which I again found present on Dec. 7th, 1902, accompanied by severe pain over the cavity and a temperature of 103°. His previous attacks had occurred at his home, where careful poulticing was practicable, but in apartments this was unsatisfactory, and so it occurred to me to try Antiphlogistine.

The material was warmed and "trowelled" on for many inches around the pleuritic centre, then covered with non-absorbent lint and jaconet.

The result was remarkable; the pain disappeared within an hour and the high temperature within two days.

Many advantages over poulticing were noticed by the patient; facility of application, no unendurable heat, rapid relief from pain, its adhesiveness rendered movement possible without tight bandaging or the alternative sudden influx of cold air which follows the separation of a poultice from the skin.

* * * * *

Chilblains to many will appear a trifling matter, but as one whose school days in winter were rendered miserable by them, I can assert that they are most maddening. Last winter my daughter, age 11, suffered from them severely. Each time Antiphlogistine was applied, the redness and intolerable itching disappeared in a night. I have tried remedies innumerable with no such result.

DYSMENORRHEA

The reputation of H. V. C. was established by its efficacy in the treatment of this condition. It relieves the distressing pain as no other remedy can do, and unlike morphine and other narcotics there are no disagreeable after-effects. It is a trustworthy antispasmodic

UTERINE TONIC

In prolapsus uteri and other conditions due to a relaxation of the muscles of the uterus and its appendages, H. V. C. stimulates pelvic circulation, thus relieving the congested organs, and re-establishes normal circulation and tonicity of these parts.

H. V. C.

MEANS

Hayden's Viburnum Compound

THE ORIGINAL AND STANDARD PRODUCT

NEW YORK PHARMACEUTICAL CO., Bedford Springs, Mass.

MENOPAUSE

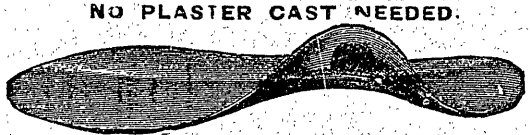
At this critical stage of genital involution H. V. C. is of the greatest importance. Its sedative action upon the pelvic nerve centers modifies and relieves those conditions so characteristically manifested at this period.

A WARNING

The enviable reputation of the Viburnum Compound of Dr. Hayden, H. V. C., in the treatment of diseases of women, has encouraged unscrupulous manufacturers to imitate this time-tried remedy. If you desire results, you must use the genuine only—beware of substitution.

HOLLAND'S IMPROVED INSTEP ARCH SUPPORTER.

NO PLASTER CAST NEEDED.



A Positive Relief and Cure for FLAT-FOOT,

80% of Cases treated for Rheumatism, Rheumatic Gout and Rheumatic Arthritis of the Ankle Joint are Flat-Foot.

The introduction of the improved *Instep Arch Supporter* has caused a revolution in the treatment of *Flat-foot*, obviating as it does the necessity of *taking a plaster cast of the deformed foot.*

The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the *heavy, rigid, metalic plates* formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *flat-foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot.*

IN ORDERING SEND SIZE OF SHOE, OR TRACING OF FOOT IS THE BEST GUIDE.

Sole Agents for Canada: **LYMAN, SONS & CO.** Surgical Specialists.

380-386 ST. PAULS ST., MONTREAL.

The true value of a food can only be measured by its assimilability. There is a great difference between the mere ingestion of food and its assimilation by the living cells.

LACTO-GLOBULIN

which is more readily assimilated than absolutely any other alimentary product, owes its remarkable qualities to the action of the Enzymes which complement its nutritive value.

The intelligent use of "LACTO-GLOBULIN" gives definite results, as an adjuvant in the treatment of constitutional and functional disturbances.

ANALYSIS ON EVERY PACKAGE.

5 oz. Package, 50c; 15 oz. package, $1.00.

Sold through the Drug Trade only.

"The Hand Book of Lacto Globulin," free samples and any further information required will be supplied to physicians on application to the

Lacto-Globulin Co.,

LIMITED.

795 CRAIG STREET, MONTREAL.

PARKE, DAVIS & CO'S
ANTIDIPHTHERITIC SERUM

PACKAGE A

Bulb Syringe Container

The Favorite Serum of the Medical Profession

PACKAGE C.

Piston Syringe Container

POTENCY! SAFETY! CONVENIENCE!

Into the preparation of our Antidiphtheritic Serum the elements of chance and guesswork never enter. To insure its perfect reliability we resort to every known precaution, every available test. Our Bulb and Piston Syringes, with hermetically sealed containers, afford quick and easy administration.

On unspecified orders our Antidiphtheritic Serum is supplied in the Bulb Syringe Container shown above, designated as "Package A."

ALWAYS SPECIFY "PARKE, DAVIS & CO."

PARKE, DAVIS & COMPANY

ADDRESS US AT WALKERVILLE, ONT.