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EDITORIAL.

THE RECENT MEETING OF THE CANADIAN MEDICAL ASSOCIATION.

The Meeting of the Canadian Medical which was held during the first week in June was a very successful affair. The attendance was large and the social functions well arranged.

The scientific side of the meeting was good. The papers and discussions at the general sessions and the sectional meetings would have done credit to any country. A number of gentlemen of reputation from the United States and one from Great Britain, added much to the value of the proceedings.

We are inclined to think, however, that the tendency is to run too much into sections. It may be a difficult matter to dispose of all the papers in any other way; but would it not be better to have fewer papers, and arrange that almost all could hear them?

We think that the specialists would enjoy hearing the papers in other departments than their own. In the case of the general practitioner it must be admitted that an effort should be made to enable him to take in nearly all the papers and discussions. In this way the meeting would be a sort of brief period of study or post-graduate course. We feel that this phase of the meeting should receive some attention in future meetings.

There is a feature of these annual meetings that must be resisted. There is a very evident tendency for the same group of persons to hold together and in this way hold all the offices and have themselves appointed on all the committees. This tendency is an ever present evil in almost all such organizations. No one for a moment finds fault with those who have done good work for the association, but that all should receive a chance. The old time custom of do-it-for-me-this-time and I-will-do-it-for-you-next-time should not exist.

THE CANADIAN MEDICAL ASSOCIATION AND A JOURNAL.

The subject of an official Journal for the Canadian Medical Association has been up for discussion for several years. We have

expressed our views freely that this is a very serious undertaking and the ways and means should be clearly in sight before the association has embarked upon the scheme.

Dr. R. A. Reeve submitted the report of the Executive Committee. The report congratulated the Association on the fact that arrangements had been made with Dr. Andrew McPhail, of Montreal, to act as editor of the new journal. But, if we remember aright, no word was said as to the salary for the present, nor in the future, should the new journal continue to be issued. We have tried to secure information for the profession, but so far have not succeeded.

Then the report went on to state that \$360 a year be paid to those who now hold the goodwill of the *Montreal Medical Journal*. At 5 per cent. this interest on a capital of \$7,200. Whether Dr. McPhail will prove a successful editor time will tell, but one thing is very evident, some one has proven himself a good bargain maker, and we do not hesitate to state, has completely out generated the Executive Committee.

Then the report stated that the *Montreal Journal* is to be made the organ of the association. And Dr. McPhedran told the meeting that he thought the association was getting good value. Where is the value? Will Dr. Andrew McPhail state that the *Montreal Medical Journal* was a paying concern? There may be some advertising on its pages, but this is only worth the commission paid an agent to secure it. In this aspect of the bargain the goodwill is not worth much. When one turns to the subscription list the goodwill is of no value at all, as the journal is only to go to members of the Canadian Medical Association. It will not do for the Executive to charge the members \$5 and send the journal to others for \$3 a year. This would be an improper use of the Association's funds.

Everything that is done by the Canadian Medical Association should be done in a strictly constitutional manner. If the Association undertakes to publish a journal, this journal must go to all the members, and to these only. Further, the Association commits itself to the necessity of furnishing the members a complete report of the proceedings. This will mean a heavy outlay of money. If the proceedings and papers are denied the other medical journals, then the Association will only have the goodwill of its own organ, whereas in the past it has had the goodwill of all the journals.

It was moved by Dr. Blanchard and seconded by Dr. Fotheringham, "that the members of the Finance Committee resident in Montreal be a sub-committee to complete arrangements between the *Montreal Medical Journal* and the Finance Committee for the Association." These persons are Drs. James Bell, F. G. Finley and E. Archibald.

DOMINION REGISTRATION.

With a patience that would do honor to any cause, Dr. T. G. Roddick appeared at the meeting of the Canadian Medical Association and again advocated the cause for which he has done so much.

The amendments that had been suggested to the Act of 1902 were submitted and approved of. It is to be hoped that when these changes are inserted in the bill the views of every province will be complied with, and we will have a truly national profession. We have given careful attention to the objections raised from various quarters; but we are bound to state that they are the creation of the fancy rather than real difficulties. As time would pass on any minor inequalities would be remedied.

The fact that the councils of the provinces would still continue and would grant the right to practice to such as wished to confine his efforts to any one province should satisfy all. Those who desired the wider qualifications could obtain it. If the standard is kept high, nothing but good would come from the adoption of the bill.

THE CONSTITUTION OF THE CANADIAN MEDICAL ASSOCIATION.

The objects are set forth as periodical meetings, the publication of information such as a journal, the publication of transactions, the granting of money for research work, and any other lawful thing that may promote the foregoing.

The membership shall consist of ordinary and honorary. The former are drawn from regularly qualified medical practitioners, or those engaged in teaching or research work in Canada. The honorary members are elected by the Executive Council.

Provincial and interprovincial and other societies may affiliate with the Canadian Medical Association, and become branches thereof.

The affairs of the Canadian Medical Association shall be managed by the Executive Council. This Council is made up of delegates elected by the affiliated societies, by the Provincial Medical Councils, and by the Canadian Medical Association, namely, president, vice-president, treasurer and secretary. The Executive Council shall elect the officers, except the president. This Council must also approve of all amendments before they are submitted to the Association.

The finance Committee, composed of five members, is also a Publication Committee. The funds of the Association are derived from an equal annual assessment upon each ordinary member, and from

the sale of the Association's Publications. The constitution also states, "And in any other manner approved of by the Finance Committee. This is giving this committee almost absolute power. The president and general secretary are *ex officio* members of this committee. This committee engages the editor and such assistance as may be required for the publication of the journal.

Membership is secured by of membership in an affiliated branch, by application direct, and by paying the annual fee of \$5. This membership is retained so long as one complies with the by-laws. Any one who fails to pay his fee before 31st December shall be suspended, but shall not thereby be relieved of his debt to the Association. "No member shall (except in case of his death or expulsion or his ceasing to be a member under the previous provisions of this article) cease to be a member without having given previous notice in writing." In this way one may render himself liable for a number of years' subscription at \$5, whether he attend meetings or not. If one loses membership he must pay up all arrears, and furnish a certificate of good standing in his branch, if he joined through a branch society. To register one must have "paid his annual dues for that and previous years."

The Executive Council is composed of 15 members elected at each annual meeting; and of those from the affiliated societies, namely, the president of these and a delegate for a membership of 15 to 50, two delegates up to 150, three delegates up to 300, and thereafter one extra delegate for each 300. The Executive Council shall hold meetings during the time of the Annual meeting of the Association; but the chairman shall call special meetings on the requisition of five members of the Council. This may become a very expensive system, as at least travelling expenses would have to be paid. Members all over Canada could hardly be expected to give up their time and bear the cost of attending meetings of the Council.

With regard to nominations and elections the following rules govern: The general officers are a president, a vice-president and local secretary for each province, a general secretary, and treasurer. The president is nominated by the Executive Council and elected by the Association. Any five members may nominate any member for any office by handing in his name to the general secretary. The president of the Provincial Association within whose boundaries the Canadian Medical Association meets shall be first vice-president.

The foregoing summary of the constitution will enable our readers to grasp its essential features. The main feature is that of permanent membership and that a member is liable for his annual fee of \$5, whether he attends or not.

No where does the constitution of the Canadian Medical Association indicate the apportionment of the membership fee between the Canadian Medical Association and the Provincial Associations. It has been stated in open meeting that 50 cents per member goes to the Provincial Society.

THE ONTARIO MEDICAL COUNCIL.

This body has been in the lime-light for some time. The annual meeting is again drawing near. It is to be hoped it will be an orderly and business-like meeting.

There are a number of points upon which the profession is anxious to hear, and it would be well if the Medical Council gave on these points a clear and definite answer.

1. The first of these would be to show what percentage of students passed in each year, on each subject, and from each school. This could be put in tabular form so that any one at a glance could tell how many candidates there were on each subject from each school, and how many of these passed. In this way the nature of the teaching could be judged, or enquiry made if any given examiner had been unduly severe. Medical education is a serious affair and we require definite information. An immense amount of money from the public and the students is annually poured into this form of higher education; and we do not wish to be blinded with a few generalities that so many passed and so many failed. The public and the profession has a right to be put in possession of the fullest information as to what it is getting for the money.

2. Another matter of prime importance is the attitude which the council proposes to take on the question of Dominion Registration, Interprovincial Reciprocity, and Reciprocity with Great Britain. The medical relationships between France and Ontario are just as free as between Quebec and Ontario. A graduate of Ontario could go to Germany and qualify with less trouble than he could if he went to Manitoba. This should send a feeling of shame to the dullest conscience. If we cannot secure the Dominion Medical Act, then those in authority in the various medical councils for all the provinces should get together and frame a standard that all would be willing to live up to, and which secured in one province would be good in another.

How are things elsewhere? In the United States, Washington State, California, Oregon, Idaho, Montana, Arizona, South Dakota, Mississippi, Alabama, Florida, Massachusetts, Connecticut, and Rhode Island. This a group of thirteen in all, and scattered in all portions of

the Republic, and some of these small states, and others, as yet, of comparatively slight importance from the medical point of view.

The States that have Interstate Reciprocity in Medical Licensure are Nevada, Utah, Wyoming, Colorado, New Mexico, North Dakota, Nebraska, Kansas, Oklahoma, Texas, Minnesota, Iowa, Missouri, Arkansas, Louisiana, Wisconsin, Illinois, Michigan, Indiana, Kentucky, Tennessee, Ohio, West Virginia, East Virginia, North Carolina, South Carolina, Georgia, Maine, New Hampshire, Vermont, New York, Pennsylvania, Maryland, New Jersey, Delaware, and District of Columbia. This is a group of thirty-six states, and by far the most important portions of the country.

We all know the condition in Great Britain. A graduate in Scotland can practise in England, and *vice versa*.

But this whole matter should go further. It should be made to include Great Britain.

3. The next plain duty the council has before it is to give a full statement of the finances. It must show what is paid each member of the council and each examiner. This accounting must give the mileage and the *per diem* allowance to each. The number of days attendance upon committees and council meetings must be set forth. The funds belong to the medical profession, and this information must be produced. The excuse that has been advanced that it would cost something is quite out of place. It will not cost anything, as the announcement must be issued anyway, and this may be inserted. But it is a wrong excuse, even if it did cost a little. It is the right of all to receive this information. We happen to know a good deal about what has been paid to certain members of the council, but prefer to have the statement in an official form for the benefit of all.

4. One more duty lies at the door of the Medical Council. It must get out the announcement promptly. The information sought for will lose much of its value if it is held back for a long time. There is to be an election this fall and every voter should know for whom to vote, and why. The members of the profession should not be asked to "go it blind." We would remind our readers of the words of Shakespeare:

Trust None;

For oaths are straws, Men's faith are wafercakes

And hold-fast is the only dog.

A NATIONAL DEPARTMENT OF HEALTH.

Canada is a young country and now in the time to lay down our foundations on proper grounds. It is much easier to start now than

in years hence when the population is much more numerous and conditions have become much more complex.

It is with much pleasure that we recognize the good work that is likely to follow from the commission on the conservation of our natural resources. The report which has been issued goes to show that there is much to do; and, judging by some of the addresses, much is going to be done.

While it is very well to take into careful account our timbers, minerals, streams, fish, fur animals, etc., we must not forget our people. In Canada there is at present about 7,500,000 people. Taking the value placed on the average of the people of countries like Great Britain and the United States, as determined by competent statisticians, at \$1,700 for all ages, we would have the grand wealth of this country in her people of \$12,750,000,000. This is a big sum. Put in words it is nearly thirteen billion dollars.

The committee of one hundred in the United States has reported that the monetary loss in that country in lives lost and time lost, due to preventable causes, \$1,500,000,000; or one and one-half billion dollars. If the same proportion held good for Canada the loss would be about \$125,000,000 a year, which could be prevented. In other words preventable sickness and deaths are causing more loss in dollars than the entire national income, for the management of which we have thirteen ministers of the crown.

Surely this need not be pushed any further. Those who run may read. It is true that the provincial jurisdiction in such matters must be carefully borne in mind. But there is ample work for a Health Department at Ottawa.

OCULISTS MAY PRACTICE.

Mr. W. J. Harvey was convicted some time ago by Magistrate George Eady, of Renfrew. From this conviction Mr. Harvey appealed, and the case was heard by Mr. Justice Middleton. Justice Middleton set aside the conviction who held that the Medical Act could not be enlarged to mean the prevention of an oculist from examining the eye and prescribing suitable glasses. We will have more to say upon this subject; but, in the meantime, wish to enter our dissent to this opinion.

ORIGINAL CONTRIBUTIONS.

THE PRESIDENT'S ADDRESS.*

By ADAM H. WRIGHT, B.A., M.D., M.R.C.S. (Eng.),
Professor of Obstetrics, University of Toronto.

IT is supposed by some that the general practitioner will soon become extinct. Although that seemed possible or probable a few years ago in some cities, such as New York, Chicago, etc., it appears that the pendulum is swinging the other way, and the family physician is now considered a necessity in most homes. There is perhaps no member of an ordinary community who comes more prominently into view than the doctor. He must run the gauntlet of criticisms very varied in character. Sometimes these criticisms are harsh and unjust, but on the whole we have no cause to complain. One of the finest characters ever described was Dr. McClure. How many such there are we know not: but there are a few—perhaps many. We might name one—Gawn Shaw Cleland of Toronto, who “cross the bar” last January. The *Toronto Globe*, in an obituary article, said respecting Cleland: “He was loved and respected by his patients and was looked upon throughout the community as another Dr. McClure.”

He it was or such as he that Sir Luke Fildes had in view when he painted that great picture, “The Doctor,” nineteen years ago. Mitchell Banks, of Liverpool, England, made the following reference to it in 1892: “Of the hundreds of medical men who have stood before that picture I am sure there was not one whose pulses it did not quicken with pleasurable pride, or who left it without thinking that it already had been, and again would be his privilege to fight against pain and suffering and death like his colleague on the canvas. Note where the scene of the picture is laid, not in some rich man’s mansion, but in a workman’s cottage. With admirable skill the painter has pitched on the early hour of morning for the time. . . . The sick child, worn with the raging fever, lies spent and exhausted. Till then the parents have been fighting on with their nursing: soothing, caressing, encouraging their little one, and hoping against hope seems all that is left to them. And there sits their friend—the gentle doctor—watching with them, and still puzzling his brains to think what more he can devise to stay the lamp of life from flickering out. He is no courtly physician, no London specialist, that man (thank God!). He is only a country doctor. But his somewhat rugged face tells of honesty and common sense, and self-reliance, and gentleness. What more do we want? The men that look like that man, whatever be their business or trade or profession. what-

* Delivered before the Canadian Medical Association, Toronto, June 1st, 1910.

ever be their wealth of their social position, I say, of such men is the kingdom of heaven." The original picture is now in the Tate Gallery, London. We do not pretend that the majority of physicians are saints or heroes; but we do contend that the practice of our profession furnishes grand opportunities for good work in the interests of suffering humanity. We are proud to think that in all parts of Canada there are physicians who make the most of such opportunities.

Some may wonder whether Fildes' doctor will continue to exist. We are told that therapeutics is becoming unpopular because there has been in the past, and is now, too much empiricism in our methods of treatment. The all-important subjects among the final branches are diagnosis, prognosis and pathology. It is supposed by some that the "McClure" and the "gentle doctor" will go out of fashion, and that the modern physician will struggle longer and puzzle more over his diagnosis, and, then in a case such as Fildes' sick child, he will turn to the mother with a bland smile on his wise face, and say to her: "Madam, this is really a most interesting case. It has been very puzzling, but I am pleased to be able to say I have made a diagnosis and prognosis. This child has malignant endocarditis and will die in about five or six hours. I can do nothing more for you now, but I shall call in the morning to make a post-mortem examination."

One of the most vexed questions of the present day is the preparation of general practitioners, *i.e.*, methods of medical education. In recent years there have been many discussions on the subject of the British Medical Association. I am glad that our friend, Dr. W. T. Connell, of Kingston, will read a paper on the subject at this meeting. The amount of work in all departments of medicine has increased so enormously during recent years that students are bewildered, confused and disheartened. The students of to-day bolt more, and cram more, and observe less, and think less, than did those of ten to twenty years ago. There seems to be little continuity between the teaching of the primary and final subjects. In the early years the students are now swallowing pure and applied science in masses too big for their assimilative organs; or, in other words, are largely memorizing facts without understanding them. It is believed by many that this unfortunate condition of things exists in many, if not most of the best medical colleges in North America, as well as in the old world. It would appear that the level-headed Britishers are realizing the situation more fully than the teachers of any other countries.

Francis Shepherd, of Montreal, in his presidential address before this Association in 1902, referred to certain defects in modern laboratory teaching. There is probably no man on this continent who understands this subject more intimately than he from two standpoints—the scientific

and the practical. He expressed the opinion that in many of our modern hospitals with their laboratories "students are not taught to observe so carefully the evident symptoms of disease, and are becoming mere mechanics.

. . . The higher and more intellectual means of drawing conclusions by inductive reasoning are almost neglected."

On the other hand we have scientists who think that such ideas are entirely wrong and not even worthy of consideration. Some of our advanced educationalists are even growing a little tired of John Hopkins, because those Baltimore men still stick to the old-fashioned idea that the student should be encouraged to observe and think and reason. We are told that they hope soon to be able to manufacture machine-made physicians and surgeons who will be vastly superior to the home-made article.

As a matter of fact, the differences between the schools of thought commenced many years before Shepherd sounded his note of warning. About fifteen years ago the late Sir George Humphry, Professor of Anatomy, Cambridge University, in an address delivered in Oxford, spoke as follows about methods of teaching medicine: "There is too great a mass of facts heaped on the memory and too little reflection on them. . . . The science of physiology and histology have become, and those of pathology and anatomy are becoming, more separated from medicine, delegated to special teachers, doubtless to the advantage and width of scope of these sciences, and to the greater knowledge of them, but I fear there is hereby engendered a tendency to take the student too far afield. . . . It is apt to lead too much to meandering in altitudes, too little to straight going on *terra firma*; too much to pride and obstrusiveness of supposed higher knowledge, too little to reasoning, and too little to power by reasoning upon simple data, and too little to that sort of reasoning which constitutes the basis of common sense. The scientific and the practical, in short, become too much separated. What is needed is a greater regard to that connection between the two which should be maintained through the whole period of study." If these opinions expressed fifteen years ago were correct they will apply with still greater force to the teaching of to-day. Let us come to more recent times—especially the last two years.

Let us quote from a physiologist of high repute. Professor Ernest Sterling, of University College, London, during a discussion at the meeting of the British Medical Association at Sheffield in 1908, said: "The tendency for anatomical education to be imparted by professed anatomists has led to increased demand upon the student in the way of accuracy of knowledge. . . . Pharmacology is practically a new science. . . . The work demanded of a student has practically doubled in amount and is steadily increasing. What is the result?"

We are trying now to get two pints into a pot that formerly held one. . . . The result is that the student is over-burdened from the very beginning of his career. In his first year we try to make him a man of science. To this end we stuff him with facts and absorb the whole of his time in classes, so that he has no leisure for independent thought.

The following extract is taken from a leading editorial in the *British Medical Journal* last April: "Biology as taught by non-medical biologists must go. All the biology a student wants can be given him in his physiological and anatomical courses, and in the study of parasitology and helminthology under the pathologist. Chemistry in the future must be taught by the physiological chemist, and physics by the physiological physicist, by medical men who have gone through the whole training and know the needs and aims of practical medicine. . . . In anatomy great reform is needed, for the size of the present textbooks, and the mass of useless detail required, has reached the limit of pedagogic absurdity."

While our college professors are studying methods in medical education, many of our general practitioners are watching the situation with a very deep and intelligent interest. We think the majority of physicians consider it unwise to endeavor to stuff a quart of material into a pint pot. Many of them also believe that our teachers should teach less in order that our learners may learn more. A certain proportion favor Fletcherization because of their belief that the intellectual pabulum given to our students should be properly digested and thoroughly assimilated.

By a process of evolution the general practitioner frequently develops into a specialist. We have also the ready-made specialist, to whom reference has previously been made. The relationship between the general practitioner and the specialist has been much discussed in the past. Dr. Matthew D. Mann, of Buffalo, read a paper last February on "Dichotomy" or "Dividing Professional Fees." It would appear from what he says that a large proportions of surgeons in the United States are in the habit of giving percentages or commissions to physicians who send them patients, without the knowledge of the latter. I hope it is not necessary to tell members of this Association that such conduct is undignified, unethical and dishonest. It is quite true that the division of fees between the general practitioner and the operating surgeon is frequently or perhaps generally unfair to the former. How can a more fair division be made? We are inclined to think the general practitioners must find that out for themselves. At the present time the relationship between general practitioners and specialists is being considered by a strong committee nominated by the Medical Society of the County of Erie, New York. We shall look forward to their report with much interest.

The general practitioner takes great interest in the work of the specialist. When he goes into a modern hospital theatre while a surgical operation is being performed he beholds something which fills him with wonder and admiration. He asks: "What are these which are arrayed in white robes? and whence came they?" The master of ceremonies answers: "These are they who have discovered something 'more rational' than antiseptic surgery as practised by Lister." The general practitioner does not object to a uniform. The surgeon may wear a nightcap a mask, a nightgown, mittens and top boots in his well-equipped hospital with all sorts of new apparatus and laboratory appliances if he pleases. There is grave danger, however, that the undue exaltation of modern histrionics may overshadow the real essentials in connection with the prevention of sepsis. We want men of the Lister type to teach our students and practitioners. The wondrous charm of Lister's simplicity in his method of teaching and operating is one of the most delightful things the world has ever contemplated. Some of our shining lights nowadays, in hospitals and medical societies, appear to aim at giving exhibitions of their skill instead of imparting some practical knowledge to the everyday doctor—knowledge that will help him while working on the side lines or in the backwoods, where theatrical costumes can scarcely come into general use.

When His Majesty our late king came to Canada in 1860 he travelled from the far East as far West as our railway trains could carry him. That far West was Sarnia, in the Province of Ontario. If he had returned twenty-five years later he might have travelled more than two thousand miles further west to a beautiful town called Victoria. There are now in that great Western district populous cities and towns in all parts, well-cultivated farms, with an active, intelligent people building up one of the greatest countries in the world.

That great new country has helped this Association very materially during the last twenty years. The crowning result appeared last year when there was held in that modern, beautiful city, Winnipeg, the largest and most successful meeting our Dominion Medical Association has ever known. We slow, sleepy folk of the East respect our brethren of the West because of their ability, we admire them because of their untiring energy, we love them because of their big, warm hearts, we enjoy their generous hospitality beyond expression. We are becoming infected with something akin to their boundless enthusiasm. Especially is this the case in connection with the question of Dominion registration.

The discussion on this subject in Winnipeg was one of the best that have occurred during the last twenty years, and the address delivered by Dr. Thornton, of Deloraine, Manitoba, was one of the best our members have ever heard. He directed our attention to the national

side of the question. He told us that "Canada had made great strides towards nationhood in many of the important details of national life, but in the practice of medicine this ideal was no further advanced than in 1866 when Confederation was accomplished. The Provinces were to-day as widely separated as if they flew different flags. There was no such thing as a Canadian physician or a Canadian Medical Association in the broad sense of the terms." We are glad to know that that broad, public-spirited member of our profession, of whom we are so proud, Dr. Thos. G. Roddick, is still taking a very active interest in this question; and we sincerely hope, both for his sake and our own, that his magnificent work will soon meet with the success which it so richly deserves.

This Association is growing not only in numbers, but also in the sphere of its work. We are now considering many matters of vital importance to the people of the whole Dominion, chiefly in the direction of the physician's noblest and most unselfish work—the prevention of disease. We shall have the pleasure this afternoon of learning something respecting the invaluable work accomplished by one of our committees, known as the "Milk Commission," during the past two years, under the able chairmanship of Dr. Chas. J. Hastings.

It would be interesting to give some account of the work done by our Executive Council, the various standing committees, the committee having in charge the establishment of a journal, the local committees, and many individual members in all parts of this big Dominion during the past year. Your President on this occasion, however, cannot find words to describe their work in a fitting manner. Even if it were inclined to undertake such a task the Committee of Arrangements has not given him a sufficient number of hours to accomplish it.

We are now all happy over the present condition of our Association. We are filled with hope for the future. We are becoming national in the true sense of the term. May I add—we are growing more imperialistic. We really want not only Dominion registration, but also reciprocity with the profession of our dear Mother Country. Although we are plunged in grief over the appalling calamity that has befallen our great Empire, our wish, our song, our hymn, our prayer is still—God save the King.

APPENDICITIS IN CHILDREN.*

By I. WOOD, M.D., Kingston.

WE know of no other subject, in the range of Medical Science, that requires more careful consideration from both the physi-

* Read at the meeting of the Canadian Medical Association.

cian and surgeon than "Appendicitis in Children." The term "children" in this paper shall include all under fifteen.

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

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

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

- 1st. These conditions may not be so rare as they are supposed to be.
- 2nd. The appendix-caeci may be the primary seat of the disease.
- 3rd. Chronic suppurative tumors in the right iliac fossa, may result from a primary lesion and perforation of the appendix.
- 4th. The possibility of surgical interference for these conditions may some day be conceived.

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

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

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

- 1st. That nature endeavored to throw a protective wall around the abscess.
- 2nd. That there was danger of this wall being ruptured by ulceration or over distension.

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

Parker's paper published in 1867, marked a great advance in the evolution of our knowledge of the true nature of disease of the appendix, its pathology and treatment. The Willard Parker operation came into general use and the treatment became, more and more, a question of surgery. Up to this time, the writers were no doubt, earnest seekers after the truth. They made careful and accurate observations but they did not seem able to interpret or correlate the facts they observed. Their knowledge of typhlitis, peri-typhlitis and caecitis was vague and indefinite, and their conception of the origin, the pathology and the location of these conditions were in the suggestive rather than the positive stage. It remained for Reginald Heber Fitz of Boston, to dispel the mists, clear away the misconceptions and bring order out of confusion. The essential features brought out in this paper (*Amer. Jour. Med. Sci.*, 1886, Vol. 92, P. 32) were:

- 1st. That all these obscure conditions, known as typhlitis, peri-typhlitis, caecitis, etc., were only different stages of a morbid process beginning in the vermiform appendix and that the word "appendicitis," used for the first time in this paper, was "coined" by him to call attention to inflammation of the appendix, as the primary lesion.
- 2nd. That an early diagnosis was imperative.
- 3rd. That operation should immediately follow diagnosis.
- 4th. That the diseased appendix should be excised.

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

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

of "Appendicitis and Diseases of the Vermiform Appendix," an excellent chapter on appendicitis in children, and for many of the facts in this paper I am indebted to this valuable work.

If we turn our attention to those special features which differentiate appendicitis in children and adults—

Anatomically we find

- 1st. That the appendix in the child is relatively larger and longer.
- 2nd. The walls are thinner, the meso-appendix is shorter, often less than half the length of the tube. This tends to kink or bend the appendix and to limit the blood supply, especially to the distal half.
- 3rd. The entrance from the caecum is funnel-shaped, the lumen is larger, the mucous membrane smoother and the valve of Gerlach often absent or ineffective, hence foreign bodies or morbid materials more readily find their way into the tube.
- 4th. The lymphoid tissue in the appendix of the child is more abundant and the blood supply is poor, hence destructive processes go on more rapidly and the liability to gangrene and perforation is greater.
- 5th. The omentum is relatively smaller and less effective in walling off a gangrenous or perforated appendix.

Pathologically we note

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

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

1st. That appendicitis in the child is more sudden in its onset, rapid in its progress and intense in its symptoms than in the adult.

2nd. That the unstable conditions of the nervous system (peculiar to children) may lead to confusion or error and may delay or prevent a positive diagnosis.

3rd. That abnormal conditions are frequently met with in children which render the clinical phenomena vague and misleading, for example, right sided pleurisy or pneumonia may simulate appendicitis—the pain, tenderness and rigidity being located in the right iliac fossa. Or in

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

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

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

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

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

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

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

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

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

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

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

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

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

ACUTE PAROXYSMAL EPIGASTRIC PAIN.*

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EPIGASTRIC pain (and by this area is roughly delimited a space between the xiphoid and umbilical region) is commonly associated with a series of symptoms which I shall term the gastric symptom complex; these being nausea, vomiting, or gastric flatulence, the latter descriptive term being used in order to isolate intestinal or colonic *distension*. Epigastric pain, either occurring alone, or associated with gastric signs, may be referred to five different regions, namely: (1) To the superficies; (2) To the stomach itself, in which case both pain and gastric complex are direct signs of the local disease; (3) To some pathological condition of some other organ occupying the epigastric region; namely, the gall bladder and its ducts, pancreas, duodenum, colon or aorta, and in these cases the pain is due to the diseased organ, while the gastric signs are secondary and usually reflex; (4) To some organ remote from the epigastrium, in which case both pain and symptom complex are both referred; (5) and lastly, the indefinite class, where the cause is central in the nervous system.

Among the large class of diseases which fill these five regions, are a series of the most intense interest to the physician, since they constantly occur in his practice and tend to cause him much anxiety. These are those diseases in which epigastric pain occurs, associated or not associated with gastric signs, but characterized definitely by the fact that the pain is acute and intermittent, tending to occur periodically at intervals of weeks, months or years.

I. *Superficies*.—Under the heading *superficial structures*, one condition only need be referred to, and that is a neuralgia of the 6th, 7th, 8th and 9th intercostal nerves. Unaccompanied by gastric signs, with local tender spots, not only in the epigastrium but in the related intercostal region, and with no rigidity of the rectus, although pain on coughing and breathing may be present, the condition is a rare one.

One case may be cited in which this diagnosis was made backed by a surgical opinion; three days after,—rigidity, continued pain, and a rise in temperature, proved the pain to have been referred and the cause to be a duodenal perforated ulcer, and yet at the onset neither collapse, rigidity nor pulse,—temperature change occurred. Here it may be noted that no lateral tender point was present in this particular case.

Much more frequent are intercostal neuralgias of lower nerves, the 10th, 11th or 12th, with lateral and anterior tender nerve terminations; but in these cases the pain is not epigastric.

* Read at the meeting of the Canadian Medical Association.

II. *Gastric diseases, causing the pain.* A—*Organic*.—The second condition producing paroxysmal pain is, acute gastritis and acute gastric indigestion, a better name for which would be gastric congestion.

Now regarding the pain of acute gastritis, one ordinarily finds general soreness and pain over the epigastrium and with this is associated the complex of nausea, gas formation and vomiting, the latter being of food primarily, while later it may be of bile or blood.

Characteristic also is the urate filled urine, salivation and coated tongue, and, perhaps, fever.

To this condition, however, one must add that at times there is added acute pain, frequently felt to the right of the midline and perhaps due to pyloric spasm.

One patient who for years had attacks of gastritis, associated usually with acute pain in the pyloric region, allowed me during an acute attack to wash out the stomach. Almost the whole core of an orange, eaten two days before, was discovered. The acute pain was at once relieved while the soreness of the gastritis remained over the stomach proper.

Gastric ulcer is the main organic disease of the stomach in which gastralgia occurs.

The pain, a typical food pain, increasing gradually in severity during its course, is usually localized to the left of the midline over the costal edge, while it is referred frequently to the midline itself, and may radiate in various directions: If a cardiac ulcer is present, the subxiphoid region is sensitive, while if it is pyloric, the location is generally nearer the umbilicus. Burning, gnawing or aching is characteristic of its nature, while it is usually increased in severity by pressure, and by solid rather than liquid food, the latter in cases relieving the pain.

Tenderness on pressure, generally, to the left of the midline, is a very strong diagnostic symptom and again to the left of the 10th or 12th dorsal vertebrae, posteriorly.

The gastric symptoms are represented by vomiting, preceded by the pain, and occurring generally after eating; and at times by gas formation. Both may be absent.

Hematemesis is of marked importance while occult hemorrhages are an assistance,—the consequent anaemia is an indication.

The gastric juice in many cases reveals hyperacidity so that the signs of hyperchlorhydria may be present.

In this typical and common disease, true paroxysmal gastralgic attacks may occur referred to the epigastrium and in many cases the constant and daily signs of the ulcer may render diagnosis simple. But one must never fail to remember that attacks of severe pain due to this disease may occur at intervals with an absolute absence of symptoms in between, and the diagnosis depends on the negation of other causes

and the characteristics of the late epigastric distress already described.

B—Functional gastric diseases.—Among the numerous functional disorders of the stomach occur several which give rise to acute paroxysmal pain. First, in this class one must refer to hyperchlorhydria, and one must note carefully that in a patient showing the typical acid eructations, timed to the height of digestion; burning epigastric pain, frequently also referred to the shoulder-blades, gastric distension, soon after meals, due to starch under digestion; and relief to all signs by simple ant-acid drugs; in such a case there may occur acute paroxysms of pain of gastralgic origin, usually unaccompanied by vomiting, which will relieve it, yet related to time of eating and occasionally complicated by local tenderness over the pit of the stomach.

Diagnosis in these cases rests wholly upon the history and clinical signs of hyperacidity.

Hyper secretion, that other troublesome functional disease in which over secretion occurs, is claimed to be due to latent ulcer, and naturally one may add that here also gastralgia occurs.

The second class of functional gastric disorders includes certain very common sources of *paroxysmal pain*, namely, the hyperalgesias and hypermotility cases of nervous origin, *the true nervous gastralgias*.

Here, on the one hand, we have the class occurring in organic diseases of the nervous system, namely, the tabetic gastric crises in which sudden paroxysmal attacks of pain occur, with vomiting of a persistent nature.

Such a possibility only impresses the careful observer with the fact, that in making a diagnosis of the etiology of epigastric pain, he must exercise the greatest care in examining every organ of the body. In this connection let me refer to one case where renal calculus was unsuccessfully probed for, while the simplest diagnosis lay in testing the pupils and body *reflexes*.

The other great class of nervous gastralgia includes the crises of the hysterical and neurasthenic patient.

Here one may separate clinically the purely sensory, where the pain originates in the sensory supply of the stomach, and the sensory-motor, where the pain is probably produced by the strong muscular contractions of the wall; such contraction in some patients eliciting pain, while in others, the motor phenomena of cardio-spasm or pyloro-spasm are alone present.

In these cases the epigastric attacks are not related to food and occur frequently at night, (although one author is to the contrary here) *the pain is localized, frequently burning in character and may cause collapse*. Vomiting usually reveals little food, and shows gastric contents of variable acidity. Yet vomiting may not occur, or if present be

a pure cardiospasm and be painless, or it may occur after each meal, and be associated with pain.

Absence of local tenderness, relief by pressure and rarely hyperesthesia of the surface is a noticeable trio of signs not to be neglected, while the mental aspect of the patient is now-a-days an additional diagnostic assistant. Local rigidity is absent, but general rigidity may be self produced.

Another feature of these cases which has repeatedly called my attention, is the variability in the hysteric of the seat of the acute pain.

In one hysterical woman, an acute pelvic pain during the occurrence of an amenorrhoea led to a diagnostic operation for ectopic pregnancy. She also frequently suffered from hysteroid attacks in which her face assumed a certain pleased expression.

Some months after the pelvic attack, she developed vomiting after meals with acute pain accompanying the spasm, and this lasted three days. Observing the condition carefully on the final day, I noticed the same smile on her face as when the former attack occurred, and the question of more serious illness was immediately annulled.

C—Pyloric spasm,—Regarding spasmodic pain from the sphincter itself, modern belief is turning decidedly against it. True enough, a painful spasm may be present, accompanying gastritis and perhaps in functional conditions. But true fissure pylorica is as yet doubtful, and in any case rare.

As to the pyloric spasm produced by hyperacid gastric juice entering the duodenum, and as a reflex in inflammation of the appendix, it appears to me that these are in all probability—referred pains.

III. *Epigastric pain due to other epigastric organs than the stomach*,—Here a large field of diseases produce epigastric pain, and usually stomach symptoms *exist* as a secondary or as a *reflex condition*.

Duodenal ulcer like gastric ulcer is frequently associated with epigastric pain. But here also the symptoms tend to constancy rather than intermittence

Pain, 3 to 4 hours after eating situated to the right and not to the left of the midline, of the same character as in gastric ulcer, but more frequently relieved by food.

Unlike its sister disease, its pain does not disappear after the hyperacid period of gastric digestion is over, but may increase up to time of next meal, and night pain is common.

Vomiting is less frequent but hyperacidity is common and occult hemorrhages are fairly frequent in occurrence.

But like *gastric ulcer*, the gastralgia or rather duodenalgia is liable to be the only symptom of the case, and again it may occur as a feature in a chronic case.

Among the rarest clinical conditions diagnosed is *pancreatic* disease and here paroxysmal colic, felt in the epigastrium, occurs, due to such causes as cicatrix, neoplasm, inflammation and hemorrhage, blocking the duct, or stone in the *duct*.

Cardinal signs are often passed over, but mainly consist in disturbances of alimentation, shown both by diminished absorption and digestion of fats, proteids and starches, with consequent body wasting; and also by increased excretion in the faeces of unsplit fats and non-digested proteids and starches, hence bulky with occasional fatty stools.

Vomiting and digestive disturbances fulfil the gastric complex while diffuse pigmentation, palpable tumor or cyst and jaundice may occur. The epigastric pain may be constant or paroxysmal.

Second only to nervous gastralgia as a cause of paroxysmal pain occurs disease of the gall-bladder and its ducts, and with this we may associate gall stones, since when *repeated* attacks of pain occur, it is most difficult to separate gall-bladder and duct condition into those which are primary in origin or are the result of stones, or other cause, even as it is impossible to separate acute appendicitis with or without concretion.

These latter two diseases, cholecystitis and appendicitis are a frequent source of worry in diagnosis, especially since they are so frequently associated, and since they both have the property of producing acute paroxysmal pain.

The characteristic gall bladder symptoms are simple enough when present, but when absent and other signs are not obtainable, diagnosis becomes a matter of difficulty.

The pain is usually epigastric or right hypochondriac and tends to radiate to the back to the right of the 8-II dorsal vertebrae, and around the chest and to the right scapular region. It may radiate to the breast and oesophagus and elsewhere.

It occurs apart from food influence, but may be started up by taking a meal, especially if cholecystitis exists; or three to four hours later by food entering the duodenum.

Apart from the paroxysm of pain, there may remain the dull aching of the associated cholecystitis.

Tenderness on pressure may be evinced over the gall bladder and liver edge, and rigidity over the right side and particularly over the upper part of the right rectus is usually marked.

Gastric complex signs are nausea, eructations and vomiting, the latter frequently being initiated by the patient himself, without gaining relief.

Characteristic organic signs are jaundice, and xanthoma of the eyes. While chills and fever preceding or during the attack favour the diagnosis.

Enlargement of the liver may occur, the spleen enlarged if infection is present, and a palpable gall bladder, even to the discerning of stones, be clinically made out.

Outside of these paroxysmal attacks, one must note that between the attacks, gastric symptoms may be present, either occurring during periods of time or being fairly constant. Usually these cases are due to adhesions following the old cholecystitis.

Pain on taking food, or a few hours after, with distress from the formation of gas and vomiting to relieve a supposedly alimentary cause, lead one to pause before diagnosing 'indigestion' particularly if the history of a former paroxysmal attack *occurred*.

One such case I may note, where operation was advised, since palpable thickening over the gall bladder was made out. However, attention to digestion and the use of mercury and iodine paint have secured comfort and freedom from pain for three years.

Colon.—An organ that is often not considered in the epigastric colony is the *colon*, and to it we owe many recurrent attacks of local pain.

Either in association with general catarrhal conditions of the alimentary tract, acute indigestion, or to local inflammation of its own wall, there is produced acute colicky pain.

Associated nausea and vomiting may confuse the diagnosis, while diarrhoea, especially if mucous is freely present, and tenesmus point to the location of the disease, which also is strongly pointed out if tenderness be present on palpation along the transverse colon—*or* if rectal medication rapidly relieve the condition.

But in my experience, mistakes in acute epigastric pain of colonic origin have occurred much more frequently in chronic conditions, when tumors, either of uterine or ovarian, or other origin, have by some means caused temporary obstruction of the bowel and led to paroxysmal attacks of pain.

Two such cases I report here, both in middle-aged women, both due to growth in the pelvis. Each showed attacks of pain referred to the epigastrium, paroxysmal in nature, in the one case occurring irregularly about a month apart.

Vomiting occurred in the latter case and gas distension of the colon in both cases.

One had been diagnosed neurasthenia and the other indigestion. Operation cured the one, and the relief of adhesions benefitted the other, as the growth was deemed inoperable.

Obstruction of the bowels may indeed prove an additional rare cause of the symptoms we are discussing, and to this one may add as

another possible cause, tubercular peritonitis, and yet another, namely, hernia in the epigastric line.

Leaving the local epigastric conditions and turning to the conditions which produce referred pain in this region we meet a wide circle of diseases.

Above the diaphragm, cardiac affection may give referred pain below the organ, and I have no doubt that all here have seen those cases of diphtheria with acute epigastric pain and a dilated heart. Similarly in pleurisy, a like referred pain occurs and in this particular I mention two cases which with right dry left effusive pleurisy respectively, yet the pain from the onset was definitely sub-xiphoid. Fortunately, or rather in diphtheritic carditis unfortunately, these conditions are acute and not acute paroxysmal.

Below the diaphragm a similar tendency to refer pain to the epigastrium is found, and I mention here the renal conditions of stone, where occasionally the pain is centrally felt; and that most difficult condition to diagnose in acute onset, namely, floating kidney, where the gastric referred symptoms, with the collapse obscure the diagnosis.

Again in the pelvic organs, dysmenorrhoea may exhibit colic felt above the umbilicus and vomiting occur.

Gastralgia of nervous origin also may be associated with it. However, the whole class of diseases from lung to uterus have one detail in common which usually ensures safe diagnosis, and that is—they have definite local signs in the organs affected which a careful examination, physical and subjective should disclose, if not at the first at least in a subsequent *attack of the pain*.

On one region I, however, must fix your attention and that is on the *appendix*.

Acute appendical attacks may produce both epigastric intermittent pain and gastric symptom complex, and particularly is the former true when the appendix stretches toward the gall bladder, and here the pain, rigidity and tenderness may lead to a diagnosis of cholecystitis; even the local pain on pressure over McBurney's point may not make the diagnosis certain.

Here one may refer to a curious relationship in difficult diagnosis between these two structures.

Just as in chronic cholecystitis, we have pain after meals with gas formation, so we have a much discussed disease chronic appendicitis, with attacks also simulating indigestion—with pain long after eating, due usually to troublesome flatus, and which is of all degrees of severity, even to gastralgic pain. Exercise and straining may bring it on. And occasionally tenderness over the appendix exists.

Only lately I saw a case of a young man who had suffered for years from indigestion, especially after exercise, flatus being a markedly prominent sign, while food made no difference in producing it.

Finally this case suffered from an acute attack and the disease was diagnosed in its exacerbation by operation as chronic appendicitis.

Class V. Central.—The only disease which I care to discuss under this heading is *spinal cord* epigastric pain.

In many cases of eroding aneurism, vertebral growths caries, inter vertebral growth, we have the picture of pain in the epigastrium and usually this is bilateral. Associated with this will probably be vertebral rigidity with the usual signs of spinal cord involvement.

In conclusion, let me call attention to the following facts:—

1. In gastric ulcer, hyperchlorhydria, duodenal ulcer, cholecystitis and appendicitis, there are conditions which we may term chronic stages in which the symptoms of epigastric pain and gastric signs are present either constantly or for periods of time. But on the other hand, *acute paroxysmal pain may be associated with each disease* or may occur as a separate manifestation.

2. Diagnosis of the seat of these paroxysmal pains requires the careful exclusion of the organs causing referred and centrally produced pain, and later the differentiation by the most minute care of the condition of the structures within the epigastric area which cause paroxysmal pain.

THE IMMEDIATE REPAIR OF LACERATIONS OF THE CERVIX AND PERINEUM WITH ESPECIAL REFERENCE TO PLACING THE PERINEAL SUTURES IN POSITION BEFORE THE LACERATION TAKES PLACE.*

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THE importance of closing up small tears of the vagina and perineum has not so far been generally recognized by the profession. Year by year we have been getting to understand that deaths during the puerperium are due to a great many causes, and we see that just in proportion as we eliminate these causes the death rate in child birth is growing less. Infection still remains the greatest cause and we have still much to do before the whole rank and file of the profession of midwifery realizes the importance of making the fewest possible vaginal examinations, and by the use of rubber gloves and other means, of

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making these few examinations as nearly aseptic as possible. But since it is practically impossible to reach perfection in this direction, we must turn our attention to lessening the avenues by which germs may enter the system, by immediately closing all tears so as to leave no raw surfaces in direct contact with the lymphatics. At one time it was thought that puerperal infection took place only through the cavity of the uterus and the tubes, or through the placental site; but since we have been opening the abdomen for the relief of puerperal septicaemia, we know that the infection frequently reaches the blood through the lymphatics receiving lymph from the perineum, vagina and cervix. In nearly every case where I opened the abdomen the chain of lymphatics running up the side of the uterus was filled with pus. More than once I have seen the temperature come down promptly after washing out the uterus and vagina and packing the latter with sterile gauze which absorbed the poisonous fluids instead of allowing them to find their way into the lymph channels.

With regard to lacerations of the cervix there are many reasons why they should be repaired at once; first of which is, the profuse hemorrhage coming from the tear of the circular artery or even of the uterine artery. We used to call these post-partum hemorrhages and thought to stop them by giving ergot. But after having given ergot religiously in one thousand confinements I gave it up, and have had five hundred since in which no ergot was given, but the torn cervix was sewed instead, and the result has been even better, as regards hemorrhage. Although it would be better to call in a specialist whenever an artificial delivery has been decided upon, this cannot be done in the country, and the practitioner must do his best by himself and with such poor assistants as he can obtain. But even in that case if he has in his bag a glass tube containing a curved needle and a length of sterile catgut, and two pairs of bullet forceps and a good needle holder, it is not so very difficult, provided the patient is on the edge of the bed and her knees held by a strong canvas leg holder. The anterior and posterior lips are seized each by a bullet forceps, both of the latter being held in the left hand while the needle is passed with a running over and over stitch starting a little above the angle of the tear and finishing near the os uteri. Owing to the relaxed condition of the parts the torn cervix can be drawn down quite easily so that the sewing is done while it is outside of the body and no speculum is necessary. By having some one pour a stream of hot water on the torn surface we can keep it free from clots until it is sewed. When the cervix has been sewed we can then direct our attention to small tears on the anterior vaginal wall which can quickly be closed with a running stitch of fine chromicized catgut. When you pull the cervix down every

part of the vagina comes into view. Besides the question of stopping hemorrhage there are the very important ones of preventing healing by scar tissue which causes such well known reflex symptoms as first pointed out by Emmett, the prevention of septic absorption, and the prevention of subinvolution which in turn leads to prolapse and other displacements.

As regards the perineum it is just as important to close even small tears in order to prevent septic absorption. During the last fifteen years I have made a regular practice of putting in a stitch or two in every case in which even a half inch of the fourchette has been torn. The result has been that my patients have been almost entirely free from the slight rise of temperature on the second or third day which it has been customary to attribute to the milk, but which I suspect is due rather to a little septic absorption through these slight lacerations. I am certain that patients who have had these small lacerations of the perineum repaired have made better convalescence than those on whom this was not done. In the case of very considerable tears of the perineum especially of those which extend through the sphincter into the bowel, the question of loss of function of the muscles of the perineum and of the pelvic fascia is still more important. Emmett has described the results of this accident so well that it is unnecessary to draw attention to them. Every member of this association knows that the separation of the levator ani and transversus perinei muscles disables a woman very considerably. Nature it is true tries to heal these tears, but she is only able to do it by granulations, which are converted into scar tissue, which latter in a place so full of nerves as this is, must cause reflex irritation when the inevitable contraction takes place. There are many other reasons which are well known to the profession why we should close all tears of the perineum. I once operated on a physician's wife who was a beautiful woman and a great social favorite, who was lacerated during her first confinement and was practically a prisoner in her room for the next twenty years, owing to loss of control of the bowels. This in turn led to the wrecking of their domestic happiness, for the reflex irritation ruined her nervous system. I admit that the immediate repair of the cervix, vagina, and perineum is difficult in a poor house with poor light and poor assistants, and it would be better to send for help in the form of an expert in plastic work, who with the help of a nurse and the family doctor, could quickly sew up all tears. But in cases in which such a man is not available the family doctor himself, if provided with catgut and silk-worm gut ready sterilized, and a few Péan forceps, some small curved needles and a good needle holder, and above all with a large curved perineum needle on a handle, can obtain very good results. The greatest difficulty consists in getting the divided ends of the levator ani muscles

and pelvic fascia, which retract at once when torn, for it is of little use to sew up the perineum without taking in the muscles as is often done. This difficulty can, however, be overcome by a method which I have devised.

Just before the child's head comes down upon the perineum the patient is anaesthetized and brought across the bed with the feet held up by a canvas leg holder or even a twisted sheet. The perineum is sterilized with soap and brush and mercuric bi-chloride and then with the large curved needle held firmly in the right hand, and with the thumb of the left hand in the rectum and the fore finger in the vagina, the needle is entered at the base of the lesser lip on the patient's left, and passed rapidly under the vagina and about two and a half inches above the fourchette, taking in both levator ani muscles and coming out at a corresponding point on the woman's right side. A silk-worm gut is threaded into it with the right hand, and the needle is withdrawn, followed by the silk-worm gut, each end of which is caught by a different Péan forceps. A second one is passed in the same way an inch lower down, but taking in the muscles of the perineum. We can generally tell beforehand by the rigidity of the perineum, haste in delivery, size of head, etc., whether the tear is going to be a bad one. If so we can put a third stitch which would take in the sphincter ani on each side of the middle line. Delivery can now go on naturally or artificially, and when the head bulges out of the perineum, you will see the silk-worm gut disappear in the tissue right up to the catch forceps at their ends. As soon as the placenta has been delivered the perineum is inspected under a good light and a stream of water, all clots being rubbed off with the finger and the stitches are tied from above downward, when we will find that there is absolutely accurate coaptation of the separated parts.

While speaking of the light in the confinement room, especially among the poor, we should always take steps before delivery, to provide a good light for two reasons: (1) that we may see how dirty the place is and (2) that we may see what we are doing. As a rule a darkened room means a dirty and ill ventilated room. In the day time arrange the patient so that the perineum will be facing a bright window, and if the confinement is likely to take place at night, provide beforehand for a good light easily available for examining the perineum. When we hear physicians say that they have never seen a lacerated perineum, they may be telling the truth, because they attended all their patients in a dark room.

The presence of the silk-worm gut stitches placed as stated, before the head comes through the perineum and hanging loosely attached by their ends to a Péan forceps does not interfere in any way

with the termination of the labor; not even if forceps are required. If by keeping the pains under control and the head well towards the symphysis there has happily been no laceration, no harm is done by their having been introduced; you will simply take off the Péan and draw them out. While if the perineum has been lacerated more or less it is a great advantage to save time and trouble by having them already in. But it is a still greater advantage to have them in exactly the right place, so as to bring the lacerated surfaces together exactly as they were before the accident. I have often heard Emmett and Coe refer to the failure of the average operator to restore the muscles, and I can add that in many cases where the repair was done immediately afterwards, I have had to do a secondary operation some years later for the restoration of the muscles.

When I first called the attention of the profession six years ago to this easy method of obtaining perfect coaptation of the divided muscles, several of those who took part in the discussion failed to grasp the point that the sutures were simply introduced but *not* tied. They thought that I tied them to prevent the perineum from tearing. They are not tied and they do not prevent the perineum from tearing. Others said that if by chance the perineum did not tear you would find yourself in the terrible position of having taken a most important but unnecessary precaution. Night after night and year after year the railway companies take a thousand precautions to save our lives while we are asleep in their cars and yet the thing never happens, to guard against which the precautions were taken. But they go on taking the precautions just the same. And so should we if it were only to save one woman in a hundred from septic absorption through the open surface of an unrepaired tear.

Others during the discussion made the objection that you might infect the woman through the stitch holes in the skin; but they are introduced under the strictest aseptic precautions, the skin being scrubbed and disinfected the same as for a laparotomy. Besides which would or should the fear of infecting the woman by the stitch holes prevent us from sewing up the skin in the old way after the muscles have been separated? Certainly not.

Another objection was, that you could never tell beforehand which perineum was going to be torn and thus you would not know when to place the stitches. But as a matter of fact you can nearly always tell when it is going to happen. It is not likely to happen in multi-parae at all, nor even in young primiparae who have been twenty-four hours in labor, several hours of which have been spent in pushing the head down upon the perineum. It is almost sure to happen when for some good or bad reason the forceps are put on twelve hours too soon before the

cervix is completely dilated and before the head has touched the perineum. In such cases if the patient has married late and the perineum is rigid it is almost sure to be torn, if not by the head at any rate by the shoulders. In such cases it is a great relief to one's mind to feel that in two minutes after the placenta has been expressed the stitches have been tied and the torn surface and muscles been securely brought together.

238 Bishop St., Montreal.

RECURRING CORYZA A MANIFESTATION OF AUTOINTOXICATION.

P. Cornet, *Press Med.*, Jan. 10, 1909, presents numerous arguments to sustain his view that recurring coryza from "simple colds in the head" to pronounced hay fever, is merely one of the manifestations of the arthritic diathesis, that is, of a family tendency to sluggish elimination of waste products and toxins. He points out that the mucosa of the nose is an excreting organ, and the excretion through this mucosa of some of the toxins generated in the digestive tract may be one factor in recurring coryza. He has had a number of instances in his experience in which an error in diet was promptly followed by an attack of coryza. It is like the congestion observed in the face during difficult digestion. Reflex irritation from the digestive tract distends the vessels, heats and reddens the face, and by stimulating the glands renders the skin greasy and pimply. This same process in the mucosa induces swelling, congestion and excessive secretion; the nerve fibres in the mucosa become irritated from the recurring or continuous autointoxication and the consequent hyperesthesia renders them peculiarly sensitive to dust inhaled or changes in temperature. He has found regulation of the diet, especially avoidance of meat and alcohol, the most effectual means of curing such patients. A little white meat at noonday is all that he allows. If local measures are deemed necessary, he applies the actual cautery to the hypersensitive points. The cauterization must be deep enough to destroy the nerve filaments, but this alone is futile unless the underlying autointoxication is combated. The hypersensitive points in the nose are mainly the protruding points where lodge the inspired dust and microbes.—*Laryngoscope*.

CURRENT MEDICAL LITERATURE.

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MEDICINE.Under the charge of A. J. MACKENZIE, B.A., M.B., Toronto.
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SPECIMEN DIET FOR INTESTINAL TUBERCULOSIS.

Breakfast 8 a.m.—Two scrambled eggs on toast; steamed fillet of fish, 4 oz.; biscuit, 2 oz.; butter, $\frac{1}{2}$ oz.; milk flavoured with coffee, 10 oz.

11 a.m.—Two tablespoonsful of raw meat juice in aerated water.

1 p.m.—Raw meat pulp, 6 oz., made into sandwiches; toast or biscuit, 2 oz., with butter, $\frac{1}{2}$ oz.; soured milk, half a pint.

4 p.m.—Milk flavoured with tea or Bengers's food; toast or triscuit, 2 oz.; one egg and butter, $\frac{1}{2}$ oz.

7.30 p.m.—Boiled or steamed fish, 3 oz.; underdone meat, 3 oz.; toast and butter; pudding, 5 oz.; with cream, $2\frac{1}{2}$ oz.; or cheese custard.

10 p.m.—Bengers's food or two tablespoonsful of raw meat juice, pure or mixed with water or milk.

—
ANTI-TYPHOID VACCINATION.

In the *Johms Hopkins Hospital Bulletin*, for March, there is a report by Major F. F. Russell of the U.S. Army, on the use of anti-typhoid vaccination in the army. He first describes the history of the treatment and the work of Wright and Leishman; the latter officer inoculated 5,473 out of 12,083 under his care, among those inoculated there were 21 cases of typhoid with 2 deaths, and among the remainder 187 cases and 26 deaths. Of those who had developed typhoid after vaccination, only 4 had had two doses of vaccine, and they all recovered, the others had had only one dose. The effect appears to be active for at least 3 years. In the German army in 1904, the results were also quite favorable per 1,000 of strength there were of the vaccinated only half as many cases and a fourth as many deaths as in the unvaccinated.

The necessity for some such measure in the army is shown by the prevalence of the disease in modern wars; in the Civil war there were 60,000 cases in the Northern army, in the Franco-Prussian war there were 73,396 cases and 8,789 deaths in the German army, 60 per cent. of their mortality, during the Boer war there were 30,000 cases and 5,877 deaths, in the Spanish war there was one case in every 5.6 men and 86 per cent. of all deaths were due to this cause. Even now in spite of our

advances in epidemiology there is no doubt that we could have a great mortality.

The vaccination of officers and men in the American army was begun February, 1909, and at present completed records are available of 1,400 individuals; since that time among 75,000 men there have been 135 cases of typhoid, and only one was a vaccinated man. The conclusions arrived at are as follows:—

1. Vaccination against typhoid undoubtedly protects to a very great extent against the disease.

2. It is an indispensable adjunct to other prophylaxis among troops and others exposed to infection.

3. It is very doubtful if there is an increase of susceptibility following inoculation.

4. Vaccination during the disease, for therapeutic effect fails to reveal any evidence of a negative phase.

5. The statement that vaccination should not be carried out in the presence of an epidemic is not justified by the facts at hand.

6. The procedure is easily carried out and only exceptionally does it provoke severe general reactions.

7. No untoward results have occurred in this series of 3,640 vaccinations.

THE SPLASHING SOUND.

In the *Medical Record*, March 5th, Weinstein describes the use of this sound as a means of diagnosis. He points out that it is normally present in the majority of cases even in healthy children, but if it is present when there has been plenty of time for the stomach to empty itself from the last meal, say a maximum of seven hours, then there is retention of food or accumulation of fluid from some source. The use of the stomach tube will now help to clear up the difficulty, retained food materials will point to atony or if more complete to pyloric obstruction. Pure gastric juice will show gastrosuccorrhœa, duodenal regurgitation will be indicated by the presence of bile.

The size and position of the stomach may be mapped out this way, but it is important to remember that the sound is produced right below the finger, as it may be conveyed for some distance, and while intestinal splashing is rare it is a possibility.

INFANT MORTALITY AND INDUSTRY.

At the Academy of Medicine recently, Dr. Oui, professor of obstetrics and the hygiene of infancy at the college of medicine of Lille, and Dr. H. Paucot, head of the obstetrical clinic of the same college, made an interesting report on infant mortality in industrial centers and the dangers of depopulation to which modern industrial customs subject our country. In the industrial centers the working woman is inevitably compelled to give her child into mercenary hands. Around Lille the care of the children that the working-women are obliged to abandon has grown into a regular occupation. Dividing the children of an industrial region into three classes, Drs. Oui and Paucot have ascertained that the mortality is 24 per cent. among children brought up directly by their mothers, 43 per cent. among children cared for by other persons than the mothers at the parents' homes, and 78 per cent. for children put in charge of care-takers. It is easy to see what peril there is leaving to these substitutes the task of bringing up children; not to speak of their ignorance of the most elementary rules of hygiene and of cleanliness, these care-takers, in order to save themselves trouble, resort to dangerous means, such as the administration of infusions of poppy-heads to the infants.

Drs. Oui and Paucot believe that the most efficacious means of remedying this state of things would be to create in each factory and in each large workroom places to which the working woman would bring her child and leave it to be looked after while working; she would thus be able herself to give it the necessary attention from time to time during the day.—*Jour. A. M. A.*

EXPERIMENTAL TYPHOID FEVER.

In the session of March 21 of the Academy of Sciences, Professor Metchnikoff made a communication on experimental typhoid fever. Up to the present, no one had succeeded in communicating typhoid fever to animals under conditions analogous to those under which man contracts this disease; that is to say, by ingestion of typhoid bacilli. M. Metchnikoff thought that the failure of the experiments made on this subject were due to the fact that the animals were fed pure cultures of the Eberth bacilli, while typhoid infection in man manifests itself after the absorption of dilutions of excreta charged with bacilli. He gave a chimpanzee food contaminated with a dilution of this kind and at the end of six days observed a disease presenting all the characteristics of typhoid

fever. There will be hereafter, therefore, a means of learning whether the vaccines, the employment of which had been proposed for man, can prevent the disease, and if the serums prepared for typhoid fever are really efficacious.—*Jour. A. M. A.*

IOTHION IN RHEUMATIC AFFECTIONS.

There is another drug, used as an external application in rheumatic affections, whose merits have not yet won for it the extended employment which it deserves. This substance is iothion, a preparation of Bayer and Co. In this country its use seems limited to physicians who practise at spas where the rheumatic and gouty most do congregate. Many of these practitioners regard it as the best means hitherto available of ensuring the absorption of iodine through the skin. In a research recently undertaken it was shown that quantities varying from 30 to 94 per cent. of its iodine content was excreted in the urine, whereas after the application of tincture of iodine not a trace was found either in the urine or saliva. When it is necessary to obtain rapidly the specific effect of iodine in tertiary syphilis the vigorous inunction of iothion appears to be clearly indicated. This measure will be keenly appreciated by patients whose stomachs tolerate iodides with great repugnance.

Dr. Nagelschmidt, of the Berlin Finsen Clinic, who conducted the quantitative investigations on the absorption of this preparation, recommends the use of iothion suppositories in the treatment of chronic and subacute prostatitis. A suppository made up of 2 grains of iothion and 30 grains of ol. cacao is retained without difficulty, and the diminution of swelling with general softening of the parts follow with striking rapidity. Pain also abates in a remarkable manner. Prostatitis is a most distressing malady, and any remedy which brings to it a modicum of relief must be hailed with welcome. It is one of the painful legacies of gonorrhœa, and the successful treatment of this disease signifies the prophylaxis of most of the ills to which the prostate is liable.—*Folia Therapeutica.*

DISEASES OF ANIMALS COMMUNICABLE TO MAN.

Mettam, *Glasgow Medical Journal*, enumerates the diseases which are communicated or are transmitted from the lower animals to man: Tuberculosis, glanders, rabies, anthrax, foot and mouth disease, various

forms of suppuration, vaccinia or cowpox, doubtfully actinomycosis. Psittacosis—a disease of parrots—has been observed in man, in persons occupied in the rearing and training of parrots; the infection is well recognized in certain parts of France, in Paris especially. In addition to these we may enumerate various forms of ringworm. These diseases are all due to known causes, with the exception of rabies; the infecting agent is in the saliva and central nervous system, but has not been seen, if we except Negri's bodies as the cause. Foot and mouth disease is due to a filterable or ultramicroscopical virus, and so, perhaps, is variola. The ringworms are moulds—trichophytons, microsporons, or favus. In addition to these diseases we have certain due to the presence of animal parasites, which are directly the result of man's carnivorous habits, to the consumption of flesh containing parasites in a stage of their life's cycle, tapeworm and trichinosis. The author gives a review of the ætiology, diagnosis, prognosis, and treatment of these diseases.—*New York Medical Journal*.

FATAL FACTORS IN PNEUMONIA.

G. Werley of El Paso, Tex., finds the causes of death in pneumonia to be a failure to recognize the importance of a few underlying principles. The patient will recover if placed under the most favorable conditions for nature to cure him. The great needs of the body in pneumonia are plenty of air, water, food, and proper rest. The first factor in unfavorable surroundings is a close room, not supplied with a plenty of cool, fresh air. The second is a failure to aid the kidneys in carrying off the toxins of the disease by giving plenty of fresh water. Overfeeding and wrong feeding are responsible for a loss of energy used up in an attempt to digest, assimilate, and excrete unsuitable foods. Meat broths are not useful because they make no energy and tax the kidneys. Sugar is a valuable energy producing food and leaves nothing but water and carbon dioxide to be eliminated. Eggs and milk are appropriate. Fright and worry are responsible for loss of nervous energy. Failure to keep the patient in a horizontal position so as to aid the heart in carrying on the circulation is responsible for many cases of death. Drugs are only necessary to aid the heart, and obtain perfect rest. There is no serious infectious disease against which the body has better natural means of defense than pneumonia. If given a good fighting chance a complete cure in five to ten days is the rule.—*Medical Record*, April 16, 1910.

SURGERY.

Under the charge of H. A. BEATTY, M.B., M.R.C.S., Eng., and A. H. PERFECT, M.D., C.M.,
Surgeons to the Toronto Western Hospital.

 PUS TUBES IN THE MALE.

William T. Belfield, of Chicago, in *The Journal of the American Medical Association*, writes an interesting article on Pus Tubes in the Male.

In the technic of vasostomy three features are important: (1) fixation of the vas, which may otherwise drop into the scrotum and be recaptured with difficulty; (2) raising the vas through the skin-cut for accurate manipulation; (3) exploration of vas for obstruction by sounding with a silkworm thread. Details may obviously be varied at the discretion of the operator. When resection of the vas is performed, a silkworm of catgut thread is passe^d into the lumen and out through the wall of each cut end and the ends tied above the skin, the thread serving as an axis splint which secures exact apposition of the cut ends of the vas. This method of anastomosis, first published by Mayo, supersedes all other methods of reuniting the divided vas.

SUMMARY.

1. Pus infection of the seminal tract plus occlusion of the ejaculatory duct soon converts vesicle, vas and finally epididymis into a closed abscess.

2. Vasostomy is the simplest and least objectionable means of evacuating pus, relieving tension and medicating vas and vesicle.

3. Among the effects of these infections on the urinary organs are bladder irritation and obstruction of the ureter with consequent kidney lesions.

4. Impotence, sterility and sexual neuroses in the male are frequent results of pus infections of the seminal tract and amenable to appropriate treatment thereof.

5. Vaccine therapy, accurately applied, is the most valuable internal measure against the infections which produce pus tubes in the male.

 URETHROTOMY.

Brewer, in *The New York Medical Journal*, found, in an examination of 120 cases operated on, that three urethræ were below 30 in calibre 21 of 30, 44 of 32, 29 of 34, 2 of 35, 17 of 36, 1 of 38 and 3 of

40. The number of strictures varied from one to seven. He concludes:
1. That internal urethrotomy, as a means of treating strictures of the anterior urethra, was a comparative safe one.
 2. That by the intelligent application of a few well known measures, alarming hæmorrhages could in nearly all cases, be avoided.
 3. That the occurrence of more or less lasting curvature of the penis after operation was probably due to extension of the incision beyond the necessary limit.
 4. That with the exception of the meatus, the practice of dividing anterior strictures on the floor of the urethra should be condemned as a dangerous procedure.
 5. That the passage of instruments through the deep urethra should, if possible, be avoided immediately after the operation.
 6. That in the majority of cases, by a thorough and complete division of all the stricture bands, a radical and complete restoration of the canal to its normal calibre might be expected.
 7. That all attempts to prevent recontraction in imperfectly divided strictures by means of dilatations were useless.

ECTOPIA OF THE KIDNEY.

Jno. C. Munro, Boston, in *The Boston Medical and Surgical Journal*, says re ectopia of the kidney:

“With regard to treatment, it is important to leave an ectopic kidney alone if it is functioning and does not give symptoms, or if there is no second kidney. In case it lies above the pelvic brim it may in some cases be transplanted and anchored, but in a number of instances where this has been done a nephrectomy was necessary later because of persistence of discomfort and other symptoms due to a misplaced kidney, not relieved by shifting its location. A pelvic kidney probably cannot be transplanted because of its short pedicle and its anomalous arteries. Hence, if it causes symptoms because of mechanical interference with the intestinal functions, it is best removed, even though it is healthy.”

SPECIFIC URETHRITIS.

1. Acute and chronic urethritis do not yield to serum treatment, but the use of serum renders the patient more readily amenable to local treatment.

2. Prostatitis is frequently benefited by the use of the serum.
3. Epididymitis has often been cured by its administration.
4. In gonorrhoeal arthritis the antigonococcic serum has proved to be practically a specific.
5. In all gonorrhoeal complications we believe serum treatment is indicated.
6. We have found the daily administration of two or four cubic centimeters of serum, depending on the severity of the case, gives the most satisfactory results.

7. No inconvenience was experienced by the patients other than a slight eruption, which soon disappeared.

The above is a fair indication of the results obtained in the treatment of a series of twenty-seven cases which applied for treatment at the genito-urinary clinic of the Jefferson Medical College Hospital.—Thomas C. Stellwagen, Jr., M.D., *Therapeutic Gazette*, April 15, 1910.

TENDON SUTURE.

Edward Rischar, M.D., in *The Journal A. M. A.*, April, 1910, says a reliable tendon coaptation by suture is assured by the following technic:

From within the tendon sheath bring a severed end of the tendon into the wound, with the least possible injury to the tendon. This is done by grasping its side with a small toothed forceps by which it is held until one of the side sutures is applied, which will then be used as a tractor until the opposite side suture is placed. These side sutures are placed about one-quarter of an inch from the stump, and grasp enough tissue to assure a secure hold for the intertendon sutures. They are firmly tied and left long.

Should one of the ends be so retracted as to be out of reach, which is often the case with the proximal end, place a probe in the sheath up to the tendon's stump. Cut the skin over the sheath to where the stump is found; then make an opening into it, bring out the stump, and apply the side sutures.

Having the side sutures in both stumps, use their long ends to pull and hold the stumps in position until the intertendon sutures are placed. These intertendon sutures are placed behind the side sutures, and their knots to one end.

The sheath is closed with fine catgut. The limb is put up in a relaxed position with perfect rest, which means wood, or, better, plaster splinting, for two weeks or longer, followed by gradually increased motion. It should be remembered that the result in tendon surgery is best without drainage; therefore, the field must be well prepared.

The advantages of the suture are:

1. It holds the tendon with absolute security and in position.
2. The major part of the tendon is unsutured, permitting early union.
3. The knots are placed where they cannot interfere with a good closure nor invite infection.
4. The method is precise, and for that reason can be carried out very quickly.

OBSTETRICS AND DISEASES OF CHILDREN.

Under the charge of D. J. EVANS, M.D., C.M., Lecturer on Obstetrics, Medical Faculty
McGill University, Montreal.

PLACENTA PRAEVIA AND CAESAREAN SECTION.

This subject was very fully discussed at a meeting of the obstetrical and gynaecological section of Royal Society of Medicine, London. The following is the report of the discussion as it appeared in the *British Medical Journal* of 7th May:

Dr. Henry Jellett, of Dublin, in a paper on the place of caesarean section in the treatment of placenta praevia, summed up his conclusions as follows: There does not appear to be any place for this operation in the modern treatment of uncomplicated cases of placenta praevia. In a few exceptional cases with a rigid condition of the cervix or premature rupture of the membranes, associated with an unhealthy atonic condition of the uterine muscle, it may be indicated. Such a condition might be treated by the vaginal plug, and, if internal hæmorrhage then resulted, by caesarean section; but, personally, I should be inclined to treat such a case, if plugging failed, by incision of the cervix and the performance of bipolar version. The fetal mortality of placenta praevia is undoubtedly very high; in the Rotunda cases it amounted to 57.3 per cent. Is there any likelihood of materially reducing this mortality by caesarean section? Apparently not, if we are to judge by the recorded results, unless we operate in every case, and who is prepared to do this? I am unable to see any place for caesarean section in the treatment of placenta praevia. What we really require in these cases is an advance in our methods of treating the collapse of hæmorrhage, and the shock, and of combating infection, as thus we could reduce the present mortality and save some of the patients who are apparently moribund when they first come under treatment.

The President, Dr. Macnaughton-Jones, said that he still believed in the soundness of the principles which he had taught students in the past

to follow in the management of the different forms of placenta prævia—the two most important of these being the indication of bipolar version and plugging. The most complete summary of the entire subject was contained in the recently published brochure of Dr. Ludovico Moncalvi, Professor Mangiagalli's assistant in the Institute of Obstetrics and Gynaecology in Milan. It entered fully into the statistics of several of the largest European clinics on such points as the nature of the placental presentation, the size and weight of the fetus and its presentations, and the whole evidence collected appeared to be on the side of those who maintained that only in a very limited number of cases, if the condition had to be treated on scientific obstetrical principles, was caesarean section called for or justified.

Dr. Herbert Spencer said that Dr. Jellett had done well to call attention to the small mortality which attended the performance of bipolar version. The cases which terminated fatally did so as the result of severe hæmorrhage and infection before the treatment was adopted, and would not be saved, but would be further imperilled, by the performance of caesarean section. He did not utterly condemn the operation, but thought it justifiable in a very few rare cases of central placenta prævia at or near full term, with an undilated rigid cervix. He called attention to the remarkable series recorded by Krönig and Sellheim of 26 cases of placenta prævia treated by caesarean section with no maternal or fetal mortality.

Dr. Champneys thought that in placenta prævia the child must take its chance, and that any special attempt to improve the chances of the child would be at the expense of the mother.

Dr. Purslow thought that plugging the vagina, if done efficiently, would give good results, and that *post-partum* hæmorrhage was a most grave complication of placenta prævia—a complication, moreover, which caesarean section would not guard against, unless the uterus was removed at the same time.

Dr. Armand Routh agreed with Dr. Jellett that there was no place for caesarean section in the ordinary or routine treatment of placenta prævia, but it might be advisable where the cervix remained rigid and undilatable.

Dr. W. J. Gow thought it was only in a central placenta prævia that treatment by caesarean section should be considered. In *post-partum* hæmorrhage occurring in cases of placenta prævia, the bleeding generally came from lacerations produced during extraction of the child. Another class of case in which he thought caesarean section indicated was when the patient had a purulent vaginal discharge in addition to a central pla-

centa praevia, as this class of case was very likely to be followed by grave septic infection.

Dr. W. S. A. Griffith had performed caesarean section for placenta praevia on one occasion with a favourable result for the mother and the child, but he thought it monstrous to talk of caesarean section as the treatment for placenta praevia except in very rare and exceptional cases.

RUPTURED TUBAL PREGNANCY.

Mr. T. Carwardine gave a demonstration with the epidiascope of a series of micro-photographs from a case of ruptured tubal pregnancy, specially prepared to show certain features of the syncytium, which are probably of considerable importance in the physiology and pathology of the embryonic vesicle. The specimen was taken from a patient, *æt.* 29, who was operated upon about 12 hours after the rupture.

The earlier slides included sections through the Fallopian tube at the point of rupture and elsewhere, the chorionic vesicle, and sections from various parts of its wall were demonstrated; the membrane being thicker where the villi were most developed. Under a high magnification the general arrangement of the villi was shown and the manner in which the investing epithelium is generally beset with cell processes, to which attention was directed.

One specimen of a chorionic villus revealed the origin of multinucleated wandering cells from the foetal epithelium having cell processes also, which, where not coagulated together by the hardening re-agent, were of a delicate silken character embracing a red blood corpuscle at one place. Some of the wandering cells were attached, others free.

A section near the point of rupture showed indications of the "cell sheet," also numerous cells derived from the trophoblast invading the blood clot and undergoing amitotic cell division. They resembled the invading cells seen in the tissues outside a chorion epithelioma.

Villi in contiguity showed great diversity in the characters of the epithelial coverings; one might have a cap of squamous elements; another, columnar cells with brush-like, free edges; a third, varieties of epithelial type, from the cubical or columnar cell to irregular multinucleated protoplasmic masses all having cell processes. A typical illustration was given of such a section, which indicated the origin of Langhans' layer from the syncytian cells; and attention was drawn more particularly to the origin from the syncytium of masses of nuclei having numerous processes, the nuclei undergoing division. Such a mass is

found free in the intervillous space, and in all probability has important significance both in the physiological condition and in chorion-epithelioma, and in support of this suggestion a drawing in Teacher's monograph was referred to, a portion of which gave similar indications, though not so clearly as in the photograph exhibited.—*Medical Press and Circular*.

THE TREATMENT OF PLACENTA PRAEVIA.

J. Veit (*Berl. klin. Woch.*, November 22nd, 1909), is of opinion that the surgical era is responsible not only for a lessening in the interest in obstetric technique but also for a falling off in the technical skill of the obstetrician. It scarcely seems worth while to learn how to perform version to-day, when the knife is in the practitioner's hand every minute. Veit considers that this is not in the interest either of the profession or of the lying-in woman. Krönig and Sellheim have suggested performing Caesarean section as a routine treatment, and according to Veit certain experienced obstetricians were polite enough to agree with these two authorities. He refuses to acknowledge Caesarean section as a means of treatment of placenta praevia, and states that he will not condescend to make any concessions out of politeness. Others may do as they like, but he is determined to let the world know that the treatment of this condition can very well be carried out without such a severe operation. In recording his experience, he states that, as a young man, practically every woman who was found to have placenta praevia was plugged and transported into the Berlin clinic, and died there. He was still an assistant when Braxton Hicks introduced his combined version; there was no more transport, the version was performed at the patients' homes, and the majority survived. After a time it was realized that the cost in children's lives was great, and in order to improve this condition the metreurynter was introduced. The result, as far as the mother was concerned, was equally favourable, and there was a slight gain in infant life. It must, however, be remembered that the mortality among the children is high partly owing to the fact that in many cases the hæmorrhage occurs before full time, and the infants prematurely born are not so resistant as full-time infants. Rupture of the membranes also yielded relatively good results. Veit points out that the technique is not simple in any of the manipulations. With regard to the rupture of the membranes, the pressure of the finger-nail must be exercised in such a way that not more of the placenta is detached from the uterine wall than has already been detached. The skilled obstetrician will therefore employ this

method with great care, and only in cases of lateral or marginal placenta praevia. With regard to metreurynter treatment, the bag employed is either that of Champetier de Ribes or Müller. The bag must be introduced into the cavity, and it is therefore necessary to rupture the members first. Again, care must be taken not to separate any more placenta from the uterine wall, since this may lead to the death of the fetus, owing to a limitation of oxygen. This method is also only applicable when membranes can be felt at the side of the placenta. It has, however, an advantage over simple rupture of the membranes, in that the position of the fetus is immaterial. In the case of simple rupture of the membranes, it is necessary that the presentation be a vertex one. The head must be able to plug the bleeding surface. Turning to combined version, Veit insists on the technical difficulty of the manipulations. It is necessary to pass a finger or more into the uterine cavity without separating any placenta from the uterine wall. Air emboli may kill the patient if the hand is passed between the placenta and the uterine wall. As soon as the operator has reached the cavity of the uterus, within the membranes, a foot is seized and brought down. The leg is then left *in situ*, and no further manipulations are to be made until the child has been born as far as the umbilicus at least. The conditions for the child are not favourable, since the presentation is that of an incomplete footling. In comparing these methods with Caesarean section, Veit admits that, in the hands of a skilled surgeon, this operation need not be dangerous. But he argues very strongly that if equally good results can be obtained without recourse to an unnatural means of delivery, the practitioner is not justified in using the unnatural method. There can be no doubt that every woman would prefer delivery in the ordinary way *per vias naturales* to being cut open. When the os is rigid or cannot be dilated sufficiently to admit of immediate delivery after version, he compares the performance of anterior hysterotomy with *accouchement forcé*. He finds that the latter method is not dangerous if the tear is sutured at once, and it possesses this advantage over the former, that no preparations need be made before carrying it out. In defence of his doctrines he cites some cases which he dealt with in order to compare the results with those obtained by others. The placenta praevia cases were sent into hospital as soon as they were recognized, and in the course of four months he was able to deal with 19, including 5 of deeply-faced placenta. All the mothers survived, while 14 of the infants were born alive and discharged alive. In summing up, he gives the following directions for the treatment of placenta praevia—he assumes that a practitioner who undertakes the treatment of placenta praevia possesses the necessary skill to avoid further detachment of placenta and to apply sutures, etc. If the child is

premature or dead, combined version and waiting; if the placenta is situated low or is lateral or marginal—(a) in vertex presentations, rupture of the membranes; (b) in all other presentations, metreurynter for eight hours, then version and extraction, with subsequent suture if necessary. If there is placenta prævia centralis, either *accouchement forcé* with suture or anterior hysterotomy. In some cases it may be necessary to plug the vagina. If the practitioner does not feel capable of carrying out these manipulations, the vagina should be packed and the woman sent as quickly as possible into the nearest clinic.—*Brit. Med. Jour.*

CANADIAN MEDICAL ASSOCIATION.

FORTY-THIRD MEETING OF THE CANADIAN MEDICAL ASSOCIATION, HELD IN TORONTO, JUNE 1ST, 2ND, 3RD AND 4TH, 1910.

The annual meeting of this year in Toronto must be regarded as having been a very successful one. There were present upwards of 400 medical practitioners from all parts of Canada. The weather, though cool, was on the whole very favourable, and the various outings were well attended and much enjoyed.

ENTERTAINMENTS.

In the evening of May 31st, those who were in the city were entertained at a smoker in St. George's Hall. The programme was good and appreciated by those who were present. On June 1st, arrangements were made by which members might participate in Lawn Bowling and Golf according to their fancy. On Thursday, June 2nd, there was an excursion to Niagara Falls. The steamer *Turbinia* left Toronto at 1 p.m. for Port Dalhousie. Luncheon was served on board the steamer. From Port Dalhousie to the Falls the party was conveyed by the Electric Car Line. On reaching the Clifton House dinner was in readiness. This excursion was very pleasant and greatly enjoyed. The visiting ladies were entertained at the Lambton Golf Club, as the guests of Mrs. Adam H. Wright and the Ladies' Committee. The party was driven out in automobiles. Many members and ladies took in the run by the C. P. R. to Guelph, on Saturday, 4th June, as guests of the Medical Profession of that city, and the president and staff of the Agricultural College. On arrival at the College luncheon was served. It will thus be seen that round of entertainments were all that could

be desired. No effort was left undone to make the pleasure side of the convention a thorough success.

NEW PRESIDENT INSTALLED.

When the delegates had assembled Dr. R. J. Blanchard, of Winnipeg, the retiring president, opened the meeting by installing Dr. Adam Wright, of Toronto, his successor in office, in the chair. Dr. Wright, he said, was well known throughout Canada: was a leader in the profession and had performed valuable services for the Canadian Medical Association.

The meeting was then opened with prayer by Rev. Dr. Hazelwood and brief addresses of welcome were delivered by Hon. Dr. R. A. Pyne, Minister of Education on behalf of the Provincial Government; by Controller J. J. Ward, Acting Mayor of Toronto, on behalf of the city, and by President R. A. Falconer, on behalf of the University of Toronto. Dr. Falconer expressed the belief that in medicine, the University was keeping pace with modern progress.

THE PRESIDENT'S ADDRESS.

Dr. Adam H. Wright touched upon a number of important topics in his address. He contended that the general practitioner was more than holding his own against the specialist. Indeed, he thought the pendulum was swinging back in favour of the general practitioner, who was now being regarded as a necessity in the home. He had to face many forms of criticism, but this he could successfully do in the future as he had done in the past.

Dr. Wright dealt in a plain and matter-of-fact manner with some of the evils of to-day in medical education. He contended that the student was given science in excess of his powers to absorb in the time at his disposal. He thought that the student now was compelled to cram more than at any former period. This used up the student's time and energy so that he had but little left for observation. He contended that there was not a proper connection between the primary and scientific subjects and the final and practical ones. It was contended that there was far too much of this tendency towards machine made doctors. It was disastrous to crowd so much work upon the student, as it could not be digested and assimilated.

All the movements towards specialism and against it were being watched by the general practitioner with keen interest. There was real danger that the white gown, the gloves, the cap, etc., might obscure the true principles of antiseptic surgery. What was urgently required was

men of the Lister type to teach asepsis in the true and simple form. There is a grave danger that some of the brilliant clinicians and operators were aiming more at exhibiting their skill, rather than at imparting sound knowledge to the student. There must ever be a vast amount of surgery done in the back woods and side lines, where theatrical costumes cannot ever come into general use, and where true Listerism, nevertheless, should be found.

REPORT OF THE MILK COMMISSION.

The report of the Canadian Medical Association Milk Commission was presented by Dr. Charles J. Hastings, chairman of the commission, and contains a voluminous review of the work done by the association during the past year. The objects of the campaign for purer milk have been sought through an investigation of the part played by milk in infant mortality, in the spread of communicable diseases, and as a cause of tuberculosis. Stress is laid on the vital importance of a pure milk supply, particularly for babies, and statistics are quoted to show the high rate of mortality among infants fed on dairy milk.

In view of the facts here presented is it too much to hope that our federal, local, and municipal legislatures will realize that human life is at least worthy of as much consideration as is farm stock and agriculture.

The report pointed out the important legislation that had been sought in some instances secured. It also pointed out what had been done by various municipalities. Much attention was given to the high infant mortality, especially in the first year of life, and from diarrhoeal diseases. In some places as many as 500 out of every 1,000 died in the first year of life. Many countries were the coming alive to this very high death-rate, much of which is quite preventable.

Attention is again called to the much-debated subject of milk as a carrier of tuberculosis. The report takes the position that there is here a real danger, especially among children.

The report further deals with the topics of certified milk and pasteurized milk. The result is that in most cities the reliance will have to be placed in pasteurized milk, as it is impossible to secure certified milk in sufficient quantity. The advantages and disadvantages of pasteurization are fully considered.

Dr. G. E. Rutherford, Veterinary Director General, Ottawa, thought that calves as well as children should be fed on pasteurized milk, because it was desirable to stamp out tuberculosis in cattle. Tuberculosis was not the only disease transmitted through bad milk; there were instances on record where scarlet fever had been traced to this origin and cowpox, anthrax, rabies, and foot-acid-disease could be transmitted by milk.

Distillery swill could yield alcohol in the milk and poison ivy eaten by cows could render the milk quite harmful. No test other than tuberculin is of any value.

Dr. C. J. Fagin, of British Columbia, described the system of dairy inspection of that Province, and praised the tuberculin test, which was raising the standard of herds.

Dr. Charles E. North, of New York, stated that only solution in cities was pasteurization. There was no possibility of securing enough certified milk.

THE RABIES SITUATION.

Dr. J. A. Amyot gave an address on this subject. He held that the situation is a serious one. The disease at present is confined to the western part of Ontario; but without the strictest precautions might readily spread. So far there has only been one human death from it, that of a boy in Dundas. There have been five deaths in Canada prior to the present outbreak.

Rabies was introduced into America at Boston, in 1798, and has spread from that point.

It has been around that section almost ever since. In Ontario the last outbreak had commenced two years ago, when there were several cases among the animals in the neighborhood of Paris, Galt and Simcoe during that summer. The Dominion Government officials had fought the disease as hard as they could.

The following year there were a few cases, but not so many, although during that year it spread as far as London and more widely everywhere about the Galt, Paris and Simcoe area. During the past winter it commenced to spread from these centres west and north, and came back towards Niagara. Then the authorities got together, and the muzzling order was the result, and the legal quarantine everywhere west of Toronto. There have been in Toronto only two or three cases during the last six months. The necessity of adhering closely to the regulation of not allowing dogs to be transported from one part of Ontario to another, and taken out of the Province, especially into summer holiday districts like Muskoka, arises from the danger of infecting wild animals like foxes and wolves, which, in their natural habits, are timid and fearful of man. If they become infected with rabies, they become bold and run into settlements. In that way there would be a constant source of supply for perhaps years to come.

The instance in Colorado of where rabies got among the skunks is a very enlightening one, because these usually timid animals invaded houses and towns and bit people.

During the past eight months Manitoba and Saskatchewan have been infected from dogs transported from Ontario, dogs that showed no symptoms at the time they left here, but developed it later.

The method of diagnosis adopted by the Dominion authorities in the cases of animals is by inoculation into susceptible animals, but for the treatment of human beings bitten this is too slow. The true state of affairs must be known at an early date. More rapid methods have to be used, and, although these are not so certain as the inoculation method, still they are sufficiently certain to make them available methods. The brain of the biting animal is examined directly for certain bodies described by Negri, an Italian observer, in one of the Pasteur institutes in Italy. It is not certain whether these bodies are degeneration bodies, or the actual living causative agents. One thing, however, is certain, that when present it is always a case of rabies. Such examinations can be made within a few hours after the receipt of the samples. Unfortunately, sometimes, through possibly faulty technique, these bodies are not found when present. In that case resort has to be made to the general symptoms of the animals suffering from the disease.

Since the fourth of March, one hundred and thirty-seven animal brains have been examined in the laboratory of the Board of Health. Of these some sixty-five or seventy have proven positive cases of rabies. The especial value of this has been that individuals bitten by these animals were able with certainty of its necessity to take the prescribed treatment. Sixty-one cases have so far been given the Pasteur vaccination treatment. This is not the treatment for the developed disease, but preventive vaccination. It takes usually three weeks for its completion, daily injections being given. It is really only a preventive measure anticipating the developing of the disease. So far no ill-effects of any kind have been noticed in any of the patients treated. Several of the cases on returning to their homes have found that the animals bitten at same time as themselves had died, or soon after died of rabies, thus justifying their precaution.

Professor J. J. Mackenzie, in commenting on Dr. Amyot's address, mentioned that he had found the same bodies mentioned by Negri while studying a former outbreak in Ontario, which occurred in 1895. He had looked upon them as degeneration products, and so termed them in an address in Great Britain in 1897.

THE ADDRESS IN MEDICINE.

Dr. W. P. Herringham, of London, England, gave the address in medicine on Chronic Bright's Disease. The address was a clear exposition of the views held by the best pathologists and clinicians of the

present day. He discussed very fully the etiology and difference in the various types of chronic kidney disease, known as Bright's disease. He pointed out the main differences in these types, in pathology, symptoms and treatment.

DOMINION REGISTRATION.

The various amendments that were prepared by a special to be inserted in the Canada Medical Act were submitted by Dr. T. G. Roddick, of Montreal, the amendments were adopted. These were published in the Canada Lancet for May. The effect of this Act will be to nationalize the medical profession. While it will not do away with the various medical councils of the provinces, it will minimize their importance, as an increasing number of medical men will secure the qualification with the wider powers and privileges.

The bill, which has been striven for for years, is one of the most important in the history of the medical association, as it is expected to lead to reciprocity with Great Britain in medical matters.

This will mean that a doctor who wishes to practice in any Province but his own, will not have to write examinations whenever he moves to any Province he may wish.

Should any wish only to practise in his own province he may take the examinations of that province.

It is fully expected that all the provinces will soon fall into line, and that the requisite Acts will be passed in them to enable the Canada Medical Act to come into the operation as it will appear when amended

THE ADDRESS IN SURGERY.

Dr. J. B. Murphy, of Chicago, gave an excellent address in surgery. He chose for his subject the Surgery of the Joints. He gave some very good advice on fractures implicating the large joints. The most important feature of his address was that dealing with infections in the joints. He urges early aspiration and the injection into the joint cavity of a two per cent. solution of formalin. This was to be repeated in two or three days. The joint was to be rested on a proper splint, so as to maintain proper position. He claimed that in this way the destruction of the joint structures can be averted, and ankylosis reduced to a minimum. He declared that the formalin had no bad effects.

THE ADDRESS IN GYNAECOLOGY.

Dr. Henry C. Coe, of New York, delivered a most interesting address at the evening session, on "The Old and New Gynaecology." In the course of it he expressed some satisfaction that the tendency to

follow surgical fads and fancies seemed to be passing, and that a more conservative era had supervened. He thought that in the gynaecology of the future the surgical aspect would be less prominent, and more attention would be paid to diagnosis and all that it involved. He stated that no man had a right to perform at the expense of a patient any operation which he could not do well; in other words, that none but a trained specialist should do it.

Speaking on the subject of marriage he said that he believed the day would come when State control of marriage would be recognized as wise. There must be a survival of the fittest, and it remained for them to take every precaution which would enhance the chances of new arrivals in the world being fit. This was not a fanciful scheme, and in some of its details was being worked out even now. It was a shame that so much attention was paid to cattle in this respect and so little to human beings.

EXOPHTHALMIC GOITRE.

Dr. S. F. Beebe, of New York, discussed the pathology of this disease. He referred to cases that came on suddenly. There might be marked symptoms and no enlargement of the thyroid. There was less iodine in the cells of the gland, but on account of the increase of the proteid there was really an increase in the amount of iodine. He thought the active principles might go directly into the blood and not be stored in the gland. In fatal cases the thymus was often enlarged, and a condition of status lymphaticus resulted. This enlargement in the thymus gland was caused by the stimulus from the thyroid gland.

Dr. A. McPhedran, in dealing with the medical aspect of the disease, said there was some enlargement in nearly all cases. The symptoms of this disease varied very much, and in the early stages was often very difficult to diagnose. In some cases the heart's action remained slow. This might be due to the fact that the heart had always been slow. There were cases with high arterial tension and some with a low tension. In the diseases relapses were common. He thought many mild cases recovered and were never heard of. Most of the drugs that had been recommended were of no value. He had found some benefit from the use of quinine hydrobromate in doses of 5 grains. If the heart did not slow down add ergotin. Rest was of the utmost value in the treatment of these cases. The nervous symptoms should be controlled by general care and proper surroundings. If there was not satisfactory improvement in a few weeks an operation should be performed.

Dr. F. J. Shepherd, of Montreal, in discussing the surgical aspects, claimed that the most rational thing to do was to remove the cause, namely, the enlarged gland. In some cases where the gland seemed

small, it was hid beneath the sternum. The urgent symptoms should be relieved before an operation is performed. In 200 cases he had not had an instance of tetany and only one of myxoedemia. He preferred a general anaesthetic and chloroform was the best

MEDICAL EDUCATION.

Dr. J. C. Connell, dean of the medical faculty of Queen's University, Kingston, in making an address on medical education, compared the condition of twenty-five years ago as shown by the college calendars with those of the present. The changing years had brought with it in the place of the old teaching of students by general practitioners in active practice an instruction in a rapidly increasing number of subjects by men who were specialists in the subjects they lectured on. An overburdened curriculum and a higher matriculation standard did not tend, however, to making the student of to-day much better equipped than the one of twenty-five years ago. There was too much for him to cover, and, although the progress of science made some additions necessary, they should be careful not to run to fads and fancies. Principles and methods should be taught rather than a great mass of details. It was of the utmost importance to cause him to think and observe for himself. He concluded by a suggestion for the organization within the association of a permanent committee on medical education.

Such a body would serve to bring together representatives of all the schools in this country and the force of his contention was admitted for the association named the following committee.—Dr. R. A. Reeve, Toronto; Dr. Jas. Bell, Montreal; Dr. F. G. Finley, Montreal; Dr. F. N. G. Starr, Toronto; Dr. Murray Maclaren, St. John, N.B.; Dr. C. J. Fagan, Victoria, B.C.; Dr. G. E. Armstrong, Montreal.

RESOLUTION REGARDING ANTI-TOXIN AND SERA.

It was moved by Dr. C. J. Fegan, seconded by Dr. A. McPhedran, that, considering the importance of anti-toxin in the reduction of the death-rate of diphtheria, its present prohibitive cost, and the lack of means to test the purity or potency of sera sold and used in Canada, the Dominion Government should be petitioned to establish a laboratory with all the necessary accompaniments for the production of anti-toxin and other sera, and to distribute them throughout Canada at the cost of production.

PROTECTIVE ASSOCIATION.

At the meeting of the Canadian Medical Protective Association yesterday afternoon, on account of the illness of Dr. R. W. Powell, of

Ottawa, he was unable to be present, and Dr. Edwin King took the chair. The report showed seven hundred members to have joined the association, which only found it necessary to defend one case of alleged mal-practice during the year. The finances are in a flourishing condition. The same officers were re-elected.

MEDICAL INSPECTION OF SCHOOL CHILDREN.

Dr. John Stewart, of Halifax, N.S., submitted a long report to the Executive Committee, making important recommendations regarding the inspection of children in public schools.

The first was that in each province the education authorities should appoint medical advisers, who would organize a complete system of medical inspection of schools and scholars.

Second, that as far as possible, the medical inspection of schools and the Public Health Department should be co-ordinate.

The third was that the system in British Columbia which provides that medical inspection of schools and scholars be compulsory, should be adopted all over Canada.

The third was that in view of the vast importance of all public health, a section for public health should be added to the permanent organization.

Dr. John Stewart, of Halifax, explained the system of inspection to be that if any child were found not up to the standard, the parents would be informed, and the child would probably be taken away from school. The system does not provide for any cures of ailments.

The following special committee was appointed to consider the question:—Dr. Stewart, chairman; Dr. Helen MacMurchy, Toronto, secretary; Dr. Jasper Halpenny, Winnipeg; Prof. A. McPhedran, Toronto; Dr. C. J. Fagan, Victoria, B.C., and Dr. J. D. Lafferty, Calgary.

THE PROPOSED MEDICAL JOURNAL.

On the recommendation of the Executive Council, presented by Dr. R. A. Reeve, the association decided to publish a journal, to be edited by Dr. McPhail, of Montreal. It acquiesced in a proposal to take over the *Montreal Medical Journal* with a guaranteed circulation of 1,200 copies and to pay interest amounting to about \$360 annually to the owners of that periodical.

COMMITTEES AND OFFICERS ELECTED.

Special Committee on Medical Inspection of Schools—Chairman, Dr. John Stewart, Halifax; Secretary, Dr. Helen MacMurchy, Toronto;

Dr. Jasper Halpenny, Winnipeg; Dr. A. McPhedran, Toronto; Dr. C. J. Fagan, Victoria, B.C.; and Dr. J. D. Lafferty, Calgary.

Committee on Medical Education—Chairman, Dr. R. A. Reeve, Toronto; Dr. Jas. Bell, Montreal; Dr. F. G. Finley, Montreal; Dr. F. N. G. Starr, Toronto; Dr. Murray Maclaren, St. John, N.B.; Dr. C. J. Fagan, Victoria, B.C.; and Dr. George Armstrong, Montreal.

Committee on Medical Legislation—Dr. A. T. Shillington, Ottawa; with power to add.

Public Health and Hygiene—Dr. A. T. Shillington, Ottawa; with power to add.

Amendments to Constitution and By-laws—Dr. H. B. Small, Ottawa, Chairman; with power to add.

Reports of Officers—Ingersoll Olmsted, Hamilton; with power to add.

Necology—Dr. J. H. Elliott, Toronto; with power to add.

The new Executive Council was elected as follows:—Drs. C. J. Fagan, Victoria, B.C.; Ingersoll Olmsted, Hamilton; George E. Armstrong, Montreal; A. T. Shillington, Ottawa; James Bell Montreal; F. N. G. Starr, Toronto; J. T. Fotheringham, Toronto; J. H. Elliott, Toronto; John Stewart, Halifax; Alex. McPhedran, Toronto; R. A. Reeve, Toronto; Murray McLaren, St. John, N.B.; Alex. McNeill, Charlottetown, P.E.I.; J. D. Lafferty, Calgary; and F. G. Finley, Montreal.

Finance Committee—Chairman Dr. Jas. Bell, Montreal; Dr. J. T. Fotheringham, Toronto; Dr. Murray Maclaren, St. John; Dr. S. J. Tunstall, Vancouver; Dr. F. N. G. Starr, Toronto; Dr. R. J. Blanchard, Winnipeg; and Dr. F. G. Finley, Montreal.

The following officers were elected for the ensuing year:—

President, Dr. George E. Armstrong, Montreal; Vice-Presidents of Affiliated Societies, the Presidents of Provincial Societies *ex officio*; General Secretary, Dr. E. W. Archibald, Montreal; Treasurer, Dr. H. B. Small, Ottawa; Local Secretaries of Affiliated Societies, the Secretaries of Provincial societies *ex officio*; Vice-President for Quebec; Dr. Simard, Quebec; Local Secretary, Dr. Campbell Howard, Montreal.

The meeting of 1911 will be held in Montreal.

In this report no attempt is made to follow the work done in the sections.

The principal papers read in these sections will, however, appear in the CANADA LANCET in future issues.

PERSONAL AND NEWS ITEMS.

—
ONTARIO.

Dr. H. O. Howitt, of Guelph, was married to Miss Saunders, of Toronto, recently.

Dr. J. O. Orr, of Toronto, and Miss Halbaus, both of Toronto, were married May 16th.

Dr. W. A. and Mrs. Young paid a visit to St. Louis. Dr. Young was President of the American Editors' Association.

Dr. Charles E. North, of New York, states that no other city the size of Toronto, has so good a milk supply.

Dr. G. Sterling Ryerson has left for Paris where he will spend some weeks in studying radium therapy with Drs. Wickham and Degrais. He expects to return by September 1st.

Dr. J. W. McCullough, of Alliston, Ont., a member of the Provincial Board of Health, is to succeed Dr. C. A. Hodgetts, as secretary to the Provincial Board of Health and Deputy Registrar for the Province.

Dr. F. N. G. Starr is spending some time in Britain. Drs. Rudolf, McPhedran, Goldsmith, Pirnrose, and Starr, all of Toronto, attended the Medical meeting in Washington.

The hospital is to be a memorial to the late king Edward. At the time of the South African War a patriotic fund was raised which now amounts to \$12,000. It is proposed to turn this over to the Children's Hospital Building Fund.

Toronto is moving in the right direction in the appointment of milk inspectors. It is thought that all the dairies supplying the city will soon be under proper inspection. This will cover the premises, utensils, etc., and also the health of the cows.

Dr. Charles A. Hodgetts has joined the service of the Federal Government. He has resigned his position of Secretary to the Ontario Provincial Board of Health, and has become the medical adviser of the Commission on the Conservation of National Energies.

Dr. H. A. Beatty, of Toronto, has been appointed chief surgeon and medical officer of the eastern lines of the Canadian Pacific Railway, with headquarters in Toronto. Dr. Beatty will succeed Dr. Girdwood, of Montreal, who is on leave of absence on account of ill health.

Dr. C. Gordon Hewitt, Dominion Entomologist, gave an address at Ottawa, before the Field Naturalists' Club, in which he stated that the common fly was a dangerous insect. The fly was a winged bundle of bacteria, it was a spreader of typhoid fever, and the summer diseases among children varied with the prevalence of the fly. It was necessary

that efforts should be made to destroy flies, and to do away with their breeding places.

The Citizens' Committee on the erection of the children's hospital, for Hamilton, met in the Waldrof Hotel on 7th June. Miss Jeanette Lewis signified her willingness to turn over to the committee \$5,000 she has raised, and efforts will be made to get the patriotic fund collected at the time of the Salvation Army war. The following Executive Committee to plan the campaign was appointed: Mrs. D. S. Gillies, Mrs. Robert Evans, Miss Lewis, C. W. Cartwright, C. A. Murton, J. M. Young and Geo. C. Copley.

The increased cost of living induced the governors of the Hamilton City Hospital to raise the rates for the institution. The governors claim that the cost of running the hospital has greatly increased in the last few years, while the income has remained stationary. It was, therefore, decided to make the following weekly increases in rates:—\$10 private wards, to \$12; \$12 private wards, to \$14; \$7 private wards, to \$10; semi-private wards, from \$3.50 to \$4.90; non-resident charges, \$4.90 to \$7; diphtheria and scarlet fever wards, \$7 to \$10; maternity hospital, \$20 to \$21. It is likely that a department of pathology will be established at the hospital. A local citizen, who desires to retain his anonymity, donated \$1,000 to the establishment of a pathological laboratory, and the board decided to make an annual grant of \$1,000 towards the maintenance of it. The Government is thinking of appointing Dr. Tytler, pathologist at the Royal Victoria Hospital, Montreal, resident pathologist at the local asylum for the insane at \$700 per year. The intention is to have Dr. Tytler practise three days each week in the City Hospital laboratory, and he will receive \$1,000 per year for doing so, as well as being allowed the use of the laboratory for his private practice. If the services of Dr. Tytler cannot be secured, some other doctor well versed in pathological lore will be engaged.

QUEBEC.

The tenth annual meeting of the Canadian Association for the prevention of Tuberculosis was held in the Royal Edward Institute in Montreal on June 7th, 8th and 9th.

The ceremonies which were being arranged for in connection with the opening of the New Medical Buildings for McGill University, have been postponed on account of the death of King Edward VII.

Dr. Oskar C. Gruner, who held the position of clinical pathologist to the Infirmary in Leeds, England, has been appointed pathologist to the Royal Victoria Hospital, Montreal, and lecturer on pathology at McGill Medical College.

In the Montreal Dispensary during the past year 23,733 applications for treatment were made. There were 8,578 general medical and surgical cases, 2,047 of the eye and ear, 1,801 cases of women's diseases, 1,015 nose and throat cases, 3,079 skin cases, 3,059 children, 2,127 tubercular patients, 262 nervous cases, and 104 dental patients.

Dr. J. Chalmers Cameron, of Montreal, was elected an Honorary Fellow of the American Gynaecological Society at its recent meeting in Washington. Dr. William Gardner, of Montreal, is another Canadian Honorary Fellow. Dr. Cameron has held the position of professor of Obstetrics in McGill for 25 years.

In the recent epidemic of typhoid fever in Montreal, there were 786 cases in the various hospitals, and of these 50 died. Putting the most moderate estimate on the value of the lives and time lost and the cost of caring for the sick, the monetary loss for these cases would exceed \$400,000.

The following Ontario men figure in the list of McGill students given out as having passed their M.D. examinations; J. A. L. Allen, Hallville; F. A. Benner, Bayham; G. E. Booth, Ottawa; F. G. Boudreau, Merrickville; P. E. Doyle, Hawkesbury; H. W. Dunnett, Ottawa; J. R. Fraser, Lakefield; W. G. Fraser, Pembroke; W. N. Gilmour, Brockville; C. A. Graves, Tilsonburg; G. W. Hutchinson, Escott; J. A. Locke, Irena; A. L. Lockwood, Westport; W. A. McCracken, Cornwall; Mt. McEachren, Fenelon Falls; A. Moodie, Perth; H. M. Raphael, Ottawa; J. W. Richardson, Mountain; T. A. Robinson, St. Mary's; G. O. Scott, Ottawa; H. M. Shephard, London; R. N. W. Shillington, Ottawa; A. Stewart, South Indian.

At a meeting of the Montreal Medical Society some amendments to the Roddick bill were adopted. That the bill is not to be regarded as authority for the establishment of a medical college. The fixing the course of study, the examinations to be undergone, and the general conditions shall be under the control of the provinces. The candidates shall be examined in English or French as he may choose and have examiners speaking the language of his choice. The subjects of examination are to be solely on the final branches. At any time a province may withdraw from the Federal Act by a resolution of the Provincial Medical Council. That amendments to the Federal Act must be approved of first by the provinces.

MARITIME PROVINCES.

The Maritime Medical Association will meet this year in St. John, N.B., July 20th and 21st. The meeting is expected to be an excellent one. Arrangements have been made for a number of distinguished visitors.

It is gratifying to notice that the medical journals of this country are taking the sound position with regard to Canadian Department of Health. The *Maritime Medical News* for May strongly advocates such a course. THE CANADA LANCET has done so for many years.

The Legislature of Prince Edward Island has passed an Act making a five years' course compulsory before beginning the practice of medicine. These years may be spent at any approved medical college or university, before candidates can pass the examinations of the Medical Council of the Island. This diploma will be recognized in Britain.

WESTERN PROVINCES.

Contracts have been awarded to Connell-Spencer Construction Company for the erection of a new hospital building for Edmonton to cost \$170,000.

Some of the medical practitioners of Regina are interesting themselves in the establishment of a sanitarium. It is to be for general cases and conducted on ethical lines. It is to be a winter and summer resort.

The Regina Branch of the British Medical Association and the Regina Clinical Society, gave a smoker in honor of the visit of Dr. George D. Porter, who paid a visit to that place as commissioner of the Canadian Society for the Prevention of Tuberculosis. All the provinces with the exception of Alberta, were combining their efforts to stamp out the disease. There are now many local leagues.

FROM ABROAD.

The American Medical Association this year held its 61st annual meeting in St. Louis, Mo., commencing on 7th June.

Dr. Stewart Lockie, consulting physician to the Cumberland Hospital, died a few weeks ago at the age of 74.

A new medical society to be called the American Psychopathological Association was organized a short-time ago at Washington.

The 12th annual conference of the American Hospital Association will be held this year in the Planters' Hotel, St. Louis, Mo., on 20, 21, 22 and 23 of September.

The medical practitioners of Glasgow, Scotland, have under consideration a plan for the establishment of a Widows' and Orphans' Benefit Fund.

William Rose, M.B., F.R.C.S., Emeritus Professor of Surgery, King's College, London, died recently. He was joint author with M. Carless, of a work on surgery.

We have received a beautiful engraving of Dr. A. Jacobie and a copy of the poem of Dr. H. Edwin Lewis which appeared in *American Medicine*. Both are excellent.

Emil Zuckerandl, of Vienna, the eminent anatomist, died a few weeks ago. He did much excellent work on surgical and descriptive anatomy. He was in his 61st year.

Dr. Hebert Leslie Burrell, of Boston, died at his home there, 27th April, in his 54th year. He was President of the American Medical Association in 1908-9. He was a distinguished surgeon and educator.

Dr. William Gordon, of Exeter, England, has gone a long way to prove his thesis that phthisis is borne by certain winds. If this should be established, the wind currents will have to be considered in locating sanatoriums in future.

The twin sisters, Rosa-Josepha, have gone through a remarkable experience lately. Rosa became pregnant and gave birth to a healthy male child. Both sisters had milk in their breasts. These twins are joined together at the sacrum

The City of Sydney, Australia, has had compulsory notification of consumption for several years. Where a case is reported the house is visited, and such steps taken as may be deemed wise to lessen the risk of spread of the disease. The act has given satisfaction.

Dr. Cresswell Baber, a distinguished laryngologist of London, died recently. He was a noted scientist and made some important discoveries, among others his blood counting apparatus. He was a man of the highest professional qualities.

Active steps have been on foot in the provinces forming the South African Union to better the condition of the medical profession. Attempts are being made to secure a united profession, with a high standard of qualification.

On March 20th, there was opened in Milan, Italy, an institution for the study of diseases of occupation. This is the first of the kind in the world. The building is a large one, and has every facility in it for the study of occupation in its relationship to disease.

Dr. Hodenpyl, of New York, died at the age of 46. He was a true scientist and did much good work, hospital work, especially along the lines of pathology. He lived up to the lofty ideals, and left the world richer by his life.

In France the vital statistics made public, show a decrease in the birth rate in that country. The births during 1909 were 770,000, against 792,000 in 1908. Since 1851 the population of the republic has increased 3,000,000 only, while the population of Germany in the same period has been increased by 30,000,000.

A number of foreign writers are at present laying much emphasis upon the psychology of consumption. Many of these writers state that the nervous system plays a very important part in the etiology of phthisis. Over mental strain, worry, and depression are present in many cases.

When a member of the medical profession attains the age of Dr. A. Jacobie with a life so full of good deeds as his, it is befitting that honor should be done him.

"He is complete in feature and in mind

With all good grace to grace a gentleman."

Infant mortality attracts much attention in many countries and its causes are being searched for. Of each 100,000 born in the following countries the number living at the end of the first year are as follows: Sweden, 88,917; France, 83,674; Belgium, 83,114; England and Wales, 82,814; Massachusetts, 82,767; Holland, 82,681; Italy, 82,481; Germany, 76,614; Austria, 75,028.

The women medical students of Glasgow, have sent in a petition to the University Court asking that they be admitted to classes in surgery and medicine, and the Western Infirmary be opened to them. The University had already decided to establish chairs at the Royal Infirmary open to both sexes. It is not likely that the Court will open up the Western Infirmary.

At a lengthy discussion at the Royal Society of London, in which Drs. J. E. Squire, Theodore Williams, Shirley Murphy, W. Olser, G. A. Heron, Nathan Raw, F. J. Wethered, and others took part, it was held by all that there was almost no risk of infection from consumption in the wards of a consumptive hospital where every precaution is taken to avoid infection.

The people of the United States suffer a loss of over 600,000 lives per annum that might be prevented by reasonable safeguards under the co-operation of the Federal and State authorities. This is the bold statement of Senator Owen of Oklahoma when introducing a bill for the creation of a Department of Public Health to be presided over by a cabinet officer.

Elizabeth Blackwell, M.D., of Hastings, England, died at her home on 1st June, in her 90th year. She came to the United States when young and practised medicine for many years in New York. She was instrumental in founding the New York Infirmary for Women and Children, which for many years there was a woman's medical college. She retired to England some years ago.

At a recent meeting of the French practitioners, there was a good deal of discussion over the subject of Criminal Abortions. M. Bertillon stated that there were 50,000 criminal abortions each year in

Paris. Prof. Lacassogne was of the opinion that there were about 19,000 yearly in Lyons. Many of these were procured by midwives, though some were no doubt the work of doctors. It was held that public bodies and municipalities should give assistance to women about to become mothers, where such assistance seemed necessary.

The Transvaal Medical Society has passed resolutions asking for a Minister of Public Health for South Africa, that a Principal Medical Officer of Health be appointed, that the management of hospitals be entrusted to boards on which will be an adequate representation from the medical profession, that on the medical questions, other than those of public health, the Government will consult with the President of the Medical Council. The *Transvaal Medical Journal* is advocating a United Medical Profession for the South African Union. This is as it ought to be.

“Governor Harmon, of Ohio, recently vetoed a bill providing for the establishment of an optometry board. He disapproved of the measure because, among other objectionable features, it sought to give a set of men without medical education authority to examine and license others in the anatomy and physiology of the eye, and this he regards as a downward step leading to peril. He gives it as his view that such a board should be under the control of the state medical board. The statement issued at length by the governor setting forth his veto is well and forcibly expressed.”—*Boston Med. and Surg. Journal*.

The various charitable organizations of Philadelphia have agreed to co-operate with the Bureau of Public Health and Charities in a campaign to reduce the infant mortality of the city during the summer months. An executive committee has been appointed by Dr. Joseph S. Neff, director of the Department of Public Health and Charities, which is representative of the city's best medical and social organizations, and includes physicians, nurses, and superintendents of hospitals. The aim of this committee is to centralize the work of all the child-helping societies in the city, and direct their work into a general channel. To accomplish this a central registration bureau will be established in the city hall. The plans of the committee are rapidly taking definite form, and some of the subcommittees have already been appointed.

At the opening of the Sanatorium for Consumptives, London, Dr. Wm. Osler said that we now have knowledge as to how to cure consumption, and it rested with the public whether it will be stamped out. In three generations it would be wiped out unquestionably, he said.

BOOK REVIEWS.

MEDICAL ELECTRICITY AND RÖNTGEN RAYS.

By Sinclair Tousey, A.M., M.D., Consulting Surgeon to St. Bartholomew's Clinic, New York City. Octavo of 1,116 pages, with 750 illustrations, 16 in colors. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$7.00 net; half Morocco, \$8.50 net. Canadian agents: The J. F. Hartz Co., Limited, Toronto.

In this large and exhaustive treatise we have static electricity dynamic electricity, electricity in animals and plants, physiological effects of electricity, electropathology, electrodes, etc., etc., carefully considered. There are special chapters on phototherapy, x-ray work, röntgenotherapy, and radium. The book is one of the very best on this subject we have seen. It is so complete that there is nothing left to be desired. With this book in one's possession one may be said to have a complete library on electrotherapy. The paper is of very fine quality and yields itself well to the press work, and, as a consequence, the illustrations come out very well. It is almost impossible to review a work of this kind in detail, as the contents are so comprehensive. There is no phase of the application of electricity that is not taken up by the author. This renders the work a most authoritative one. The author states that it is almost impossible to have a work on this subject up-to-date. Notwithstanding this admitted difficulty the present volume is as nearly perfect in this respect as could well be imagined. We trust the volume will have many readers. If it has, it will also have many friends.

TUBERCULOSIS.

By Arnold C. Klebs, M.D., Consulting Physician (Tuberculosis) to Cooks Co. Institutions; Director Chicago Tuberculosis Institute, etc., etc. New York; D. Appleton & Co. 939 pages, illustrated. Price, \$6.00. Toronto: D. T. McAlinsh & Co.

This book is made up of a series of articles contributed to its pages by a number of well known writers. These are Edward R. Baldwin, Jarvis Barlow, Hermann M. Biggs, Lawrason Brown, Thomas D. Coleman, Leonard Freeman, Ludwig Haktoen, R. H. Hutchings, Arnold C. Klebs, S. A. Knopf, L. L. McArthur, Charles L. Minor, William Osler, Clemons Von Pirquet, M. P. Ravenel, Henry Suvall, E. L. Trudeau, and Gerald B. Webb.

Every phase of the study of tuberculosis is taken up by some one of these writers. On the frequency of the disease it is stated that of a

number of series of autopsies on persons dying of all sorts of diseases, other than tuberculosis, evidence was found of infection with tuberculosis at some time in the past in from 50 to 66 per cent. It is stated that there is a very even distribution of the disease in civilized countries, regardless of climatic conditions. This is no doubt due to conditions inherent to civilization.

There is a vast amount of useful information on the prevention and treatment of the disease. On the whole this volume may be said to set forth what is known regarding tuberculosis at the present moment. There is a great deal of work yet to be done. Civilized countries are only playing with the question as yet. This book will, therefore, do much good.

DUODENAL ULCER.

By B. G. A. Moynihan, M.S. (London), F.R.C.S., Senior Assistant Surgeon at Leeds General Infirmary, England. Octavo of 379 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$4.00 net; half Morocco, \$5.50 net. Canadian agents: The J. F. Hartz Co., Limited, Toronto.

Dr. Moynihan has made himself an authority of world wide repute on diseases and surgical conditions of the abdomen. It is with pleasure that one reviews a new work from his pen. In the preface the author states "Among the many and great developments of modern abdominal surgery, few of the problems which were to be unravelled have proved more interesting than that concerned with duodenal ulcer. Ten years ago ulceration of the duodenum was looked upon as a rare disease, and its confident recognition during life was believed to be hardly possible. To-day we know that this disease is common, and its discovery in the majority of cases presents no great difficulties to the trained clinician. In my own experience the diagnosis of duodenal ulcer is made with a degree of accuracy that is not exceeded in the case any other abdominal disorder."

Such a statement as this is very important in two respects, namely, the frequency of the disease, and the readiness with which it can be recognized. One turns that to the chapter in diagnosis. If the pain does not come on for two hours or more after taking food the ulcer is almost certain to be in the duodenum. Then, again, the duodenal ulcer has a remarkable tendency to appear and recur in the cold and wet seasons. There is no such tendency in ulceration of the stomach. In gastric ulcer the pain is referred to the middle line. In duodenal ulceration this common also, but there is usually complaint of pain on the right side over the right costal margin up towards the breast, or round to the

back. "Tenderness, on deep pressure, if present, is always to the right." In gastric ulcer there may be haematemesis without melaena, or in marked excess over it. In duodenal ulcer the melaena occurs alone, or in marked excess of the haematemesis. In cholelithiasis there is some difficulty; but in duodenal ulcer "there is method in the natural history of duodenal ulcer; there are the definite attacks, attributable to well recognized causes, appearing at certain seasons, eased by diet, instantly relieved by alkalis or by lavage, to be followed presently by the complete abeyance of all symptoms. Such a definite periodicity is never seen in gall-stone disease." In gall-stone cases the pain comes on suddenly, and often ceases suddenly, and it is referred to the shoulder-blade. In duodenal ulcer the pain does not come on so suddenly and is never so severe. Alkalis do not relieve the pain of all gall-stone attacks. The general diagnosis is well stated, and will enable any one to decide with very great accuracy whether the case is one of duodenal ulcer, stomach ulcer, or gall-stones.

Coming to the subject of treatment the author opens the chapter with this statement: "In my opinion the treatment of a chronic duodenal ulcer should always be surgical." The methods of performing the operation are clearly laid down. We can advise our readers to carefully study this work. It will prove both a pleasant and profitable task.

REDUCTION CURES AND GOUT.

Part ix. of *Clinical Treatises on the Pathology and Therapy of Metabolism and Nutrition*, by Carl Von Noorden, Professor of the first Medical Clinic, Vienna. New York: E. B. Treat Company. Price \$1.50.

In this little volume we have the genesis of obesity, such as from overfeeding, lack of exercise, and constitutional causes. Then the author discusses the indications for reduction. Under the reduction cares he takes up those from diet, those from muscular exercise, those from mineral waters, from hydrotherapy, and from thyroid therapy. On the latter he states that when obesity is caused by over-eating, the use of thyroids is not of much value and results very temporary when obesity is due to hypothyroidism, the use of the gland may be continued for a long time. The second portion of the volume deals with gout and its treatment. In this disease there are deposits of urates and the fate of uric acid differs from the normal, as there are disturbances in its excretion. The sources of uric acid are taken up. The treatment is set forth in plain language. The author goes over the ground of the purin-free foods, the effects of alcohol, the composition of the diet, mineral waters

and drugs, etc. This is an interesting and instructive book. It throws a good deal of light on some vexed questions in medicine. All of Dr. Von Noorden's writings are interesting, and this volume is quite so.

INANITION AND FATTENING CURES.

Part viii. of *Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition*, by Carl Von Noorden, Professor of the first Medical Clinic, Vienna. New York: E. B. Treat Company. Price \$1.50.

In this next volume Dr. Von Noorden discusses two subjects, namely, Inanition and Fattening Cures. The author carefully explains what he understands by inanition, and to what extent the different organs share in the loss of weight. When dealing with the Fattening Cures the reverse conditions are discussed. The author points out very clearly how the various tissues add weight and how this can be best accomplished. Dr. Von Noorden is always clear and instructive.

TUBERCULOSIS.

My Personal Experiences with Tuberculosis by Will. M. Ross. Published by the author, Stevens Point, Wis. Copyright by Will. M. Ross, 1910. Price 50 cents.

In this pamphlet of 64 pages we are told how the author regained his health after he had gone to the southwest in a futile effort to regain it. The pamphlet is interesting reading and contains many useful suggestions. It would be valuable in the hands of the lay consumptive who seeks guidance.

THE PATHOLOGY OF THE LIVING AND OTHER ESSAYS.

By B. G. A. Moynihan, M.S. (London), F.R.C.S., Honorary Surgeon to Leeds General Infirmary; Professor of Clinical Surgery at the University of Leeds, England. 2mo of 260 pages. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$2.00 net. Canadian agents: The J. F. Hartz Co., Limited, Toronto.

The book contains articles on the pathology of the living, inaugural symptoms, gastro-enterostomy, diagnosis and treatment of cancer of the stomach, surgery of the common bile ducts, obstructive jaundice, Courvoisier's law, mimicry of malignant disease in the large intestines, cancer

of the sigmoid flexure and rectum, etc. These articles are in Dr. Moynihan's clear style and set forth his views ably. These essays are of very special value to the abdominal surgeon. The author has done well to collect these papers into the present compact volume.

INTERNATIONAL CLINICS.

A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. Edited by W. T. Longcope, M.D., Vol. iv., 19th Series, 1909. Philadelphia and London: J. B. Lippincott Company. Price, cloth, \$6.00 year.

This is a well filled volume of a long and excellent series. The articles are on treatment, medicine, surgery, röntgenology, gynaecology, obstetrics, genito-urinary diseases, paediatrics, parasitology, laryngology, and pathology. We can recommend this volume with the same feelings of confidence as we have had in reviewing others of the series. Mr. Roberts, Montreal, is Canadian Agent.

STIMSON ON FRACTURES AND DISLOCATIONS.

By Lewis A. Stimson, B.A., M.D., Professor of Surgery in Cornell University Medical College, New York. New (6th) edition, thoroughly revised. Octavo, 876 pages, with 361 engravings and 65 plates. Cloth \$5.00, net. Lea and Febiger, Publishers, Philadelphia and New York, 1910.

This new addition of a very important book is of interest to general practitioners as well as surgeons, since the injuries covered in its pages are universal in occurrence, and demand immediate treatment by reason of their urgency. The wide acceptance of this work as the leading authority is shown in the demand which exhausts frequent large editions. Dr. Stimson has improved this renewed opportunity by revising his work to the latest date, making it representative of his own enormous experience, and including the accepted views of specialists throughout the world, so that his book is cosmopolitan in the knowledge presented. It is unique in another important point, namely, that it covers dislocations as well as fractures, two cognate forms of injury best studied together. Rare as well as common lesions are included, so that the work is encyclopedic in scope. As malpractice suits are especially to be guarded against in treating these injuries, every medical man can best protect himself by following *Stimson*, the authority accepted, not only by his own profession, but also by the courts. This new edition

has been increased in text, and has been enriched with many additional engravings and plates.

We have had the pleasure of reviewing this work on former occasions. Each edition shows marked improvement. The author has spared no effort to make this edition as thorough and as modern as possible. We can recommend this work as one of the latest and most trustworthy on the subject of fractures and dislocations, and be-speak for it a wide circulation.

EMERGENCIES OF GENERAL PRACTICE.

By Sargent & Russell (Percy Sargent, M.B., B.C., F.R.C.S. Surgeon to Out-Patients, St. Thomas' Hospital; Surgeon to the National Hospital for the Paralyzed and Epileptic, Queen's Square and, Alfred E. Russell, M.D., B.S., F.R.C.P., Physician to Out-Patients, St. Thomas' Hospital), London: Oxford Medical Publications; Toronto: D. T. McAinsh & Co. 364 pages, illustrated. Price \$4.50.

Of late there has been a tendency for the surgeon and the physician to become joint authors of books. We think this is an excellent method, and the present volume is a good example of how the two can work together in the preparation of a really good book. This volume deals with urgent and acute conditions, both surgical and medical. This is one of the excellent Oxford publications that have been appearing for some time. The book is got up in a very attractive style. The paper and binding are good, and the illustrations first class. For the student and younger practitioners this book is the acme of perfection.

A TEXT-BOOK OF PATHOLOGY.

By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia, Second Edition. Octavo of 856 pages, with 437 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$5.00 net; half Morocco, \$6.50 net. Canadian agents: The J. F. Hartz Co., Toronto.

The author states that this edition has undergone a thorough revision. Since the first edition appeared many advances have been made in pathology, and the author has kept his work well up to date. The publishers have done their part in a most praiseworthy manner. The binding, paper and illustrations are excellent. The present edition of Dr. McFarland's work brings the subject of pathology within the range of all. It is a scholarly exposition of the fundamental principles of disease, and we recommend it very highly.

POST-MORTEM MANUAL.

A Handbook of Morbid Anatomy and Post-Mortem Technique. By Charles R. Box, M.D., B.Sc. (Lond.), F.R.C.S. (Eng.), Physician to Out-Patients, St. Thomas's Hospital and Assistant Physician to the London Fever Hospital; Lecturer on Applied Anatomy and Demonstrator of Morbid Anatomy, St. Thomas's Hospital. London: J. & A. Churchill, 7 Great Marlborough Street. Price, cloth, six shillings net. 1910.

This is a very neat volume of 335 pages. The publishers have given the reader an attractive book, in so far as paper, binding and press work are concerned. The illustrations are well executed and aid the text very much. The author is an experienced pathologist and has had ample opportunities to know practically what he wishes to teach. This book is far more than a mere guide as to how to make a post-mortem examination. It is a very excellent work on pathology. Every organ in the body is gone over in the most careful manner. This is the sort of book that will do much good, as it is sure to be read. Brief, accurate and attractive give its qualities.

 THE JOHNS HOPKINS HOSPITAL REPORTS.

This is Volume XV of the splendid reports issued from the press of the Johns Hopkins Press. This volume contains 542 pages and is well illustrated. There are three articles in it, one Diarrhœa in Children, on Skin Transplantation, and Epidemic Cerebro Spinal Meningitis treated by Serum Therapy. The rest of the volume is entirely devoted to pneumonia in every phase of the disease. The chapters on this disease make up a most valuable contribution on the study of pneumonia.

 OBITUARY.

DUNCAN H. HUTCHINSON, M.D.

Dr. Duncan H. Hutchinson, of Port Rowan, dropped dead at one o'clock, while attending his horse in the stall, the cause of his death being heart failure. Dr. Hutchinson was the son of the late Donald Hutchinson, and was born in Oxford county forty-five years ago. He was a resident of that village for about eight years. He leaves a widow and three small children.

 J. T. LEWIS, M.D.

Dr. J. T. Lewis, of Hillsboro', who served to terms in Parliament, died recently aged 80 years. He leaves a wife. Dr. Lewis had been in poor health for a long time.

J. A. GRAY, M.D.

Dr. Gray, for many years coroner for the County of Peterboro, died in the Nicholls Hospital, 15th June. The day before about 2 o'clock Dr. Gray fell from the window of his home, 205 Sherbrooke Street, broke several ribs and sustained concussion of the brain. He never recovered consciousness from the time of his injury. He was also C.P.R. doctor at this point. He secured his license in 1874.

WILLIAM WHEELOCK DELANCEY.

Dr. DeLancey died of pulmonary tuberculosis at Phoenix, Arizona. He was born in Williamstown, Annapolis County. He was a descendant of an early pioneer family. On his mother's side he was nephew of the late Justice Burbidge. He took his medical course in Jefferson College, Philadelphia. He was ill for a year, and died at the early age of 27 years.

MISCELLANEOUS.

UNIVERSITY OF TORONTO EXAMINATIONS IN MEDICINE,
DEGREE OF M.B.

Degree with honors—1, J. V. Follett; 2, H. E. Alexander; 3, T. M. Weir; 4, W. Geiger; 5, M. N. Faris; 6, J. B. Mann; 7, F. Adams.

Medals—J. C. Watt, gold; J. V. Follett, first silver; R. M. Butterfield, second silver; P. W. Barker, third silver.

Graduates in arts, in natural sciences, or in the biological and physical sciences—P. W. Barker, R. M. Butterfield, D. A. Clark, W. A. Clarke, J. G. Gallie, M. E. Hall, R. A. Jamieson, R. E. Johnston, C. B. Kelly, G. L. Macdougall, P. K. Menzies, V. H. K. Moorhouse, H. H. Murray, S. M. McLay, A. H. Talyor, H. A. Turofsky, J. C. Watt, M. B. Whyte, Miss C. F. Woodhouse.

Group I—Medicine, clinical medicine, pathology and therapeutics—1, J. V. Follett; 2, R. M. Butterfield.

Group II.—Surgery, clinical surgery, surgical anatomy and pathology—1, R. M. Butterfield, 2, H. E. Alexander, J. C. Watt; 4, W. Geiger; 5, J. V. Follett; 6, F. Adams, H. D. Harrison, Miss J. McDonald; 9, T. M. Weir; 10, J. B. Mann; 11, N. T. Beeman; 12, M. B. Whyte; 13, I. W. Dickson.

Group III.—Obstetrics, paediatrics, gynaecology and pathology—1, H. E. Alexander; 2, J. V. Follett; 3, W. Geiger; 4, J. C. Watt; 5, T. M. Weir; 6, J. B. Mann; 7, M. N. Faris, G. P. Parker; 9, Miss J. McDonald; 10, R. M. Butterfield; 11, P. W. Barker, N. T. Beeman; 13, F. H. Buck.

Group IV.—Medical jurisprudence, toxicology, hygiene and psychiatry—1, J. C. Watt; 2, H. E. Alexander.

Pass—J. G. Alexander, D. W. Allen, E. B. Allport, W. C. Arnold, H. DeW. Ball, *R. A. Belfry, *T. A. Brandon, F. A. Brewster, H. Buck, J. M. Burnett, R. Campbell, F. T. Campbell, J. P. Campbell, R. W. Clark, W. W. Cruise, *H. A. Culham, *R. E. Davis, *W. J. Defries, W. F. I. Dey, J. R. Dickson, *Miss M. A. Doherty, H. H. Eyres, H. M. Elliott, *W. K. Feare, *H. E. Ferguson, W. E. Ferguson, *G. J. Forster, *P. N. Gardner, H. C. George, G. J. Gillam, A. T. Gillespie, R. R. Graham, Miss E. M. Guest, W. L. Hackett, G. H. R. Hamilton, G. M. Hanna, *F. S. Harper, M. A. Harrington, D. C. Hart, F. R. Harvey, R. H. Henderson, S. M. Holmes, D. A. Hopper, E. M. Horton, *W. W. Hume, E. W. Huxtable, H. L. Jackes, H. E. Johnson, J. B. Jupp, *A. D. W. Kay, *J. A. Kearns, T. S. Kirby, R. T. Lane, A. S. Lawson, B. Lealy, H. DeW. Lees, A. B. Lemesurier, H. D. Livingstone, F. W. Loring, A. Lowrie, B. N. Macaulay, *F. O. Mahoney, C. R. Marlatt, H. H. Mitchell, R. R. Montgomery, J. E. Montgomery, W. G. Montgomery, N. A. Morrison, *R. L. Morrison, *H. B. Moyle, A. McAlister, E. C. McArthur, *E. L. McIntyre, *D. G. S. McKay, R. A. McKay, K. A. McLaren, *J. M. McLean, J. Nedd, J. M. Nettleton, W. F. Nicholson, O. W. Niemeier, A. Pain, R. L. Parr, J. P. Patton, F. E. Petman, T. R. Pickard, J. L. Poirier, *G. Priestman, W. A. Proud, A. B. Ritchie, H. C. Robertson, *A. G. Scott, E. R. Selby *J. F. Shaw, C. Sheard, jun., A. C. Sinclair, *P. D. Spohn, W. O. Stevenson, S. J. Streight, F. J. Thompson, *E. R. Tyrer, W. W. Upton, E. G. Vernon, *G. L. Williamson, C. S. Wright.

C. W. Hurlburt is granted aegrotat standing of the fourth year.

The following students have completed supplemental examinations in the following subjects:—Medicine—G. C. Gunn, G. C. Kidd, S. W. H. Nelson, W. L. Ritchie, J. G. R. Stone, L. B. Williams. Clinical medicine—S. Ellis, W. Jamieson, G. C. Kidd, S. W. H. Nelson, J. G. R. Stone, J. T. Thomas, L. B. Williams.

Surgery—W. T. McLean. Pathology—D. B. Jamieson, W. L. Ritchie, N. W. Rogers. Obstetrics—W. L. Ritchie. Gynaecology—G. C. Kidd.

The following students are required to pass supplemental examinations in the following subjects before completing the fourth year:—Medicine—Miss M. A. Doherty, P. J. Emerson, W. K. Feare, H. E.

Ferguson, G. J. Forester, P. N. Gardiner, W. W. Hume, F. O. Mahoney, R. L. Morrison, H. B. Mole, E. L. McIntyre, D. G. S. McKay, G. Priestman, J. F. Shaw, P. D. Spohn, G. L. Williamson. Surgery—H. A. Culham, R. E. Davis, W. J. Defries, Miss M. A. Doherty, P. J. Emerson, H. E. Ferguson, A. D. W. Kay, J. A. Kearns, F. O. Mahoney, H. B. Moyle, E. L. McIntyre, J. D. McPhee, G. Priestman, P. D. Spohn. Clinical medicine—R. A. Belfry, H. A. Culham, R. E. Davis, Miss M. A. Doherty, W. M. Ecclestone, W. K. Feare, H. E. Ferguson, F. S. Harper, W. W. Hume, J. A. Kearns, G. Linscott, F. O. Mahoney, R. L. Morrison, H. M. Nicholson, W. G. Penny, A. G. Scott, J. F. Shaw, P. D. Spohn, G. L. Williamson. Clinical surgery—T. A. Brandon, J. F. Shaw. Pathology—T. A. Brandon, W. J. Defries, P. J. Emerson, G. J. Forester, E. R. Tyrer. Obstetrics—E. L. McIntyre, J. M. McLean. Hygiene—W. K. Feare, F. O. Mahoney, E. L. McIntyre, D. G. S. McKay, P. D. Spohn. Ophthalmology, otology, laryngology and rhinology—R. A. Belfry, R. E. Davis, W. J. Defries, Miss M. A. Doherty, P. J. Emerson, H. E. Ferguson, G. J. Forster, P. N. Gardner, W. W. Hume, F. O. Mahoney, E. L. McIntyre, D. G. S. McKay, J. M. McLean, G. Priestman, P. D. Spohn. Clinical psychiatry—H. A. Culham, G. Priestman. Paediatrics—W. J. Defries, W. W. Hume, J. M. McLean.

THIRD YEAR.

Medicine, clinical medicine, surgery, clinical surgery, pathology, practical pathology, topographical anatomy, obstetrics, therapeutics, jurisprudence and toxicology—Pass—C. C. Alexander, *A. C. Armstrong, A. H. Baker, *H. R. Barker, W. D. Barrett, *N. J. Barton, H. W. Benson, C. C. Birchard, R. Blanchard, W. O. Bonser, C. Bouck, J. C. Bradley, L. Broe, L. F. Brogde., F. T. Bryans, F. S. Burke, C. H. Burroughs, C. M. Burroughs, D. R. Burwash, *W. H. Butt, *W. C. Campbell, J. G. A. Campbell, W. R. Cann, G. W. D. Carleton, G. M. Carson, J. P. S. Cathcart, W. E. Caven, N. A. Christie, *G. W. Clark, C. W. Clark, G. H. Clement, L. H. Coates, W. M. Cody, M. G. Cody, *H. H. Colwell, *C. F. Connolly, G. G. Copeland, *W. A. Costain, Miss S. A. Cunningham, *H. C. Davis, R. D. Defries, D. L. Dick, R. G. Douglas, A. S. Eagles, *E. V. Emery, D. T. Evans, N. J. Ferrier, A. Fettes, E. J. Finnerty, Miss Fotheringham, C. L. R. Fuller, *J. J. Finn, J. A. Gardiner, A. R. Gilchrist, T. J. Glover, H. H. Gordon, R. M. Gorssline, L. O. Griffin, R. E. Guyatt, L. C. Hagmeier, J. E. Hagmeier, W. R. W. Haight, T. R. Hanley, A. P. Hart, H. H. Harvie, Miss E. M. Hayes, I. D. Hayes, *H. Heffering, P. V. Helliwell, *C. W. Henders, *D. P. Henderson, G. L. Hodgins, R. A. Hodgson, W. L. Hutton, R.

A. Ireland, L. P. Jones, L. A. Jones, *W. J. Keeley, E. E. Kells, G. W. Kells, *W. J. Kirby, L. W. Kergin, C. O. E. Kister, A. N. Kitt, J. M. Lajoie, *J. C. K. Langford, W. J. Leach, A. V. Leonard, *A. F. Lepper, *M. Levy, J. M. Livingstone, *R. D. Mace, *J. E. Macklim, W. Mainprize, *H. K. Manning, W. G. Martin, *A. C. Martin, *J. J. Middleton, E. W. Mitchell, H. B. Moffat, H. M. Mosdell, *J. K. Mossman, C. J. McCabe, P. S. McCaffery, A. I. McCalla, *J. F. McCracken, M. McDonald, *G. J. McFarlane, E. H. McGavin, E. A. Mackenzie, *W. J. MacKenzie, J. McLean, *C. A. MacMurchy, *C. A. Macpherson, J. A. McPherson, J. W. McQuibban, G. A. McQuibban, T. W. Nancekivell (aeg.), *G. A. O'Leary, H. Orr, T. D. Park, F. S. Park, M. A. Pollock, A. G. Poole, *F. H. Pratten, L. A. Roy, J. A. Reid, *J. Richards, E. A. Richardson, D. Riggs, J. F. Riggs, Miss I. M. Roberts, G. B. Rose, *A. E. Ross, A. Roszell, H. L. Rowntree, M. C. Salmon, F. R. Scott, *L. J. Sebert, *T. J. Sexton, *N. Shachnove, *N. C. Sharp, R. L. Shields, H. J. Shields, C. W. Sinclair, *G. M. Sinclair, L. O. C. Skeeles, W. D. Smith, S. R. Smith, W. W. Smith, *I. R. Smith, H. G. Smith, *H. F. Sproule, F. Stainsby, G. B. Stalker, Miss E. L. Stewart, R. R. Stirrett, *J. D. Struthers, *D. Sweeney, P. J. Sweeney, W. C. Swenerton, F. L. Thompson, H. E. Thompson, H. M. Tovell, R. N. Tripp, W. R. Tutt, M. C. Vaughan (aeg.), *A. H. Veitch, C. W. Waldron, *F. B. Ware, A. L. Wellman, F. W. Weston, W. L. Whittemore, *W. M. Wilkinson, W. A. Wilson, C. R. Wilson, J. P. Wilson (aeg.), H. M. Yelland, C. R. Young, *R. W. Young, E. W. Zumstein.

M. C. Vaughan is granted aegrotat standing of the third year. T. W. Nancekivell is granted aegrotat standing in the subject of pathology, therapeutics, jurisprudence and toxicology of the third year, and materia medica of the second year. J. P. Wilson, is granted aegrotat standnig in the subjects of topographical anatomy, obstetrics, thierapeutics, medicine and surgery of the third year.

The following students have completed supplemental examinations in the following subjects:—Medicine—E. S. Baker, E. R. Selby, G. L. Williamson. Clinical medicine—E. S. Baker, R. A. Belfry, R. E. Davis, W. K. Feare, H. C. George, H. E. Johnson, J. G. Lee, E. R. Selby, A. C. Sinclair, H. A. Turofsky, G. L. Williamson. Surgery—R. A. Belfry, R. E. Davis. Clinical surgery—F. S. Harper, J. A. Kearne, B. N. Macaulay, R. L. Morrison. Pathology—D. A. Hopper, J. B. Jupp, S. M. McLay, N. W. Rogers, P. D. Spohn. Topographical anatomy—E. S. Baker, A. D. W. McKay. Obstetrics—G. L. Williamson. Jurisprudence and toxicology—A. Steinberg.

The following students are required to take supplemental examinations in the following subjects before completing the third year:—Medicine—W. D. Brace, W. H. Butt, H. H. Colwell, H. C. Davis, W.

J. Kirby, M. Levy, J. J. Middleton, G. A. O'Leary, N. Shachnove, I. R. Smith. Clinical medicine—A. C. Armstrong, H. Bell, W. C. Campbell, G. W. Clark, D. P. Henderson, M. Levy, A. C. Martin, G. L. McFarlane, W. J. MacKenzie, J. Richards, L. J. Sebert, D. Sweeney. Surgery—A. C. Armstrong, H. H. Colwell, W. A. Costain, H. Heffering, W. J. Kirby, A. F. Lepper, J. E. Macklim, H. K. Manning. Clinical surgery—N. J. Barton, C. F. Connolly, C. W. Henders, D. P. Henderson, A. J. Keeley, J. C. K. Langford, A. F. Lepper, A. C. Martin, J. J. Middleton, G. L. McFarlane, W. J. Mackenzie, A. H. MacMurphy, C. A. Macpherson, T. J. Sexton, N. Shachnove, N. C. Sharp, I. R. Smith, J. D. Scruthers, F. B. Ware, W. M. Wilkinson. Pathology—W. D. Brace, H. H. Colwell, H. C. Davis, H. Heffering, A. J. Keeley, M. Levy, G. A. O'Leary, F. H. Pratten, A. Steinberg, F. B. Ware, R. W. Young. Topographical anatomy—W. H. Butt, W. C. Campbell, H. H. Colwell, E. V. Emery, H. Heffering, D. P. Henderson, R. D. Mace, H. K. Manning, F. H. Pratten, J. Richards, F. B. Ware. Obstetrics—H. R. Baker, J. J. Finn, J. K. Mossman, J. F. McCracken, F. H. Pratten, A. E. Ross, N. Shachnove, H. F. Sproule. Therapeutics—A. C. Armstrong, W. D. Brace, W. H. Butt, G. M. Sinclair, I. R. Smith, H. F. Sproule, F. B. Ware. Jurisprudence and toxicology—N. Shachnove, H. F. Sproule.

SECOND YEAR.

Anatomy, Physiology, Biochemistry, Histology, Bacteriology:—

Honors—1, A. A. Fletcher; 2, C. C. Macklim; 3, K. M. B. Simon; 4, R. W. Gliddon; 5, F. A. Brokenshire; 6, F. M. Walker; 7, F. E. Webb; 8, A. E. McKibbin; 9, W. G. Loughheed; 10, A. M. Bell; 11, H. W. Wookey; 12, J. Thomson; 13, H. R. Hargrave.

Pass—S. L. Alexander, W. C. Allison, H. H. Argue, *J. P. Austin, C. A. Brisco, *Miss E. G. Brown, J. F. Burgess, A. J. Butler, T. L. Butters, Miss A. A. Cameron, T. C. Clark, W. D. Cruickshank, T. D. Cumberland, F. C. Davis, G. P. Dunning, O. E. Finch, T. C. Galbraith, G. C. Graham, G. G. Grier, E. R. Hastings, R. Home, B. F. Keillor, C. F. Knight, E. P. Lewis, J. L. Mahoney, A. Matheson, J. G. Morgan, G. S. McAlpine, Miss A. McEwen, *H. R. Macintyre, H. A. McKay, *J. G. McKie, T. H. McKillip, D. B. McLean, *J. F. McQuay, S. W. Otton, R. C. Phelps, *N. L. Phoenix, W. S. Pickup, *L. K. Poyntz, W. A. Reddick, S. A. Richardson, W. L. Robinson, H. P. Rogers, A. C. Roswell, T. M. Savage, W. A. Scott, W. B. Seaton, J. D. Shields, *G. L. Sinclair, E. A. Smith, H. A. Snetsinger, Miss A. B. Speers, *E. H. Stephen, J. L. Telford, J. G. Turnbull, W. V. Watson, G. A. Watson, G. E. White, H. A. Wolverton, *H. S. York.

The following students have completed supplemental examinations in the following subjects:—Anatomy—E. S. Baker, H. DeW. Ball, R. E. Humphries, A. H. MacMurchy, N. W. Rogers. Embryology—T. F. Kelly. Chemistry (Organic)—E. A. McQuade. Materia Medica—C. F. Connolly, L. G. Hagmeier, A. C. Martin, J. F. McCracken, C. A. Macpherson, J. M. McLean, N. Shachnove, Miss Stewart, R. N. Tripp, F. B. Ware.

The following students of the biological and physical science course have completed their examination in materia medica:—J. G. A. Campbell, G. G. Copeland, T. R. Hanley, I. D. Hayes, Miss E. M. Hayes, P. V. Helliwell, W. J. Kirby, A. N. Kitt, C. O. E. Kister, J. M. Livingstone, A. I. McCalla, T. W. Nancekivell (aeg.), F. S. Park, M. A. Pollock, Miss I. M. Roberts, L. A. Roy, N. C. Sharpe, H. J. shields, G. M. Sinclair, L. O. C. Skeeles, H. G. Smith, G. B. Stalker, W. L. Whittemore, W. A. Wilson.

The following students are now required to take supplemental examinations in the second year in the following subjects:—Anatomy—Miss E. G. Brown, T. F. Kelly, J. G. McKie, N. L. Phoenix, H. S. York, A. Matheson. Physiology—A. Matheson, H. R. Macintyre, J. F. McQuay, N. L. Phoenix, G. L. Sinclair. Organic Chemistry—A. F. Mavety, S. W. H. Nelson. Histology—E. A. McQuade, E. H. Stephen. Bacteriology—J. P. Austin, H. R. Macintyre, J. G. McKie, L. K. Poyntz. Embryology—A. F. Mavety, F. B. Ware.

FIRST YEAR.

Biology, mammalian anatomy, histology, embryology, inorganic chemistry, physics, anatomy.—

Honors—1, H. K. Detweiler; 2, C. L. Morgan; 3, W. J. McLean; 4, W. Hamilton; 5, L. G. Pearce and J. W. Peck; 7, F. L. Eberhart; 8, W. W. McKenzie; 9, B. D. Lowrey; 10, R. G. Struthers; 11, G. S. Gliddon; 12, T. G. Wilson; 13, A. Taylor; 14, H. A. Cates and D. E. Ross; 16, J. M. Bremner. E. R. Duncan granted aegrotat standing in biology, histology and inorganic chemistry; honors without rank.

Pass—H. R. Adams, G. C. Anglin, *H. R. Baines, C. C. Ballantyne, *S. S. Ball, *A. F. Bastedo, J. R. Beaven, *R. E. Biggs, G. E. Binley, J. E. Bond, J. R. Boyd, *R. J. W. Brooke, H. E. Brown, H. H. Burnham, W. W. Buttle, G. L. Caldwell, K. W. Cameron, *J. Chasels, H. Clarke, *L. H. Cooke, H. R. Conn, *R. E. Crane, W. Cross, *R. E. Dalton, T. G. Drake, *J. A. Duck, *C. B. Eby, G. S. Fouids, W. J. Gardiner, Miss E. H. Gordon, T. F. Graham, B. L. Guyatt, H. P. Hamilton, R. E. Hartry, *R. Horkins, *J. R. Howitt, J. N. Humphrey,

*H. B. Jeffs, *J. E. Knox, O. J. S. Little, W. T. Little, H. S. Martin, J. C. Maynard, *H. K. Mitchell, *Miss L. I. Moodie, J. F. McCorvie, W. V. McIntosh, R. D. Mackenzie, K. G. McKenzie, C. Newell, V. K. O'Gorman, L. C. Palmer, A. A. Parker, M. H. Paterson, D. A. Quick, W. R. Reeds, E. F. Risdon, O. S. Ross, H. P. Rudolf, *W. F. Shaw, W. E. Sinclair, R. F. Slater, R. S. Smith, R. P. Smith, *F. W. Stalter, *H. C. Sutton, E. C. Syer, M. G. Thomson, *W. L. Tyrer, D. R. Wark, *W. White, *R. R. Wilson, C. S. Wynne.

The following are matriculant students taking the examination of the first year:—Pass—*Miss E. M. Cowling, *O. J. Day, *F. M. Dure, G. M. Flock, *J. B. Hanley, *A. McLeod, G. H. Robinson, *G. A. Smith.

The following students have completed supplemental examinations in the following subjects:—Biology—C. E. Trow. Mammalian anatomy—E. J. Clifford. Embryology—T. M. Savage. Inorganic chemistry—E. A. McQuade. Organic chemistry—J. F. McQuay. Physics—A. C. Martin.

The following students are required to take supplementary examinations in the following subjects before completing the first year:—

Biology—A. F. Bastedo, J. Chassels, O. J. Day, J. R. Howitt, J. E. Knox, W. F. Shaw, H. C. Sutton.

Histology—F. M. Dure.

Inorganic Chemistry—R. E. Bigras, O. J. Day, F. M. Dure, H. B. Jeffs, G. H. Robinson, G. A. Smith, W. L. Tyrer.

Physics—R. E. Crane, O. A. Day, J. B. Hanley, H. K. Mitchell, Miss L. I. Moodie, F. W. Stalter, H. C. Sutton.

Mammalian Anatomy—H. R. Baines, S. S. Ball, J. Chassels, L. H. Cook, R. E. Crane, R. E. Dalton, C. B. Eby, J. B. Hanley, R. Horkins, W. F. Shaw, H. C. Sutton, W. L. Tyrer.

Embryology—H. R. Baines, R. E. Bigras, J. Chassels, R. E. Dalton, J. A. Duck, F. M. Dure, J. B. Hanley, L. G. Hodder, J. R. Howitt, Miss L. I. Moodie, J. F. McQuay, G. L. Sinclair, H. C. Sutton, R. R. Wilson.

Organic Chemistry—A. F. Bastedo, R. J. W. Brooke, J. Chassels, Miss E. M. Cowling, L. G. Hodder, H. B. Jeffs, N. L. Phoenix, G. H. Robinson, G. L. Sinclair, F. W. Stalter, W. White, R. R. Wilson.

Anatomy—H. R. Baines, Miss E. M. Cowling, H. B. Jeffs, A. McLeod, G. H. Robinson, F. W. Stalter, W. L. Tyrer, W. White, R. R. Wilson.

THE HENRY PHIPPS INSTITUTE FOR THE STUDY,
PREVENTION AND TREATMENT OF
TUBERCULOSIS.

Mr. Henry Phipps of New York has selected the University of Pennsylvania to carry on the work of the Phipps Institute. Mr. Phipps has already acquired ground in Philadelphia on which will be erected a hospital for this purpose. The extent of the benefaction exceeds \$5,000,000.

The report of the Committee appointed to consider the future policy of the Institute has been approved by Mr. Phipps and the Trustees of the University.

The work will be divided into three general departments, each of which will be presided over by a director. For the Directorship of the Laboratory, Dr. Paul Lewis, now of the Rockefeller Institute, has been selected. For Directorship of the Sociological Department, Mr. Alexander M. Wilson, of the Boston Association, for the Relief and Control of Tuberculosis. Dr. H. R. Landis has accepted the appointment as Director of the Clinical Department.

In addition to a board of eight directors who will be directly responsible to the Trustees of the University, an Advisory Council has been created and will meet annually at the Institute. The following have accepted the invitation to serve as members of this body: Dr. Samuel G. Dixon, Harrisburg, Pa.; Dr. S. McC. Lindsay, New York City; Dr. William H. Baldwin, Washington, D.C.; Dr. Hermann M. Biggs, New York City; Dr. William H. Welch, Baltimore, Md.; Dr. Theobald Smith, Boston, Mass.; Dr. Gideon Wells, Chicago, Ill.; Dr. Simon Flexner, New York City; Dr. James A. Miller, New York City; Dr. Lawrence Brown, Saranac, N.Y.; Dr. Henry Baird Favell, Chicago, Ill., and Dr. James Pratt, Boston, Mass.

WILLIAM HENRY WELCH.

The election of Dr. William H. Welch to the presidency of the American Medical Association marks an epoch in the medical history of Maryland. It is particularly noteworthy that of the many eminent medical men of our State, Dr. Welch is the first upon whom this honor has been conferred by the physicians of this country. In our opinion the association has made a wise choice, and its activities and influence are certain of advancement under the stewardship of this remarkable

and lovable man. The range of Dr. Welch's activities is marvellous. His capacity for work is wonderful. His influence as teacher, physician and public-spirited citizen has been far-reaching. As an index of his worth as a citizen may be cited the many public civic offices to which he has given his time, among them being presidency of the State Board of Health, membership in the School Board of Baltimore, the Sewerage Commission and the Charter Revision Committee of Baltimore.

As a maker of men Dr. Welch stands out conspicuously among the medical educators of America. To his training the medical profession of America is indebted for such men as Councilman, Opie, Abbott, McCallum, Bloodgood, Williams and Flexner.—*Maryland Medical Journal*.

MEDICAL FEES IN ANCIENT BABYLON.

It is curious to find that the custom of regulating medical fees by the social position of the patient is, at least, four thousand years old. In the Code of Hammurabi, a king of Babylon, who ruled about 2250 B.C., a scale of medical fees is laid down which takes note of differences in rank between the upper class, the middle class, or freemen, and slaves. Thus, for setting a broken bone, the patient was to give five shekels of silver to the physician; if the patient were a freeman, however, the fee was to be three shekels, and if a slave, two shekels, to be paid by the owner. For other specific operations, fees were also fixed. The fees were, however, apparently contingent upon success, and failures were severely penalised. "If a physician . . . open an abscess (in the eye) of a man with a bronze lancet and destroy the man's eye, they shall cut off his fingers." "If a physician operate on a slave . . . and cause his death, he shall restore a slave of equal value." The Code contains many other similar provisions. It is not easy to come to a just estimation of the relative value of the fees ordained, but a fair approximation can be reached. At the same time, the yearly wage of an ordinary labourer was eight shekels of silver. For treatment of a fracture, therefore, a physician was paid five-eighths of the yearly wage of a labourer. If this could be represented relatively in our currency, it would probably mean a fee of between £30 and £40. In spite of the penalties for malpractice, physicians in Babylon had some cause to be contented with their lot.

MEDICAL PREPARATIONS, ETC.

"THE LAXATIVE DE LUXE."

The Abbott Alkaloidal Company, of Chicago, Ill., claim for Thalosen that it is the best phenolphthalein-laxative produced in this country or abroad. That is a big contention but there are a host of medical men who stand ready to uphold it. If any of our readers are unacquainted with it we recommend that they take the time to write for the complimentary trial package of the tablets offered in current advertisements.

Thalosen appears to be an out-of-the-ordinary laxative and the samples will prove a revelation to those who know phenolphthalein only in the commonplace forms in which it has been exploited for several months past.

Each tablet contains one grain of phenolphthalein with senna and sulphur in correct proportions, in an aromatic base. For convenience it is segmented into quarter doses. Whether it is because a refined grade of the drug is used in its making or because of the presence of synergistic drugs we do not know but Thalosen is certainly more satisfactory in its action than the phenolphthalein-laxatives that have come from other sources. In this combination one grain of phenolphthalein seems to go farther and operate more completely and regularly than twice the dose of this drug given alone or in other combinations.

The tablets are edible as candy; for children and older people who demand palatability it is the evacuant of choice. One physician who apparently cannot say enough for it recently described Thalosen as "the laxative de luxe" and we notice that the manufacturers are very properly making use of this apt title in their printed matter.

SANATOGEN.

For upwards of six years this preparation has been on the market. It has been tested in many conditions where both a tonic and nourishment are required. It has been found to be very valuable in convalescence from all severe illnesses. The basis of Sanatogen is the casein of milk. Combined with the casein there is a relatively large amount of organic phosphorus, in exactly the form that can be readily absorbed and assimilated. It is both a food and a medicine and very useful for run down people and those suffering from anaemia and nervous debility. In stomach troubles, in the feeding of children, in the nourishment of the aged, and sleeplessness it has been found very useful.

ENTEROCLYSIS.

S. Newmayer, M.D., Phila., states:—Among the varied causes of convulsions none play a more frequent and important part than autointoxication. They are more frequent in children, due generally to a possible overfeeding, improper food or constipation. The intestinal canal contains a variety of toxins derived from the ingesta, bile and putrid material. There is continuous absorption from the intestines, including the taking up of toxins.

In the acute infections, where convulsions is oft-times a forerunner, autointoxication from the intestinal tract undoubtedly is of no minor importance. Infections are the result of microbes and we know these bacteria produce something injurious to the system—they elaborate poisonous ptomaines or toxic substances. Nature tries to rid the body of this poison through its various channels of elimination, one of which is the intestinal canal.

It is here we can aid nature with our antiseptics. The value of internal intestinal antiseptics I believe is greatly over-rated. Many of these drugs are soluble and absorbable and those that are not are so often given in such small doses that in the long journey from the mouth through the intestinal tract they have spent most of their value before they have proceeded far.

Not to employ internal antiseptics would be unwise. But I would urge a more liberal use of antiseptic solutions by means of the rectal tube. This enteroclysis has not only its antiseptic value, diminishing the toxicity of the intestinal tract, but oft-times an antipyretic action. This mode of treatment has not been very popular with the physician because of the unclean work, but I am confident the results well repay one for the labor.

In all cases of convulsions, immaterial of the cause, and in any other condition pointing to autointoxication, I flush the lower bowel with a solution of Glyco-Thymoline, one to two ounces to the quart of water.

Glyco-Thymoline is always kept in my emergency grip.

A VERY GRAVE ERROR.

The experience of many of the best men of the profession, not only of the United States but abroad, has established the clinical value of antikamnia tablets. Among those who have paid high tributes to their value and occupy positions of great eminence, may be mentioned

Dr. J. Acheson Wilkin and Dr. R. J. Biackham, practitioners London. They have found these tablets of value in the neuralgias and nervous headaches resulting from over-work and prolonged mental strain, paroxysmal attacks of sciatica, brow-ague, painful mensuration, la grippe and allied conditions. Indeed the practitioner who has such cases as the latter come under his observation, and who attempts their relief by opiates and stronger drugs, when such an sufficient and harmless an agent can be used, commits a grave error.

Experience goes to prove that two antikamnia tablets in an ounce of sherry wine, taken every two or four hours, will carry the patient through these painful periods with great satisfaction.—*Medical Reprint*, London, Eng.

A. CONSERVATIVE HOUSE.

Some of the members of the medical profession would open their eyes could they look over the files of the Denver Chemical Mfg. Co., manufacturers of Antiphlogistine, and see the many, many requests for window hangers, store advertising, etc., which they are constantly refusing. This company could get an almost unlimited amount of advertising, good advertising too, at no expense, except for the printing of the cards or booklets, if they did not have too great a pride in the honorable position which they occupy as purveyors to the medical profession. Perhaps they feel the ethical requirements of their position more keenly on account of the personnel of the company. Half the members of the board of directors are physicians who have spent each of them many years in active practice, the president of the company being an ex-president of the State Society, and the head of the advertising department is himself a physician, and was for many years the secretary of his County Society.

With such a personnel, it is not surprising that the advertising is not only strictly ethical, but even ultraconservative in spirit.

CONVICTED OF SUBSTITUTION.

As, in the realm of logic, one fact is worth a thousand theories, so, in connection with the practice of substitution by the druggist, one concrete instance will more clearly convince the physician of the reality and prevalence of this evil than will many arguments. In Montreal, Canada, one H. H. Lyons who conducted three retail drug stores and who calls himself the "King of Cut-rate Druggists," has evidently been

a persistent offender. Before a police magistrate of the city mentioned, he was recently convicted of the criminal offence of attempting to obtain money under false pretences, in that he deliberately dispensed a preparation of iron and manganese of his own manufacture instead of Pepto-Mangan, which was plainly specified on the physician's prescription. The evidence in the case was so definite and conclusive, that the presiding judge had no hesitation in finding the defendant criminally guilty. Much credit for this exemplary result must be accorded to Messrs. Leeming-Miles Co., Ltd., Canadian agents for M. J. Breitenbach Co., manufacturers of Pepto-Mangan, who obtained and caused to be presented the evidence necessary to bring about the conviction of this flagrant substitutor. It is to be hoped that the laws in the United States may be modified to conform substantially to those of Canada and thus permit the prosecution and conviction of such offenders under the criminal statutes.

DISEASES OF WOMEN AND THE GENERAL PRACTITIONER.

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

For over 25 years Hayden's Viburnum Compound has proven its efficacy in dysmenorrhœa, amenorrhœa, menorrhœgia, metrorrhœgia and irregularities incident to the menopause.

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

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

Argument: The therapeutic value of Hayden's Viburnum Compound has built up an enviable reputation for its efficiency, hence its many substitutes. Why let a druggist put up something inferior upon your prescription for the original H. V. C.?