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# The Maritime Medical News.

(HALIFAX, NOVA SCOTIA.)

A MONTHLY JOURNAL OF  
MEDICINE and SURGERY.

VOL. VIII.—No. 1.

JANUARY, 1896.

Subscription  
\$1 per annum.

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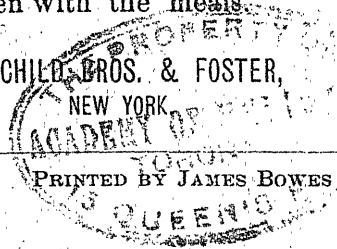
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# CONTENTS.

	PAGE.
<i>ORIGINAL COMMUNICATIONS</i>	
Appendicitis. By J. F. BLACK, M. D. ....	1
Report of two cases. By R. A. H. McKEEN, M. D. ....	9
<i>SELECTION.</i>	
Diet in Treatment of Skin Diseases. ....	14
<i>MEDICAL PROGRESS.</i>	
<b>MEDICINE:</b>	
<i>Tuberculin</i> .....	19
<b>SURGERY:</b>	
<i>Antitoxins in Surgery</i> .....	25
<i>SOCIETY PROCEEDINGS.</i>	
<b>NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION:</b>	
<i>Tubercular Tumor of Larynx:</i> E. A. Kirkpatrick.....	29
<i>Lupus:</i> D. A. Campbell.....	30
<i>Abdominal Operations:</i> E. Farrell.....	30
<i>Fracture of Olecranon:</i> N. E. Mackay.....	32
<b>ST. JOHN MEDICAL SOCIETY:</b>	
<i>Resolutions respecting Tuberculosis:</i> } Doherty.....	32
<i>Treatment of Colles' Fracture:</i> .. }	
<i>EDITORIALS.</i>	
<i>Appendicitis</i> .....	34
<i>Maritime Medical News</i> .....	38
<i>BOOK REVIEWS.</i>	
<i>Pregnancy, Labor and Puerperal State:</i> Grandin and Jarman....	38
<b>BOOKS AND PAMPHLETS RECEIVED</b> .....	39
<b>NOTES AND COMMENTS</b> .....	39

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About \$100,000 have been expended during the last two years in extending the University buildings and laboratories, and equipping the different departments for practical work.

The Faculty provides a Reading Room for Students in connection with the Library, which contains over 15,000 volumes.

**MATRICULATION.**—The entrance examination of the Medical Boards of the different Provinces in Canada, is accepted by the University as equivalent to the Matriculation examination, which is held by it in the months of June and September.

**COURSES.**—The regular course for the degree of M. D. C. M., is four sessions of about nine months each. Arrangements have been made with the Faculty of Arts of McGill University, by which it is possible for a student to proceed to the degree of B. A., and M. D., C. M., within six years, the Primary subjects in Medicine, i. e., Anatomy, Physiology and Chemistry, being accepted as equivalent for Honour Natural Sciences, of the Third and Fourth years of the Arts course.

**ADVANCED COURSES.**—The Laboratories of the University, and the various Clinical and Pathological Laboratories connected with both Hospitals, will after April 1896, be open for graduates desiring special or research work in connection with Pathology, Physiology, Medical Chemistry, etc. A Post-Graduate course for practitioners will be established in the month of April, 1896, and will last for a period of about six weeks.

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

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

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#### The Treatment of Influenza or La Grippe.

It is quite refreshing these days to read of a clearly defined treatment for the grip. But in an article in the *Lancet-Clinic*, December 28th, 1895, Dr. James Hervey Bell, 251 East 32d Street, New York City, says he is convinced that too much medication is both unnecessary and injurious. He has few remedies; prescribes them with confidence; and "trusts the rest to nature."

When called to a case of influenza, the patient is usually seen when the fever is present, as the chill, which occasionally enters in the disease, has generally passed away. Dr. Bell says he then orders that the bowels be opened freely by some saline draught, as honeyadi water or effervescing citrate of magnesia.

For the high fever, severe headache, pain, and general soreness, the following is ordered:

℞ Antikamnia Tablets (5 gr. each), No. xxx.

Sig. One tablet every two hours.

If the pain is extremely severe, the dose is doubled until relief is obtained. Often this single dose of ten grains of antikamnia is followed with almost complete relief from the suffering. Antikamnia is preferred to the hypodermic use of morphia because it leaves no bad after-effects; and also because it has such marked power to control pain and reduce fever. The author says that unless the attack is a very severe one, the above treatment is sufficient.

After the fever has subsided, the pain, muscular soreness and nervousness generally continue for some time. To relieve these and to meet the indication for a tonic, the following is prescribed:

℞ Antikamnia & Quinine Tablets, No. xxx.

Sig. One tablet three times a day.

This tablet contains two and one-half grains of each of the drugs, and answers every purpose until health is restored.

Occasionally the muscular soreness is the most prominent symptom. In such cases the following combination is preferred to antikamnia alone:

℞ Antikamnia & Salol Tablets, No. xxx.

Sig. One tablet every two hours.

This tablet contains two and one-half grains of each drug.

Then again it occurs that the most prominent symptom is an irritative cough. A useful prescription for this is one-fourth of a grain sulphate codeine and four and three-fourths grains antikamnia. Thus:

℞ Antikamnia & Codeine Tablets, No. xxx.

Sig. One tablet every four hours.

Dr. Bell also says that in antikamnia alone we have a remedy sufficient for the treatment of nearly every case, but occasionally one of its combinations meets special conditions. He always instructs patients to crush tablets before taking.

THE  
MARITIME MEDICAL NEWS,  
A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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No. 1.

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Original Communications.

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APPENDICITIS.

BY J. F. BLACK, M. D., HALIFAX, N. S.

Delivered at Annual Meeting of Maritime Medical Association.

*Mr. President and Gentlemen :*

I have been asked to say something by way of introduction, to a discussion on the subject of "*Appendicitis*." As you know, this is the term which is now applied to a condition of affairs existing in the right iliac region, to which various names have been given in the past and which has superseded typhlitis, perityphlitis, paratyphlitis—localized peritonitis, etc., etc. It seems probable, that although in some few instances the term may be a misnomer, the appendix vermiformis not being involved, yet in the great majority of cases some claiming in 90 p. c., the origin of the trouble is in that apparently insignificant organ, and therefore the use of the name is justifiable. Appendicitis may be said to be a little in the wane in fashionable surgery, at all events it is not as much heard of in the medical and lay newspapers as it was a short time since. It is not probable that the apparent epidemic was a real one, but rather that attention having been drawn to the disease, cases were recognized which were formerly regarded as simple attacks of peritonitis or of localized abscess. And on the other hand we do not hear so much about it *now*, because it has fallen into line as one of the recognized affections and no longer deserves notoriety as a novelty. As to the physiological function of the appendix



vermiformis in spite of all the theories and conjectures which have been advanced, I do not think we have got farther than to regard it as a survival of some organ which formerly either in man or some of his prehistoric ancestors had a useful purpose to serve. Why too it should so often be a focus of disease, does not seem apparent, the old idea of its acting as a convenient receptacle for cherry stones, shot, grape seed and other useless contents of the intestinal canal seems not to be borne out by experience, and not even in many cases do we find the faecal impactions which in the absence of more tangible solid matters were formerly supposed to act as a cause of irritation and subsequent inflammation. The etiology of the disease would seem to be a catarrhal inflammation of the mucous lining of the appendage, either due to foreign accumulations as above or extension of inflammation from the bowel, or as a localized idiopathic affection, or as has been suggested due to the presence of some special micro-organism not yet detected. However inaugurated, the inflammatory process results in thickening of the mucous membrane and in narrowing and often occlusion of the communication with the caecum, this leads in time to accumulations of mucous or of intestinal contents and succeeding ulceration, perforation and suppuration with the accompanying symptoms of localized inflammation or peritonitis, the perityphlitis of our fathers. I need hardly detail to you *the symptoms* of the condition as they form a group which in a well marked case can hardly be mistaken. In a less typical instance, however, and especially in the female subject, it is by no means always easy to be sure of your ground, and it is here that skill and especially an extended experience are necessary to make an accurate diagnosis. The *characteristic* symptoms of appendicitis are localized pain, tenderness, swelling, and rigidity of abdominal wall on right side, while trouble is confined to appendix itself the swelling is not distinct, and if appendix is situated posteriorly may not be detected at all. A great deal of stress has been laid upon the assistance of a localized point of tenderness; this is known as McBurney's point and is situated about midway on a line drawn from the anterior superior spine of the ilium to the umbilicus. It is to be searched for by pressing with the point of one finger, my own experience would show it to be usually a little lower down than the situation mentioned. Fluctuation is often difficult to detect on account of the rigidity of the abdominal muscles. In addition to these local conditions, vomiting and constipation are usually well marked symptoms. The presence of these may often

lead us to suspect intestinal obstruction, the differential diagnosis would be made by the condition of the temperature and pulse, these being unaffected in obstruction at least at first, whereas in appendicitis they are changed from the beginning. Instead of constipation it is well to bear in mind that we may have relaxation of the bowels in appendicitis. In females, especially adults, inflammatory conditions of the right ovary or tube may easily be confounded with appendicitis, here an important aid to diagnosis comes from examination per vaginam, and both in female and male patients examination by the rectum should not be neglected.

The history of the case is often helpful, as very often we may get an account of one or more previous attacks of similar character, which would of course favour the idea of the existence of appendiceal trouble. In many cases, however, the most careful investigation will leave the diagnosis in doubt, and often it will remain for an exploratory incision to clear it up definitely.

*Prognosis.*—This varies very much according to the nature of the attack. If the inflammation is of a plastic type and the peritoneal cavity is not involved the case will probably end favourably. If, on the other hand, perforation takes place, and there being no limiting fibrinous deposit, the escape of the contents into the cavity of the peritoneum is very apt to have fatal results. In the recurrent form every attack is more serious because of the greater risk of perforation.

*Treatment.*—Coming to question of treatment we meet at once the two conflicting parties—those who contend for surgical interference in all cases, and those who claim that medical measures alone are sufficient. Here, as in so many other instances, I think that the truth lies in the middle line, for although I believe it is understood that I am to consider more particularly the surgical aspects leaving the medical for someone who may follow me. I am by no means one of those who think that every case of appendicitis should be operated upon, as a matter of routine practice. I have seen too many cases recover without surgical interference not to be disposed to hesitate. Of course certain cases clearly demand operation and that without delay; but there are many where it is a very nice question whether to operate at all, and if so, just when.

Again, I would like to insist that the same case admits of different treatment under different circumstances, or to put it in another way that given two exactly similar cases operation might be justifiable in one and not in the other, on account of conditions outside the case

itself and incident to the medical attendant. I think it can hardly be denied that while it might be criminal for a surgeon without experience and without proper surroundings to undertake operation in the one case, it might be almost equally a dereliction of duty for a surgeon accustomed to the operation with proper surroundings and operative facilities to refuse to do it in the other. This to my mind is a principle of very wide application in regard to important surgical operations and one which is too much forgotten by surgeons ambitious to follow the lead of men whose surroundings place them entirely in a different position from others. The surgical treatment of appendicitis may be spoken of under two heads, viz., the treatment of a case during its acute stage; and secondly, the treatment of a recurrent case during an intermission. It is in connection with the first that chiefly comes up the dispute in regard to the merits of medical and surgical treatment.

As I have said there are certainly many cases which yield to non-operative procedures and which should be so treated; but when the disease is of a suppurative or perforating tendency these means will usually fail and surgery will have to come to their aid. It is the determination of the time when it is proper to resort to operation which to me seems to be the difficult problem, and as to which there seems no very general agreement. When we can feel assured by fluctuation being present that suppuration has occurred, the indication is to operate at once, and if possible, prevent involvement of the general peritoneal cavity; here it is not always wise to insist on removal of the appendix if that be difficult; but rather to be content with evacuation of the pus and good drainage.

But very often we cannot detect suppuration when present, and it is here the difficulty occurs. Waiting will often be fatal to the patient, and so we must be guided by other symptoms, viz., those of formation of pus elsewhere in the body as chill, increase in the swelling, a hectic temperature and persistent local tenderness, with these there may or may not be redness of surface. Having these symptoms and the disease not improving under medical measures, operation is indicated. The most serious cases, however, are those of the perforating nature. These form a class of themselves, and it is in them especially that delay is dangerous, for escape of the contents means general peritonitis and probably a fatal result.

It is therefore most important to recognize cases of this character early, and this may best be done, according to a late writer, by

remembering that "an acute perforative appendicitis usually begins with severe diffuse abdominal pain, extreme pain and tenderness in right iliac fossa, vomiting usually persistent, temperature moving up rapidly 4 or 5 degrees. Pulse 110 to 120. Face showing the patient very ill. In addition may be able to feel the swollen appendix. In case of this, or many more, and if after careful watching for a short time, under medical treatment no improvement occurs, operation should not be delayed. All of symptoms may not be present, but if others are and in marked degree surgeon should not hesitate. Great point is not to regard any one indication as essential, for any one of them may be absent."

This writer makes what seems a very good classification of appendicitis under four heads as follows :

1. Mild cases without abscess or perforation, these being the most numerous, and the ones which recover without surgical interference.
2. Appendicitis with abscess formation.
3. Acute perforating appendicitis.
4. Relapsing appendicitis.

Of this fourth class we may now say a few words. We all know that patients who have once had an attack of appendicitis are liable to recurrences, and it is to prevent a fatal result in some one of these almost inevitable returns that the majority of "appendicitis operations" so-called, are performed. The wisdom of the operation in such cases can hardly be questioned, the point for decision is how many attacks shall a patient be allowed to have before his appendix shall be removed. Upon this point a great deal of difference of opinion prevails, some would operate after one attack, others only after two or three attacks show that recurrence is probable. I think, as a rule, if a patient has had two attacks of well marked character no longer delay is justifiable, and if a greater number have occurred of course the case is stronger still. We must remember that the mild nature of the early attacks is no guarantee that future ones will not be more severe and dangerous to life, besides later attacks are apt to be more tedious, and if not really dangerous to life, often results in chronic ill health.

It must be admitted that, as in the case of certain other operations, for removal of organs, probably a good many appendices have been removed which might never have caused further trouble, but again they might, and again in the hands of a good surgeon accustomed to the operation the risks are now very slight.

The time usually chosen for operation in one of these cases is a little while after the subsidence of an acute attack, though some prefer to wait until evidence exists of an oncoming one. Whether the appendix vermiformis of the average Canadian is better behaved than that of other people, or whether surgeons with us are more conservative than elsewhere I do not know, but speaking for the city of Halifax I believe I am right in stating that only two operations for recurrent appendicitis during intermission have been done here. I feel that this argues us as being lamentably out of the fashion and behind the times, but the fact remains. One of these was a case upon whom I operated at the Victoria General Hospital in October last. The case was sent to me for operation by Dr. Turnbull of Musquodoboit, with a very full, complete history, of an acute attack of appendicitis from which he had lately recovered. This was his fourth attack during the past four years, and the doctor very properly urged his having the appendix removed as soon as he was in fit condition. I will read a short history of the case prepared by the house surgeon, Dr. Cogswell.

*Appendicitis: Operation: Recovery.* R. W., male, aged 23. Single. Admitted to hospital October 2nd, 1894. General health good except a few slight attacks of rheumatism. Mother died of an abdominal tumor, otherwise family history good.

During the past four years has had an attack of what his doctor called appendicitis. The first two attacks were very slight, but the last two have been much more severe. Last attack began on 17th July, 1894, with severe pain in right iliac region, vomiting and fever. Tenderness over McBurney's point. No tumor was detected until sixth day of sickness when a distinct mass could be felt in right iliac fossa. This could also be detected per rectum. He was confined to the bed for about a month.

When he was admitted to the hospital he was comparatively well. No tumor could be felt, but there was slight tenderness in right iliac region. Troubled with constipation.

Patient was anxious for an operation. October 13th Patient was etherized. Parts were sterilized and an incision about four inches in length was made over region of appendix. Appendix was found without trouble and ligatured with catgut, then cut off. Mucous surface of string touched with pure carbolic acid, and then the serous coat was drawn over it and stitched together with catgut. Normal saline solution was used during the operation. Peritoneum stitched

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Contains the elements which are in the "Staff of Life," but it is much more than a bread. When bread is taken into the stomach the starch in it (wheat flour contains about 70 per cent. of starch) must be changed into sugar before it can be used up in the body, whereas our Malt Extract, owing to the process it has gone through, is at once taken up by the system without taxing the digestive organs in the least, and the active principle in it, which is called by chemists "Diastase" acts at once on other food, changing it into the form whereby it can be readily absorbed, and go towards enriching the blood and repairing the waste which is continually going on.

As the Winter Tonic "par excellence" we do not hesitate to designate Wyeth's Liquid Malt Extract; it is particularly beneficial in Winter in that it promotes circulation, assists digestion, and is in itself a grateful food to patients who can hardly tolerate other diet, thus it increases vitality and aids the formation of fat to help withstand the severity of the season.

As a food for consumptives, many physicians find it to be about the only thing that some idiosyncratic patients can touch at all.

As to its advantages, during lactation this claim has been so fully substantiated by thousands of practitioners throughout America that the article has now become almost an essential requisite for mothers nursing, because of the large percentage of nutritious matter with the very small percentage of alcohol it contains; in the usual dose of a wine-glassful three or four times daily it excites a copious flow of milk, improves it in quality and supplies strength to meet the great strain upon the system at that period, nourishing the infant and sustaining the mother at the same time

Yours respectfully,

**JOHN WYETH & BRO.,**  
per DAVIS & LAWRENCE CO., Ltd., Gen'l. Agents.

**We have no hesitation in stating, that as a Tonic, Stimulant and Roborant, WYETH'S BEEF, IRON AND WINE has proven more uniformly beneficial than any combination we have ever known. It is substantially a universal tonic.**

In the majority of cases, along with failure of strength, and indeed as one cause of that failure, there is an inability to digest nourishing food. Hence it is very desirable to furnish nourishment in a form acceptable to the stomach, at the same time to excite this organ to do its duty. On the other hand, again, wine stimulus, although needed, is ill borne if given by itself, producing headache, excitement and other symptoms which may be avoided by the addition of nutritious substance, such as the *Essence of Beef*. Iron, also, can be taken in this way by the most delicate or sensitive woman or child, to whom it may be inadmissible as usually given.

### **Conditions in which Physicians recommend**

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**To give strength after illness.**—For many cases in which there is pallor, weakness, palpitation of the heart, with much nervous disturbance, as, for example, where there has been much loss of blood, or during the recovery from wasting fevers, this article will be found especially adapted. Its peculiar feature is that it combines Nutrient with Stimulus.

**To those who suffer from weakness** it is a Nutritive Tonic, indicated in the treatment of Impaired Appetite, Impoverishment of the Blood and in all the various forms of General Debility. Prompt results will follow its use in cases of Sudden Exhaustion, arising either from acute or chronic diseases.

**To Growing Children**—Especially, those who are sickly, get great benefit from this preparation. It builds up by giving just the nourishment needed, and in a very palatable form.

**To people who are getting old**, who find their strength is not what it used to be, they experience a decidedly tonic effect from its use as occasion requires.

**To clergymen, teachers** and members of other professions, who suffer from weakness, WYETH'S BEEF, IRON AND WINE is very effectual in restoring strength and tone to the system after the exhaustion produced by over mental exercise.

**For Overwork**—Many men and women know that the continuous fatigued feeling they labor under is due to overwork, still they find it impossible just yet to take complete rest. WYETH'S BEEF, IRON AND WINE gives renewed vigor, is stimulating, and at the same time is particularly nourishing.

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with silk, wound closed with continuous silk suture. Patient had considerable pain after operation. Temperature did not rise above  $100^{\circ}$  until eight days after operation when it went as high as  $101^{\circ}$ . On the next two days it reached as high as  $103\frac{1}{2}^{\circ}$ . It then dropped and remained normal. Wound was not touched until seventh day when it was found nicely healed. Stitches were removed on 11th day after operation. Patient made a good recovery. Was discharged November 14th, 1894.

You will notice that the case is a typical one of appendiceal disease. It followed the usual course of recurring appendicitis, the attacks increasing in severity. There was nothing about the operation or the subsequent history calling for remark. The rise of temperature on the 8th, 9th, and 10th days was somewhat disturbing and not easily accounted for. On looking at the specimen you will notice that beyond some thickening there is no special evidence of disease. This I have noticed in many of the appendices I have seen removed, even in cases where as in this one repeated and unmistakable attacks of the disease had occurred.

In such instances one is apt to feel that the organ was not sufficiently diseased to require removal, but extended experience has shown that an appendix once diseased is always a source of danger, and although the evidence of disease may not be very visible, still inflammatory action is very easily lighted up again and the new attack occurs.

As to the operation itself I need say little, as it is now so fully described in text books and so commonly witnessed by any one visiting the large hospitals abroad. It may, however, be of interest to speak of the plan introduced of late by Dr. McBurney, perhaps the best authority on this disease in America, and which I saw him put in practice several times a few weeks since at the Roosevelt Hospital, New York.

The novelty consists in the method he adopted of preventing the possibility of the occurrence of hernia at the abdominal cicatrix, instead of making an incision directly through all the abdominal tissues. In same line he makes first an incision in the usual situation through the skin, then with scissors he incises the fascia. Next, instead of *cutting* through the muscular structures he makes an opening by separating between the fibres of the external oblique muscle having these held apart by retractors he finds the internal oblique and separates the fibres of this running as you know in a different



direction. Below this the fasciæ and the peritoneum are divided in the ordinary way, and the appendix sought for and dealt with. In closing the abdominal wound a separate layer of fine catgut sutures is put in the peritoneum, in each of the muscular layers and in the fascia, the skin being then sewn with silk. Thus the wound is very efficiently closed, and although the operation is more tedious and by no means easy for a beginner, it seems worth the trouble. Of course there are very many interesting questions from a surgical point of view on which I might enlarge, but I will not take up your time with these.

In conclusion I would say that while doubtless there are many cases of appendicitis which recover without surgical interference, still it is always difficult to say at first whether you have to deal with a case of this kind or one of a more serious character. And it seems to me that when a medical man, who does not feel himself competent to deal with the case surgically, meets with a case which does not readily yield to medical treatment, it is his duty to call in a surgeon so that they may together watch the case, and so that when the time comes for operation no unnecessary delay may take place whereby life is often sacrificed owing to the disease, have passed the stage for useful interference.

## REPORT OF TWO CASES.

### 1.—ACUTE INVERSION OF UTERUS.

IMMEDIATE REPOSITION; RECOVERY.

### 2.—STRANGULATED HERNIA, GANGRENE, RUPTURE, SUTURE, RECOVERY.

BY R. A. H. MCKEEN, M. D., GLACE BAY, C. B.

Read before the Maritime Medical Association at Halifax.

*Mr. President and Gentlemen :*

The two cases which I have the pleasure of reporting to this Society are of sufficient rarity in the ordinary run of country practice at least to perhaps prove of interest

CASE I.—On the morning of April, 1895, I was called to see Mrs. L., aged 26 years, mother of four children. On entering the room I was hastily informed that she had been delivered half an hour previously of a healthy child at term, and that the placenta had not come away. The blanched appearance of the patient and the almost equally colourless faces of the attendants seemed to warrant a hasty diagnosis of considerable hemorrhage as well as retention of placenta. Quickly washing and disinfecting my hands, I made an examination and found the first surmise correct. The bed was filled with loose blood and clots, and the patient lay in a state of profound weakness. Placing one hand over the fundus uteri a well marked cup shaped depression could be felt. Per vaginam the placenta was found to be partially extruded from the uterus and apparently the part within that organ was not attached. The problem of how to complete the expulsion of the placenta, and yet overcome a somewhat advanced condition of inversion was to be settled. Cautiously passing two fingers within the servix, I attempted to get above the placenta and withdraw it, settling by digital examination the question of its condition as regards attachment. When the fingers had been insinuated within the cervix I was confronted by a new difficulty, in that further progress was impeded by contraction round the placenta. Pains there had been none during manipulation so far, and, as the patient afterwards stated before my arrival, but as my left hand made counter pressure over the fundus through abdominal walls a sharp contraction came on, accompanied by most violent voluntary efforts by the patient, shooting placenta and

inverted uterus into the bed. By visual inspection it was clear that the placenta was not entirely separated, and I had the unique privilege of inspecting the process while I completed the separation. Assistance there was none. The midwife who had attended the case before I was called did not seem to appreciate the opportunity afforded for examining the inside of the parturient uterus. Seizing the inverted fundus in my right hand I pushed it back as rapidly as possible; when the ring was reached there was a momentary contraction, which fortunately relaxed and the displacement was corrected. By holding one hand within the uterus and rubbing the fundus vigorously through the abdominal wall good contraction was secured, and the hemorrhage ceased. Ergot was given hypodermically. There was considerable shock, which was overcome by whisky and strychnine hypodermically, with heat to the surface of the body.

The highest temperature subsequently was  $101^{\circ}$ , and a very good recovery was made. Within two hours after the reposition of the uterus the lochia became colourless, and continued so nearly a week, after which, for a few days, it was red.

The cause of the inversion can fairly be placed to traction on the cord, which the patient says was made before there were any contractions of the uterus.

Some years ago I saw a similar case with Dr. W. McKay, due to the same cause. The woman was left all day after the accident occurred, and when Dr. McKay was called the patient was exsanguinated and in collapse, and died within a few minutes after reposition was attempted.

Dr. C. P. Bissett, of St. Peters, informs me that he has met two cases; one fatal before his arrival at the house, the other terminating in recovery; both caused by traction on the cord.

Many midwives I know are in the habit, after delivery of a woman, of leaving the uterus unsupported until the child is attended to, then laying hold of the cord and pulling without making any pressure over the fundus. The results are met with in various complications from retained membranes and sepsis to inversion and prolapse of the uterus.

CASE II.—May 4th, was called to see Mrs. R., aged 43 years, mother of eight children, youngest two years. She complained of cramp like pains in abdomen accompanied by nausea and vomiting. The abdomen was not swollen and there was no rise of temperature. Gave an enema of hot soap-suds, which brought away a small amount of fecal matter.

The patient had been troubled with habitual constipation for some time. A hypodermic injection of morphine and atropine was also given. A comfortable night followed.

May 5th.—She expressed herself as much better and wished to sit up.

May 6th.—Was again called and found that after taking a dose of castor oil vomiting had returned, accompanied by great nausea but pain was not severe. A repetition of the morphia accompanied by small doses of Bismuth and Calomel again resulted in improvement.

May 7th.—The symptoms returned and I searched for possible obstruction, although by the use of enema I could secure a fair result. No *hernia* was discernible, nor could any evidence of obstruction in the bowel be localized. This made me feel that the case was probably one of a series of cases of gastro-intestinal disturbance, then prevailing in that locality. The next day menstruation came on, and the gastric symptoms reappeared in an aggravated form: a complication which she stated was of frequent occurrence at the monthly periods. The changes were rung on the usual remedies recommended. Sometimes with encouraging results but quickly followed by relapse. There was some pain, though not severe, but nausea was most distressing. At no time was the matter vomited stercoraceous until Thursday, when patient informed me that she had vomited very disgusting matter in the forenoon. This had been thrown out: what was then in a dish by the bedside being simply water that had been drunk during the day, mixed with bile.

Friday morning there was some improvement, but in the evening she had grown worse, and there was now clearly stercoraceous vomiting. I again went carefully over the abdomen, and more as a matter of form searched for hernia, of which I had previously found no evidence. However, in the right groin I discovered a tumour considerably larger than a hen's egg and quite hard and tense. I then found that the condition was one of incarcerated femoral hernia, and a slight attempt was made to reduce it by taxis. This proving impossible it was decided to call assistance, place the patient under an anæsthetic, and, if necessary, operate. Drs. McKay, Fraser, McLennan, and Morrison kindly came in consultation and rendered every assistance. At 1 a. m. the patient was placed on a table; ether was given, and as rigid measures adopted to insure asepsis as could be carried out in a private house. Her temperature was  $100^{\circ}\frac{1}{2}$ ; pulse 134. A tentative effort at taxis was again made and abandoned. I then cut down on

the sac. Opening this there was a small amount of fluid found, and the appearance of the strangulated gut, a portion of small intestine, was reassuring. The orthodox method of enlarging the constriction was followed, and it was somewhat difficult to get even the hernia knife into the ring, so tightly was the gut constricted. On freeing the bowel and gently pulling it out to examine the part pressed on in the ring, its contents began to flow into the wound. This was found to come from a rent about one-half inch long in the outer side of the bowel, surrounding which was a zone of gangrenous gut. The remainder of the bowel was apparently fairly healthy. One of three courses was now imperative; 1st, either resect a portion of bowel, using a Murphy button to approximate the divided ends; or, 2nd, stitch the bowel to the wound in groin; or, 3rd, suture the perforation. The latter course was chosen, using silk ligatures with continuous Lembert sutures. To make this secure it was necessary to go well away from the affected portion and turn the latter in. This completed the hernia was returned. It did not seem prudent to attempt special treatment of the ring, as in the event of a failure to repair the perforation the leakage into the abdominal cavity would certainly prove disastrous. A large drainage tube was therefore inserted, the wound closed to its lower angle with silk worm gut, and a dressing of gauze and absorbent cotton, with sheet wadding, (the two latter having been previously baked to insure asepsis) applied and held by a spica bandage. The patient came out of the anesthesia well and there was no subsequent vomiting. Morphia was given to insure quiet. The highest temperature was recorded next day  $101^{\circ}\frac{2}{3}$ , which quickly fell and thereafter ranged from  $99^{\circ}$  to  $100^{\circ}\frac{2}{3}$ . The pulse dropped to 104 within two hours after operation. On changing the dressings in three days there was no pus but a slight discharge on the gauze quite dark in colour. The drainage was not removed until the 5th day, when the discharge was found to be from the sloughing sac. This was easily removed by dressing forceps, and the stitches taken out of the lower part of the wound. Iodoform gauze now replaced the drainage, and on the 7th day the bowels were moved by an enema.

Subsequently the progress was rapid, and only as a safeguard could the patient be induced to remain in bed, which she finally left in three weeks after operation. Since then her bowels have acted in a satisfactory manner. There is no sign of a return of the hernia, and a pad is worn, which will be changed for a truss as soon as the cicatrix permits of pressure.

Now as to the lessons to be learned. First, is the need for repeated search for hernia in every case of persistent vomiting. My belief is that in this case there had been a reducible hernia existing for two years, as patient afterwards said she often had found a lump in the groin which would disappear. The first vomiting was probably not due to the hernia, rather the latter was forced down, subsequent to my examination, by the vomiting, and then became strangulated. Secondly, careful attention to details will secure asepsis even under the most adverse surroundings. The only pus in this case was round a stitch at lower part of wound and could have been obviated probably, had time permitted a more thorough scrubbing.

## SELECTION.

### DIET IN TREATMENT OF SKIN DISEASES.

Walter G. Smith, M. D., (*British Med. Journal*, Nov. 30th, 1895,) says: I propose to dwell rather upon the limitations of our knowledge and the imperfection of our data, in the hope that clearer views may emerge from our discussion. Let me, in the first instance, ask, Have we any certain or exact scientific knowledge of the influence of diet in the causation of diseases of the skin? The belief in the potency of this influence is universal with the laity, and widely acknowledged by the profession generally. But the practice of physicians is partly traditional and is, unfortunately, not always based upon real conviction or sound knowledge, and many circumstances conspire to tempt them to give formal advice which rests upon a slender foundation. The present opportunity seems a suitable time to re-examine the ground-work of our belief, and it may fairly be expected that the discussion to follow will result in a better definition of our position as medical advisers upon dietetics towards our clients—the public.

I start with the two propositions that the real influence of diet in the causation of skin diseases is a small one, much less than it is credited with, and that our substantial knowledge of the subject is very limited. Fundamentally the action of food and of drugs is to be explained upon similar general principles. But great as are the difficulties of forming a correct judgment of the mode of action of a drug, still greater are the complexities which surround questions of dietetics in the causation of cutaneous affections. We are always and in all places confronted with the problem of the idiosyncrasy of the individual, which is a real and perplexing difficulty, and should make us more cautious in formulating cut and dry rules for the guidance of our patients' stomachs.

In very many cases an intelligent and temperate patient knows, or ought to know, better than his doctor what suits him and what aggravates his complaint; and I heartily endorse Sir W. Robert's simple and sensible rule of conduct, namely: "It may be regarded as certain that any food or foods accessory, the use of which is followed by a sense of discomfort, is not beneficial to that individual." And

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 Its **Curative Power** is largely attributable to its stimulative, tonic and nutritive properties, by means of which the energy of the system is recruited  
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Current literature during the past year or two has furnished a number of communications relating to the therapeutic properties of Saw Palmetto, and we desire to call the attention of the profession to the fact that we are prepared to supply the remedy in the form of

## FLUID EXTRACT.

Dose.—One half to two fluid drachms.

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## COMPRESSED TABLET TRITURATES,

REPRESENTING ONE-HALF AND ONE MINIM RESPECTIVELY.

Dose.—One tablet every two or three hours.

**MEDICINAL PROPERTIES.**—Saw Palmetto was originally employed for the relief of Prostatic Enlargement, as it occurs in elderly persons, but more recently it has been found to possess marked aphrodisiac properties when administered in small doses at short intervals. Not infrequently it will be found to produce most salutary effects when enlargement of the prostate is associated with sexual incapacity, the exhibition of the remedy being followed, it is said, by renewed vigor of the reproductive organs. In this class of cases, however, it is needless to add, that caution should be exercised, to avoid the depression which is certain to follow over-stimulation.

Samples of these triturations will be furnished to physicians on request, with a view to obtain further reports calculated to determine more definitely the position it is entitled to occupy in therapeutics.

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conversely, as Pye Smith puts it: "What most people eat is for most people wholesome, and what a natural appetite finds appetising seldom disagrees."

The tendency of modern enquiries has been largely towards the more exact determination of etiological factors. Hence we have been gradually led to minimise, laying stress upon vague and indefinite conceptions, such as diathesis and the like, and of these vague causes diet is, I think, one so far as the skin is concerned. Moreover, the rise and progress of bacteriology has profoundly modified our notions of the cause of many diseases of the skin and influenced our treatment. I need only allude to the pathology of boils, carbuncles, and acute suppuration generally.

Although it is by no means proven that eczema, and even less psoriasis, are parasitic diseases, still the mere ventilation of such a possible cause for these affections tends to throw into the background loose speculations and traditional surmising as to the effect of dietetic causes in originating diseases of the skin.

We may picture to ourselves four modes or ways at least in which diet may possibly influence the skin.

1. Through the general nutrition of the body. Nutrition is influenced in a very subtle manner by the quality of the food (Roberts), and insufficient or improper food lowers the tone of all the tissues, skin included. Under such conditions we meet with scorbutic purpuric affections. Destructive and pyogenic microbes find a more suitable soil whereon to fasten, and hence a greater liability to pustular and gangrenous developments. The fungus of "thrush" lies in wait for debilitated constitutions, and favus is more common among the neglected and ill-fed poor.

2. By acting as a reflex stimulus from the gastro-intestinal tract. This is doubtless the most common mode. The physiological relationship between the skin and the digestive mucous membrane is incontestable, and proofs are abundant. Over-eating, on the one hand, and on the other the use of unsuitable, indigestible, or irritating articles of diet are frequently followed by either neurotic or vasomotor disturbance in the skin—for example, urticaria. The skin affections producible in this way are all transitory, and disappear spontaneously, as a rule, when the causes cease to act. Many people eat far too much, and overload their digestive capacity. And some of them would pay a worse penalty than they do were it not for the dinner pill, the morning saline, or the occasional visit to Carlsbad. Three

practical considerations flow from these thoughts, namely: (a) The utility of purgatives in such cases; (b) the importance of good cooking in avoiding or overcoming dietetic irritation; (c) the due regulation of the diet as to quality and kind.

3. By absorption into the blood of irritating substances or of products of chemical change, which indirectly affect the skin. In this direction we may look for explanation, in part at least, of the occasional injurious effects of tinned and preserved foods. Pathogenic bacteria may undoubtedly enter the body with articles of diet. We are all familiar by daily observation with the hyperemia of the skin which ensues upon full doses of alcohol.

4. The skin may suffer in virtue of being one of the channels or avenues of elimination. Certain drug eruptions arising from volatile oils or oleo-resins—for example, copaiba, cubeb, and turpentine—are perhaps explicable upon this hypothesis. And upon similar grounds we caution our patients against the use of highly seasoned foods and spices (that is, volatile oils) in erythematous and acute inflammatory affections of the skin.

To turn now to another aspect of the question, namely, diseases of the skin in relation to diet. We can at once make three groups: (1) Cutaneous diseases liable to originate in, or acknowledged by common consent to be materially influenced by, diet. (2) Cutaneous diseases possibly, but not proven to be, influenced by diet. (3) Cutaneous diseases certainly not affected by diet, for example, herpes, pemphigus, lichen ruber, ichthyosis, ringworm, etc.

In Class 1 we may instance: (a) Erythema—certain forms of; (b) urticaria; (c) pruritus; (d) acne rosacea; (e) acne vulgaris—perhaps. Bulkley states that in some persons crops of acne follow the free use of buckwheat; and Pye-Smith affirms that in some patients a fresh outbreak of follicular inflammation can be produced at will by eating “crystallised” fruits, strawberry jam, or orange marmalade.

In Class 2 may be placed psoriasis, most cases of eczema, and of acne vulgaris. Eczema in children is very frequently attributed to dietetic influences, such as too free use of sugar or even of milk. But, for my part, I quite concur with Dr. Cheadle in never having been able to satisfy myself that eczema is a diet disease. Many infants attacked with severe eczema are of a ruddy colour, have a good appetite, and with all the appearance of excellent health.

It is the present habit to ascribe many skin diseases to gout, and we hear every day of “gouty eczema,” “gouty psoriasis,” and the like,

and various queer nondescript ailments are shunted off the main line to a gout siding. Patients ask for and expect to get from us minute directions about their culinary arrangements, yet few English practitioners conversant with diseases of the skin would go so far as Brocq in saying that the regulation of the diet is the most efficacious internal treatment for eczematous patients. The hypothesis of leprosy having been transmitted by food of any kind, in particular by fish, has not been established by further examination. Boils are often ascribed to errors or deficiencies in diet. With our present knowledge of the pathogeny of boils, it is to my mind incredible how a crop of boils, as is stated on good authority, can arise through mere change of diet, for example, a surplus of animal food. In England the consumption of meat is 136 lbs. per head per annum, in France it is only 46 lbs. per head per annum. Are boils so much more common in England? Eczema affects the sexes almost equally, although men probably eat two-thirds of the total meat and drink probably three-fourths of the total alcohol consumed in the United Kingdom.

If we direct our thoughts to determine what special articles in our dietary may be held responsible for harming the skin we have not a long list, as will be gathered from the preceding remarks. Coffee, tea, perhaps; highly spiced foods, excessive use of hard salted meat, shell-fish, abuse of alcohol, and foods, such as starch and other carbohydrates, which may lead to production of excess of acids (acetic, lactic, butyric) in the intestines. A widespread and deeply-rooted custom is the strict prohibition of salted food in diseases of the skin. For many years I have ignored this dictum, and neither my patients nor myself have had reason to regret the liberty accorded to them. Chloride of sodium is a very harmless salt, and some people with weakly digestion or a jaded appetite will relish and easily digest a thin slice of ham when the stomach would revolt against other meat.

Does alcohol in moderation cause any skin affections? That it is apt to aggravate itching and increase an already existing congestion of the skin is quite true. Most of the Asiatic populations, with the exception of the Japanese and the Indian Parsees, drink no alcohol. Yet I do not know that this experiment, on the large scale, indicates any advantage to those races *quoad* the skin.

I cannot but believe that the ill-effects of alcohol, and I may add of tobacco, are exaggerated by their extreme opponents, at any rate, as regards the skin. Plenck, quoted by Bulkley, remarks of acne: "Plures curavi suadendo ut vinum bibere incipient."

Lastly, a word as to the practical outcome of all this. How are we to intelligently answer the questions so often addressed to every one of us by our clients? "What shall I eat? What shall I drink?" In cases such as diabetes, gastric ulcer, and enteric fever there is a tolerable degree of unanimity in our answers. But what about the slighter ailments and indispositions which constitute the bulk of our practice?

A large number of our patients with affections of the skin are not obviously out of health, and are well able for their day's work in the world. Yet these persons are apt to ponder over their health, put us through a catechism as to their diet, almost constrain us to go beyond our knowledge, and even glory in the dietetic chains which are fastened around them by their medical advisers. Unluckily it sometimes happens that one practitioner's rules flatly contradict those of his neighbour, and so a shrewd patient is liable to arrive at the unpleasant conclusion that, as Sir W. Roberts puts it, our notions on dietetics are little better than a farrago of whims and fancies.

We are too formal in our rates, and impose unnecessary and unmeaning restrictions. We prescribe diet by printed forms, making no allowance for idiosyncrasies, and giving even our educated patients little or no latitude or opportunity for exercising their own sense of what is good and what is bad for them. In my judgment the main precept we need enjoin as a golden rule upon our patients suffering from diseases of the skin is moderation and temperance in all matters of eating and drinking, especially as regards alcohol. And we should seek to train the public to observe for themselves whether such and such an item of diet really agrees with them or not.

With all this borne in mind there is plenty of room for judicious advice tempered with common sense, and a hint or a suggestion is often better, although less showy, than the imposition of conventional rules. This latter course is, no doubt, sometimes requisite with the hypochondriac, the sensualist, or the careless, who will not listen to, or are incapable of understanding, the still small voice of healthy instincts and of personal experience.

To sum up in a few words :

1. Very few skin diseases are directly traceable to dietetic causes, but improper diet may aggravate existing eruptions. Idiosyncrasy must be largely allowed for.
2. The diseases that may so arise are of a transitory character, and mostly belong to the class of erythemata.
3. Diet has very little influence in promoting the cure of cutaneous eruptions. The results are far behind popular expectations, even in such cases as acne rosacea, where we are led to hope for much.
4. Avoidance of alcohol, regulation of the bowels, and the cure of anaemia are of infinitely greater importance than special dieting in the diseases of the skin.

# MEDICAL PROGRESS.

NOTES, ABSTRACTS, SELECTIONS.

## Medicine.

REPORTERS—JAS. MCLEOD, M. D., Charlottetown,  
W. H. HATTIE, M. D., Halifax.

### Respecting Tuberculin.

The introduction of Koch's "lymph" for the treatment of tubercular affections is a matter of such recent history as to do away with the necessity of any review. All know how much was expected of the new agent. All know how far these expectations fell short of realization. All know how the tuberculin came into almost immediate disrepute. But although the world at large lost faith in the new method, those who had been devoting themselves particularly to the study of the disease—processes dependant upon bacteria were not so easily discouraged, and it seems as though the apparent failure of Koch's treatment served but to stimulate many to further and more extended work. To-day we have the principle of serotherapy (which owes its inspiration to the work of Koch and Pasteur) applied to many maladies and with considerable success. And it would even appear that the condemnation of tuberculin was somewhat premature,—that it was not accorded the careful, dispassionate trial which it really deserved. In Berlin, where the treatment has been quietly persisted in, the results are said to be very encouraging.

In this connection it is interesting to note the recently published reports of two necropsies—one from either hemisphere. In the *Montreal Medical Journal* for Sept., 1895, Dr. Adami has a short but highly suggestive report upon the condition of the lungs of a man who had been one of Koch's earliest tuberculin patients. Until 1890 the man, a native of Finland, had enjoyed good health, but at that time he developed the usual signs of pulmonary tuberculosis. He was admitted to the Victoria Hospital in Berlin, under Koch, and remained for a year, receiving periodic inoculations with tuberculin. The treatment was followed by relief of his symptoms, and he

returned to Finland apparently restored. Later he came to Canada and was employed in the engineering laboratory of McGill University, Montreal. In January of this year (1895) there was a recurrence of the pulmonary symptoms; during March he had several severe attacks of hemoptysis which were very exhausting, and his death occurred about the end of April.

At the autopsy, in addition to the recent tubercular changes, there was found ample evidence of the previous existence of extensive tubercular disease. "Both apices showed old tuberculosis in the shape of well-encapsulated caseous masses and small contracted cavities with dense envelopes and smooth but uneven internal aspect. In addition, the upper two-thirds of the uppermost lobe of the right lung and the upper half of the upper lobe of the left lung were greatly consolidated, contracted and presenting very marked interstitial fibroid change." Thus it appears that a very extensive area of lung tissue was involved in the original attack of tubercular disease, and that throughout this area the process was arrested at a time corresponding with the period of treatment of tuberculin. From the appearances which the lungs presented at the autopsy, Dr. Adami concludes that the fatal attack was not due to a fresh infection from without, but to a sudden flaring up of the disease process in the walls of an old, incompletely contracted cavity, where all along the bacilli had been able to perpetuate themselves, and had at last gathered sufficient numerical strength to bring about re-infection. The result of the treatment, therefore, fell short of complete cure, having only effected an arrest and limitation of the disease.

Dr. Adami's paper is concluded as follows:—"Perhaps the most interesting feature of the specimen was the evidence it gave of the extent of pulmonary tuberculosis capable of being arrested by Koch's treatment. Both apices had been clearly the seat of extensive tuberculous change. There was extensive tubercular pleurisy, much caseation, and the development of numerous (five or six) cavities in the two apices. The treatment that the patient had undergone during his year's stay in the Berlin hospital had succeeded in bringing the lesion to a standstill during four years."

The second necropsy is reported by Dr. J. G. Sinclair Coghill, in the *Lancet* for Nov. 16, 1895. The patient was one of ten who had undergone tuberculin inoculations at Dr. Coghill's hands previous to May, 1891. Eight of these ten are to-day alive and well, shewing no evidence of tubercular disease. One died 18 months after cessation

of the treatment, but not from tuberculosis. The death of the tenth—the subject of the present report—occurred Dec. 17, 1894.

The patient had been put upon the treatment with much hesitancy. He had been ill for three years, a severe cough with expectoration had lasted two years, and for twelve months there had been exhaustive night sweats. There had been no hemoptysis, but emaciation had been progressive. "There was flattening at both apices, above and below the clavicle, but more so on the left side, where movement was also more restricted. On the right side in front the percussion note was impaired to the third rib, with expiration prolonged, vocal resonance increased, and distinct amphoric breathing under the clavicle. Behind the note was impaired at the apex, expiration was lengthened, and increased vocal resonance to spine of scapula. In front of the left lung there was absolute dulness to the third rib and impaired to the fifth rib. There was loud superficial cavernous breathing with pectoriloquy to the lower margin of the third rib, with moist crepitation over the whole lung. Positively there was absolute dulness at the apex and in the supraspinous fossa; in the latter there was amphoric breathing but no crepitation."

Reaction from the tuberculin was pronounced, so the injections had to be proceeded with very cautiously. "In this case," says Dr. Coghill, "I was much impressed with what seems almost to amount to a law—that, in proportion to the extent and activity of the tuberculous lesions, the greater and more prolonged is the reaction of the same doses of the lymph; hence, the more advanced and active the pulmonary lesion, the greater the necessity for proportionally smaller doses and longer intervals in its administration."

Three and a half months after commencement of the treatment, the patient left hospital, though he was still kept under observation, and he continued to receive periodic inoculations until the temperature ceased to react to the tuberculin. When he left hospital he had gained 13 lbs. in weight, and looked and felt very much better, but physical examination of the lungs shewed that the disease had not been recovered from, and the sputum contained bacilli. With the continuance of treatment the physical signs improved and the sputum decreased in quantity. Throughout the treatment the condition of the heart had been very unsatisfactory—shewing evidence of great weakness. The patient's end came quite suddenly, and was the result of cardiac failure.

The necropsy shewed signs of old pleuritis on both sides. "The



whole of the upper lobe of the left lung was occupied by a cavity with thick fibrous capsule and lined by a pyogenic membrane with pus-moistened walls. The middle lobe was adherent to the upper and also entirely excavated, and the capsule and lining presented similar characters. These vomicae did not communicate, and each opened independently into a bronchus. The right lung contained a caseous nodule surrounded by a thick fibrous capsule. The whole upper third of this lung was occupied by a cavity with an extremely thick fibrous wall. The lining membrane had no pus on its wall—indeed, it seemed almost dry: it communicated with a small bronchus. \* \* \* \* The bases of both lungs were much congested hypostatically, and contained a few capsulated caseous nodules scattered throughout their substance. The heart was extremely small and anæmic, and its walls much thinned. The right side was dilated and full of blood.”

Dr. Coghill has no hesitation in describing the arrest of this extensive area of acute pulmonary tuberculosis to judicious tuberculin inoculation. “This case,” he says, “confirms me in the opinion I have always held, and still hold, that tuberculin has potent therapeutic efficacy in the treatment of tuberculosis when used judiciously and with caution in doses and under conditions adapted to each individual case.”

In line with these reports it seems in place to review briefly the “clinical results from the use of tuberculin and its modification anti-phthisin (Klebs),” tabulated by Dr. H. Longstreet Taylor in *Medicine*, Oct., 1895. Thirty-nine cases in all were subjected to the inoculations, but in several which did not improve, the treatment was abandoned very soon after its commencement. Nine of the cases went on to a fatal result, eight continued to progress unfavorably, six improved, and sixteen improved greatly.

In thirteen of the cases treatment was begun early in the course of the disease. Of this number, one is dead, one is worse, and eleven are greatly improved. Eight patients came under treatment in the second stage of the disease—one of these is dead, two are worse, one has improved, and four have improved greatly. The remaining eighteen cases presented themselves in the third stage of the disease. Seven are dead, only two of which were given long courses, the other five having been given but a trial and the treatment abandoned; five are worse, one of whom was given but a trial; five are improved, and one has improved greatly.

Dr. Taylor's experience has led him to this conclusion: “Person-

ally, I am thoroughly convinced that tuberculin is our most certain remedy for this disease—not, however, that it is or even can be so modified as to become a specific. Its careful use is not dangerous. In beginning cases its use should be encouraged, and in advanced ones, without too pronounced sepsis, it may be given a trial.”

From these reviews we should extract some food for reflection. If tuberculin has been thrust aside hastily and without due consideration—if its apparent failures or injurious effects were the result of incautious use by over-enthusiastic men, then it is the obvious duty of the man of medicine to give the whole question careful reconsideration, and to decide whether he should not again include it among his therapeutic agencies. It will at any rate be interesting to note further developments in the study of this agent, and also to study in parallel the results obtained from the anti-tubercle serum of Paquin (*vide Journal of Amer. Medical Assoc.*, March, 1895), and that of Maragliano (*vide* editorial reference in *British Medical Journal*, Aug. 17, 1895).

It is well to bear in mind, however, that in connection with this very subject over-enthusiasm has already proved a danger to be studiously avoided, and a value should not be placed upon these digests until the question has been viewed from its various sides. It is not uncommon to find in the autopsy room well defined evidence of a localized tubercular process which has undergone changes resulting in a complete cure of the lesion; altho' perhaps no special treatment had been directed against the morbid condition. It is unusual, however, to find signs of such extensive implication of tissue, as in the cases of Dr. Adami and Coghill, with ultimate healing. Yet instances have been reported in which recovery has followed widespread involvement of the respiratory organs. Thus in illustration of a paper before the Glasgow Medico-chirurgical Society (published in the *British Medical Journal*, Oct. 31, 1891), Dr. Joseph Coats exhibited a lung in which practically all trace of lung tissue had disappeared, leaving simply a congeries of cavities. The process here had been distinctly tubercular, yet healing had obtained after all the lung tissue had been destroyed and excavated, and a wall of wholesome fibrous membrane lined the cavities which had been produced. The opposite lung in the same case shewed evidence of a less advanced tuberculosis which had been arrested.

This instance is culled from a short epitome of literature upon “Arrested Tuberculosis,” which I contributed to this journal in

March, 1892. In the same abstract I quoted statistics from various authorities which, in the sum, represented 19,713 necropsies in which 1,079 bodies, or about 5½ p. c. shewed unquestionable signs of obsolete tubercle. Coats has asserted, on the strength of his own observations, that about 23 p. c. of persons dying of non-tubercular affections have had some form of internal tuberculosis at one or another period during life.

These statistics were collected during a period considerably antedating the employment of tuberculin, so perhaps it should not be claimed too positively for the cases reported by Drs. Adami and Coghill that the improvement following the primary attack was the result of the use of tuberculin alone. But whatever there was in the treatment which led to such manifest improvement, it is interesting to speculate as to what the result would have been had the treatment been persisted in for a longer time. These cases add to the certainty which is now coming to be generally felt, that tuberculosis is not necessarily an incurable affection and that even after the disease has come to involve a considerable area of lung, we should not form too gloomy a prognosis.

# Surgery.

REPORTERS—J. STEWART, M. B., Halifax,  
MURRAY MACLAREN, M. B., St. John.

## Antitoxins in Surgery.

In surgical writings of recent years it has not been difficult to detect an air of complacent satisfaction with the progressive inroads of Surgery into the hitherto unquestioned field of Medicine.

The surgeon, tentatively poaching on the territory of the physician, discovered new fields for operation. The end justified the means, and it seemed as though the apothecary was to be banished and the surgical instrument maker to reign in his stead. The journals vied with each other in reporting these wonderful extensions of surgery, and stuck appreciative feathers in the cap of Chirurgus until that worthy's head-dress resembled the plumose adornment of an Ojibbeway medicine man.

But now these fickle journals convey the impression to all who care for these things that Chirurgus has had his day, and that Medicus is to have his innings.

The all engrossing subject now, in surgery as well as medicine, is sero-therapy, or perhaps more correctly toxin therapy. More or less an element in medical treatment from time immemorial, though its action, and even existence, was unknown; supported by the humoral pathology of a bye gone day, and now tending in great measure to re-introduce this theory of morbid processes; seen "as in a glass darkly" in Jenner's great discovery and brought definitely into the field of exact science by Pasteur and Koch in their work on immunity and protective inoculation, it is now being extended in all directions, and the time may come when, for many diseases at present yielding bright triumphs of surgical skill, the only operation necessary may be the very trifling one of hypodermic injection.

It is only yesterday that tuberculosis was pronounced more a surgical than a medical subject. The extension of the pathology of tuberculosis to scrofulous or strumous conditions is one explanation of this paradox, and the successful extension of surgical methods to the abdomen, the chest, and even the brain, is another. But though the

“tuberculin” treatment of Koch was premature, and found wanting, experimenters are still working out the idea, and with fair prospect that in time, not only may a serum be produced which will antagonise the action of the tubercle bacillus, but even secure immunity against it. And what that would mean to our race we can somewhat understand when we remember that one-seventh of all mortality is due to this disease.

But tuberculosis is scarcely yet generally recognized as a surgical affection and there is nothing novel in the idea that medicine should supply the remedy. It is different when we come to tumours. The purely medical treatment of most tumours is as much an anachronism as the surgical treatment of a pulmonary abscess is a novelty. And yet what do we see and hear? Sarcoma and carcinoma, are they again to pass into the hands of the physician?

The new Humoralists, with their toxins and alexines and so forth are to blame—or to praise for this. The real practical man is, after all, the scientific man, and the “learned rubbish” of botanists, zoologists and chemists with their chemiotaxis and phagocytosis, and antitoxins, turns out to be the pure gold of the healing art.

Now it is evident there is a big tidal wave of enthusiasm rolling in this direction. And it is well that the experimenters should have enthusiasm. They need it all. It is also well that their work should be scanned by critical, yes, even skeptical eyes. The results of the laboratory must pass the ordeal of the clinic. And at present we cannot conscientiously say that they have done so. To this negative there is one exception. We believe the diphtheria antitoxin has won its place and will soon be regarded as a requisite in treatment. Others have a good prospect of earning recognition, and others are in the balances, and likely to swing there for some time.

For surgeons, the toxin treatment of tumours is of course the most interesting. Let us glance at its history.

Various references to a curative influence of erysipelas in different diseases have appeared during the last two hundred years. Neuralgia, rheumatism, chronic joint diseases, the cutaneous manifestations of syphilis, and even mental diseases, are among the affections reported as cured, or favourably influenced by an attack of erysipelas. Some of these are probably mere coincidences, but some notes are furnished by observers of the highest repute, such as those on lupus by Hebra, and there are many authentic cases of the disappearance of tumours after an attack of erysipelas.

One of the earliest attempts to utilise this clinical experience was by Ricord, who endeavoured in this way to cure phagedænic chancres by inducing an attack of erysipelas.

In 1856 Busch was partially successful in a case of lymphosarcoma of the neck. The patient was inoculated by being placed in a bed previously occupied by a case of erysipelas.

In 1882, Fehleisen, who had discovered and isolated the streptococcus of erysipelas, made various attempts at an *erysipèle salutaire*. His first case was one of multiple fibro-sarcomata of the skin. He inoculated a pure culture of the fourth generation by scarification. An attack of erysipelas was induced and a certain amount of degeneration occurred in the tumours, but the result, on the whole, was not encouraging. He continued his experiments, operating thus in severe cases of different tumours, with one quite successful case and one partial success.

In 1888 Bruns reported cures in cases of lupus, scrofulous glands, nasal polypi, keloid and sarcoma, but found that carcinoma was not amenable to this treatment. Coley, of New York, working on the same lines, came to the conclusion that the curative effect was not due to the development of the streptococcus itself, but to the action of its toxic products, and so experimented with filtered cultures. And about the same time a French observer, Roger, discovered that a mixed cultivation of the bacillus prodigiosus with the streptococcus gave a better result, and Coley now uses this mixed culture, not, however filtered, but subjected to a temperature of about 136° F. which destroys the germs, but leaves their toxins active. In this way the inoculation is much less dangerous; at any rate it is not now an *infective* process.

Coley's results are certainly surprising. He reports over 25 per cent. of cures in sarcomata, and nearly 5 per cent. in carcinomata. Others have not been so successful.

The dangers inherent in the erysipelatos process have prevented this treatment from having a very extensive trial, and hitherto it has scarcely been used, except upon inoperable cases.

Emmerich has elaborated a "carcinoma antitoxin" but it has not met with a favourable reception from his German colleagues. Prof. Czerny, of Heidelberg, has studied the subject and given Coley's method a trial. In a paper published in September, he has arrived at the following conclusions: That sarcomata may, under favourable conditions, be improved, or even cured, but that in carcinomata a

diminution in rate of growth is all that can be expected. And since results vary, this treatment cannot replace operative measures, but should be reserved for inoperable cases, and perhaps after operation as a prevention of relapse.

And now, while the streptococcus of erysipelas is being appealed to for help against malignant tumours, a toxin is being prepared to combat erysipelas! The latest addition to the list of antitoxins is the anti-streptococcus toxin, and cases are reported of the successful treatment of erysipelas, puerperal septicæmia and cellulitis.

Dr. Marmorek, of the Institut Pasteur, who has elaborated this antitoxin, considers that all the pathogenic streptococci are of the same species and that the varieties in the lesions depend on the point of entrance, and on the virulence of the type. He has by ingenious methods of cultivation, obtained extremely virulent types, so that even a fractional part of one-millionth of a cubic centimetre of a culture is fatal to a rabbit. He reports 411 cases of erysipelas treated with a mortality of 3.4 per cent., which is considerably less than the average mortality under our ordinary treatment. But in these statistics the distinction should be very clearly drawn between "idiopathic" and traumatic cases.

The material is also being prepared by Ruffer in the British Institute of Preventive Medicine, and a successful example of its use in a case of erysipelas neonatorum is given in the *Brit. Med. Journal* of Dec. 7. (B. M. J., 95 II., 1418).

Encouraging results have been obtained in the treatment of tetanus by an antitoxin, but the statistics are somewhat vitiated by want of a distinct classification of cases, chronic cases, as is well known often recovering under ordinary treatment.

This wonderful development of pathology and therapeutics is in its infancy, and while the results are still uncertain and defective, and even in some cases discouraging, it is evident that vast possibilities are opening up before us, not in the domain of medicine only, but also in that of surgery.

J. S.

## Society Proceedings.

### HALIFAX BRANCH OF BRITISH MEDICAL ASSOCIATION.

*Stated meeting Nov. 1st, 1895.*

After the disposal of routine business, Dr. Farrell, on behalf of the special committee appointed at the last meeting in respect to a public bacteriologist, said that a meeting had been held and that Dr. A. P. Reid, the chairman, would submit a report at the next meeting.

#### **Tubercular Tumour of Larynx.**

DR. KIRKPATRICK presented a patient suffering from a tubercular growth in the larynx. By aid of the laryngoscope the members of the society saw this grayish exeresence situated in the arytenoid commissure. In appearance it resembles and might easily be mistaken for a papilloma. The microscope, however, has established beyond a doubt the tubercular nature of the formation. Dr. Kirkpatrick stated that the patient's lungs had been examined by several competent physicians, who had reported no evidence of tuberculosis of those organs, also that the patient remained in good health and had gained ten pounds in weight during the twelve months he had been under observation. These facts led to the conclusion that the case was one of primary tuberculosis of the larynx, and as such was interesting in view of the fact that many authors claim that such a disease can only occur in connection with the pulmonary affection. As represented by Bosworth, tubercle may occur primarily in any region of the body, and it is difficult to understand why the larynx should be exempt from a primary invasion. The local treatment followed consisted of occasional removals of portions of the growth and applications of lactic acid, beginning with a 50 p. c. solution and gradually increasing the strength to 80 p. c.

DR. FARRELL stated that this tubercular process was so different from the course pursued by tubercular affections in other parts of the body, that if the nature of the growth had not been demonstrated by the microscope, he would be slow to believe it to be tubercular.

DR. CAMPBELL said that the case was one of great interest from many points of view. While tubercular ulcers of the larynx were



common, tubercular growths were rare. Cases, however, had been reported where such growths were found in the larynx without any positive evidence of tuberculosis elsewhere as was the case with this patient.

DR. WALSH had known the patient for many years. At times he presented symptoms suggestive of incipient tuberculosis, and always had derived benefit from anti-tubercular treatment.

### **Lupus.**

DR. D. A. CAMPBELL exhibited a patient suffering from lupus vulgaris. The disease was of seven years duration and involved the greater part of the face. As a result of the disease the patient was completely blind, and there was marked contraction of the oral and nasal orifices. There was also a large and very characteristic patch on the back. An injection of tuberculin was followed by a decided local and constitutional re-action, the general health was good and there was no evidence of tuberculosis in the family. The disease was too extensive to admit of successful treatment.

DR. HATTIE remarked that he had seen several cases of lupus treated by injections of *tuberculin* at the Montreal General Hospital with fair results, the improvement being marked up to a certain point. Relapse, however, took place in most cases.

### **Abdominal Operations.**

DR. E. FARRELL reported three cases where he had recently performed laparotomy.

*Case No. 1.* Procidentia. Operation ventral fixation.—The case was of interest as it was the only case of procidentia he had ever seen in a virgin. The os and cervix protruded from the vulva, but there was neither rectocele or cystocele. The displacement was easily reduced. Some years before the occurrence of this trouble the patient had worn a plaster of paris jacket on account of spinal disease. Probably the compression of the abdominal walls by the jacket had in some way induced the procidentia.

The treatment of procidentia by ventral fixation had not been successful in his experience, but he thought in this case a good result could be obtained by the operation. The operation was done in the usual way and up to the present time the patient was doing well.

*Case No. 2.* Miss Eva S., æt 21, admitted to Halifax Infirmary with an ovarian cystoma. The operation was a simple one. The cyst was free from adhesions, contents clean and thin like water and

easily evacuated. Pedicle ligatured with stout silk, peritoneum with fine catgut, muscles with stout catgut, integument with silkworm gut. Patient made an excellent recovery.

*Case No. 3.* Mrs. D. B., æt. 36, came complaining of great pain, irregular menstruation and amenorrhœa. No children. Vaginal examination in right ovarian region a large mass, somewhat tender. Sound passed  $1\frac{1}{2}$  inches. Seemed to be but little connection between uterus and tumour, which is evidently in right broad ligament. Uterus pushed to one side. Operation. Abdominal wall very fat and thick, the intestines protruding to so great an extent as to necessitate their being laid upon the chest wall and covered with hot towels. A hard mass could be felt apparently in the right broad ligament. Could just see top of ligament and the tumour. Ovarian artery ligatured and cut, the fold of the broad ligament opened and little by little the tumour was removed from its surroundings. Shelled out the tumour and the remaining portion of sac, ligatured stump of same and returned it into abdominal cavity, replaced intestines, sutured peritoneum with fine catgut, several mattress sutures, etc. Patient made an uninterrupted recovery.

DR. J. F. BLACK reported a case of Hysterectomy. Patient unmarried woman of 38. Previous health good. For about 3 months presence of abdominal swelling had been noticed, but little or no discomfort from it. Menstruation very little interfered with. Bowels regular—no disturbance of bladder.

Examination shewed tumour about size of foetal head, in medium line, apparently cystic, and more or less freely movable. Uterus normal in size, somewhat displaced to right, moving rather readily when pushed from side to side.

*Diagnosis.*—Probably tense ovarian cyst, possibly tumour connected with uterus.

*Operation.*—On opening abdominal cavity difficult to make out uterus. Tumour still seemed to be cystic, but large trocar failed to give any fluid. Further examination shewed it to be an outgrowth from left side and fundus of uterus and entirely incorporated with it. Hysterectomy proceeded with, flap operation through cervix being done. Good recovery: no bad symptoms up to present—ten days after operation. Specimen shown appeared to be a myoma involving nearly all of body of uterus.

Point of greatest interest—difficulty of diagnosis before operation, since even after opening of abdomen the tumour still felt like a cyst.

both to operator and assistants—probably explained by great vascularity of the growth. Post mortem appearance that of a solid myomatous tumour.

### Fracture of Olecranon.

DR. N. E. MCKAY exhibited a patient who met with a fracture of the olecranon process. He cut down upon the injured part and wired the fragments and obtained a most excellent result. The use of the Esmarch bandage was followed by paralysis of the parts below the point of constriction. A full report of this case appeared in the M. M. NEWS, June, 1894.

### ST. JOHN MEDICAL SOCIETY.

At a meeting of the St. John Medical Society held Dec. 4, 1895 the following resolution was moved by Dr. W. W. White, seconded by Dr. J. Scammell, and carried unanimously :

*Whereas*, Tuberculosis, in one form or another, destroys approximately one-sixth of the human race, and is very prevalent in this community :

*And whereas*, Being an infective disease, due to a specific germ without which it cannot exist, it is largely preventable.

*And whereas*, A Royal Commission in England, appointed in 1890, to enquire and report what is the effect, if any, of food derived from tuberculous animals upon human health, reported on Nov. 22, 1894, to parliament, that in their opinion an appreciable part of the tuberculosis that affects man is obtained through his food :

*And whereas*, Tuberculosis is a common disease in New Brunswick among dairy herds and other domestic animals, not readily recognized as such by farmers and slaughterers, but capable of detection in nearly all cases by an expert :

*Therefore resolved*, That the prevention of the spread of tuberculosis by infected meat and milk is a subject which well deserves the careful consideration of the authorities :

*And further resolved*, That the St. John Medical Society petition the commonality of St. John, municipal council, local board of health and slaughter house commission, to appoint committees to act with a committee from this society in considering the best means of protecting the public from the dangers of tuberculous food.

The president appointed the following committee: Drs. W. W. White, Wm. Bayard, P. R. Inches, J. H. Grey, Jas. Christie, Murray MacLaren, J. H. Morrison, J. H. Scammell.

At a meeting of the St. John Medical Society held Nov. 27, 1895, Dr. Doherty read a very interesting paper on "The Treatment of Colles' Fracture." The peculiar deformity observed is not entirely or

principally due to a fracture of the radius within an inch or so of the wrist joint, but there takes place at the same time a dislocation of the lower end of the ulna and this dislocation is responsible for the characteristic silver fork appearance. Where the radius is broken and no luxation of the ulna takes place, the hand will be carried to the radial side in consequence of the shortening, but the silver fork appearance will be absent. In the treatment great stress is laid on the necessity to reduce the luxation. In order to do this it is necessary to anaesthetize the patient. Great force is often required to restore the parts, which may usually be effected by seizing the hand of the patient by one hand, and his forearm by the other, while the ulna is pressed into place against the surgeon's knee. When the reduction takes place, it will be found that the fracture has been brought into place. The thumb of the surgeon should be pressed under the ulna, while the finger of the same hand holds down the wrist. A simple roller  $\frac{1}{2}$  to  $\frac{3}{4}$  inch in diameter and 2 inches wide, is gradually introduced between the thumb and ulna, the roller to abut against the pisiform bone. A strip of adhesive plaster, two inches wide, is drawn with considerable force around the wrist, and on account of the swelling that will naturally ensue, should be divided over the back of the wrist. This plaster should be so adjusted that its distal edge will be on a line with the end of the radius. A sling 3 inches wide completes the dressing. As the sling supports the forearm by making pressure directly over the roller, gravity will cause the hand to hang in such a position as to favor the retention of the ulna in position.

J. H. SCAMMELL,

*Secretary.*

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EDITORS.

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9 Prince Street, Halifax.

**Editorial.**

THERE are some who say Medical Science is making no progress. Let them look at appendicitis. A few years ago there was no such word: now, special monographs, entire sessions of surgical societies devoted to it, and rows upon rows of preparation jars on the shelves of museums testify to its existence.

A disease has long been known, occurring chiefly in young people, affecting mostly lads and young men, its general features being pain in the right iliac region, vomiting, tympany and perhaps peritonitis, and occasionally so severe as to resist all treatment and to prove fatal in a few days or even hours. This disease went under various names, and varieties of it were recognised, but the generic term *typhlitis* generally represented them all. The caput caecum or *typhlon* was regarded as the seat of the disease, hence the name.

The observations of the post mortem room revealed in time that not the caecum, but the apparently insignificant appendix vermiformis was the true seat of the disease in most cases. It took a long time to

realize this. Even ten years ago the term appendicitis was scarcely known. It is not a desirable term from a literary point of view, but it has won its way, and it would be affectation not to use it. And it is now distinctly recognized that in fatal cases of this disease we almost certainly find ulceration, or perforation, or gangrene of the appendix.

It is interesting to follow the history of human thought in medicine as in other departments. The result of the accumulated evidence of the appendix as the starting point of the disease and the extension to it of the wonderful achievements of antiseptic surgery, as in other inflammatory conditions within the abdomen and pelvis, carried surgeons on a tide of enthusiasm, and operative treatment for the conditions now grouped under the name of appendicitis became a thing of every day and one of the dazzling feats of surgery. As R. T. Morris put it: "We had awakened to the full appreciation of the fact that through all the centuries we have been burying unnecessarily a certain class of patients." But the very brilliancy of the success of surgical treatment seemed to blind us to the fact that all cases of this disease had not usually proved fatal. And on the other hand it brought this little insignificant morsel of anatomy into the focus of scientific investigation. Anatomists wrote pages on its form and position, its attachments and relations, histologists revealed new elements in its structure, comparative anatomists made special studies of it, and pathologists found fresh fields to conquer. We are pretty safe in saying that no part of our anatomy has received a more searching examination during the last five or six years.

And the results of surgical treatment have been brilliant. Unmistakably a great stride has been taken, but reformers generally stride too fast and too far. And there have always been people who opposed reformers and sometimes it is fortunate for humanity that they have done so. And so there is war in the camp, and surgeons and physicians who should join hands are shaking fists.

DR. FOWLER, of Brooklyn,\* one of the ablest writers on this subject, who has had a very large share in clearing up the pathology and laying down the treatment for these conditions, says that the less medical treatment these cases get the better. And many agree with him. On the other hand, able men who have also studied the subject minutely, aver that the great majority of cases require only judicious medical

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\* A Treatise on Appendicitis. Lippincott, Phila., 1894.

treatment, and only a small minority call for surgical aid. And they are right. As usual in disputes there is a misunderstanding.

What do we mean by appendicitis? We have to remember that the whole of this brilliant departure in surgery is based on pathological investigation. For its *raison d'être* we appeal to the records of the post mortem room. But what of the vast number of cases which recover? Whether in these the appendix is affected, and if so, primarily affected, is, fortunately for the patients, a matter for inference only. There are cases of all degrees of severity. It is only the last terms of the series that can speak clearly as to morbid anatomy. There is another source for inference as to the nature of disease than the post mortem table. We have clinical evidence. "Nulla est alia pro certo noscendi via, nisi quamplurimas *et morborum et dissectionum* historias . . . inter se comparare." and the pathologist who ignores the clinical record has blinded his right eye.

If by appendicitis we mean an affection which is certain, sooner or later, to result in ulceration of the appendix with consequent peritonitis, either plastic or diffuse, good and well: let us waste no time in medical treatment once the diagnosis is made. But in this case appendicitis is not the disease formerly known as typhlitis, but only a special form or degree of it. It is indubitable for it is the common experience of all practitioners that the majority of the cases which present the symptoms of local disturbance or inflammation in the region of the caecum and appendix get well under medical treatment.

The records of the operating theatre show that in some cases where all the symptoms of appendicitis were present, the appendix when exposed was neither gangrenous nor ulcerated: it may have been the seat of inflammatory thickening or merely presented a curious condition of rigidity or spasm, but was otherwise healthy. And, on the other hand, cases are on record in which the appendix has been removed, and yet attacks of "appendicitis" have recovered.

In DR. BLACK'S paper on "Appendicitis," which appears in this issue of the NEWS, he indicates that the reaction against unrestricted operating has set in. TREVES, one of the leading authorities on this subject, has always deprecated over-zealous surgical treatment. And BARLING, in the Ingleby Lectures on Appendicitis, lately published, takes the same broad view of the subject, and in his classification, which is that adopted by DR. BLACK in the paper referred to, and which, being a clinical classification, is probably the best for practical purposes includes the milder forms of the disease. These are often

due to digestive disturbances, as in the case of a sluggish and overloaded colon.

DR. FOWLER, in his work to which we have already referred, regards the casual relationship of indigestion with septicæmia. But innumerable cases are on record in which indiscretion in diet, perhaps even in particular articles of diet, have preceded the symptoms with such constancy as to force the conclusion that they are more than a coincidence. An admirable paper in the *Lancet* (1895, vol. i., p. 389) by DR. J. W. WHITE, of Philadelphia, points this out very clearly.

There is another type usually amenable to medical treatment, and this may be called "rheumatic appendicitis." As a result of exposure to cold, and it may be in conjunction with other rheumatic conditions, there is pain in the ileo-cæcal region. Recent researches have shown that the structure of the appendix is largely lymphoid tissue like that of the tonsil, and the relationship of the tonsil to rheumatic conditions is well known. This histology of the appendix throws light on the peculiar condition known as "recurrent appendicitis," and which has a parallel in the repeated attacks of quinsy to which some individuals are subject, sometimes precipitated by cold, sometimes by digestive disturbances in which the liver figures largely.

But even among cases which begin mildly and progress slowly, there are some which do not respond to medical treatment, and others recover only to recur frequently. There comes a time when surgical treatment must be employed, and gives, perhaps, the only hope for life.

If, in spite of treatment, whether pain persists or not, there is continuous vomiting with unrelieved distension of the bowels, operation is indicated. Whenever pus can be demonstrated, an operation is certainly called for. As a rule, surgical treatment is more urgently called for in the case of children, because in them the tendency to diffuse peritonitis is greater than in adults.

In any case, even though symptoms are not severe, if by the third day there is no sign of improvement, it will probably be best to operate.

As to recurrent cases, there is often room for debate. We think that where the attacks are slight, of short duration, and at long intervals, we may regard the case as, to coin a term, "appendical quinsy," and be content with treatment on general principles. But if the attacks are severe and the intervals short, or becoming shorter, the indication is clear for surgical interference.



As will be seen, we begin our eighth year in a new dress. The need of a local periodical in the maritime provinces has been proven, though not a few difficulties had to be overcome. It only remains to make the journal worthy of continued support. Arrangements are nearly completed by which we hope to make our contents more varied and instructive. Through judicious legislation the standard of medical attainments has been steadily advancing among us, and that should be reflected in our columns. Our aim has been and always will be to give publicity to local transactions. This cannot be done without assistance, more especially from the secretaries of medical societies. We heartily thank the many friends, contributors, subscribers and advertising patrons who have so generously aided us in the past and trust they will stick by us in our future undertakings.

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### Book Reviews.

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PREGNANCY LABOR AND THE PUERPERAL STATE. By Egbert H. Grandin, M. D., Consulting Obstetric Surgeon to the New York Maternity Hospital, Consulting Gynecologist to the French Hospital, etc.; and George W. Jarman, M. D., Obstetric Surgeon to the New York Maternity Hospital, Gynecologist to the Cancer Hospital, etc. Illustrated with forty-one Photographic Plates. Philadelphia: The F. A. Davis Company; London: F. J. Rebman, 1895.

This is a work of some 260 pages, and as its title page indicates is devoted to the subjects of Pregnancy, Labor and the Puerperal state. The subjects dealt with under Pregnancy are the Diagnosis, Differential Diagnosis, Duration and Hygiene of Pregnancy, followed by chapters on the Pathology and the Diagnosis of the position and presentation of the Fœtus. The second part of the work has chapters on the Mechanism of Labor, Clinical Course of Labor, Management of Normal and Abnormal Labor, and Care of the New-born Infant. The concluding part of the work is devoted to the consideration of the Normal and Pathological Puerperium. While this work is designed for the student, still a careful reading will repay the practitioner, because it is a well written book and the facts are well arranged. Though we find much to recommend, we do not admit the necessity or wisdom of special works on special parts of any subject. The student should not confine or limit his reading to such works. The authors frequently refer to another of their works for fuller information--this we consider objectionable. The illustrations, on the whole, are well chosen and serve to make clear points, otherwise difficult to elucidate by words merely. Some of the illustrations we think unnecessary. The work of the publisher has been well done.

## BOOKS AND PAMPHLETS RECEIVED.

GRANULAR LIDS: WITH CASES IN PRACTICE.—By A. Britton Deynard, M. D., New York.

THE LIMITATION OF SURGICAL OPERATIONS AS A MEANS OF RELIEF OR CURE IN EPILEPSY.—By Thomas H. Manley, New York.

DIPHThERIA ANTITOXIN.—Reprints from McLure's Magazine for March, 1895, of articles by Herman M. Biggs and William H. Park, M. D. Parke, Davis & Co.

VARIOUS FRACTURES, SIMPLE AND COMPOUND. A Clinical Report of Fifteen Cases. By Thomas H. Manley, M. D., New York.

DEFORMITIES FOLLOWING FRACTURES OF THE SHAFTS OF BONES, WITH OBSERVATIONS ON TREATMENT.—By Thomas H. Manley, M. D., New York.

MARSHLANDS.—A monthly magazine, Amherst, N. S. Vol. I. No. 1.

OXYHAEMOGLOBIN AND ALLIED PRODUCTS.—Frederick Stearns & Co., Detroit.

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 NOTES AND COMMENTS.

ANY one desirous of obtaining an elegant calendar could not do better than forward 25 cents to Frederick Stearns & Co., the well known manufacturing chemists of Detroit. It is an excellent illustration of photography in colors.

\* \* \* \*

*The American Medical Review* is the name of a new monthly journal published in New York. The journal is neatly got up, the contents are varied and interesting, and the price is very reasonable, \$1.00 per year. Its aim appears to be to give a brief summary of current literature, and if succeeding issues are equal, it deserves a large patronage. The editor is Daniel Lewis, M. D.

\* \* \* \*

*Pædiatrics* is the name of a new journal published semi-monthly in London and New York. It is owned by Dillon Brown, M. D., of New York, and edited by George A. Carpenter, M. D., of London, assisted by an able staff of collaborators. The journal is printed on good paper, copiously illustrated, and the reading matter is choice and varied. We wish the new periodical success.

THE SANITARIAN.—Twenty-fourth year, 1873–1896.—*The Sanitarian* will continue in the future, as it has been hitherto, devoted to the promotion of the art and science of sanitation, mentally and physically, in all their relations: by the investigation, presentation and discussion of all subjects in this large domain, as related to personal and household hygiene, domicile, soil and climate, food and drink, mental and physical culture, habit and exercise, occupation, vital statistics, sanitary organizations and laws—in short, everything promotive of or in conflict with health, with the purpose of rendering sanitation a popular theme of study and universally practical.

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All correspondence and exchanges with the *Sanitarian*, and all publications for review should be addressed to the editor, Dr. A. N. Bell, Brooklyn, N. Y.

\* \* \* \*

E. B. TREAT, publisher, New York, has in press for early publication the 1896 INTERNATIONAL MEDICAL ANNUAL, being the fourteenth yearly issue of this eminently useful work. Since the first issue of this one volume reference work, each year has witnessed marked improvements; and the prospectus of the forthcoming volume gives promise that it will surpass any of its predecessors. It will be the joint authorship of forty distinguished specialists, selected from the most eminent physicians and surgeons in America, England and the continent. It will contain reports of the progress of Medical Science at home and abroad, together with a large number of original articles and reviews on subjects with which the several authors are especially associated. In short, the design of the book is, while not neglecting the specialists, to bring the general practitioner into direct communication with those who are advancing the Science of Medicine, so he may be furnished with all that is worthy of preservation, as reliable aids in his daily work. Illustrations in black and colors will be consistently used wherever helpful in elucidating the text. Altogether it makes a most useful, if not absolutely indispensable, investment for the medical practitioner. The price will remain the same as previous issues, \$2.75.

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In calling the attention of the profession to the institution, the Faculty beg to say that there are more major operations performed in the Hospital connected with the school than in any other institution of the kind in this country. Not a day passes but that an important operation in surgery and gynecology and ophthalmology is witnessed by the members of the class. In addition to the clinics at the school published on the schedule, matriculates in surgery and gynecology, can witness two or three operations every day in these branches in our own Hospital. An out-door midwifery department has been established, which will afford ample opportunity to those desiring special instruction in bedside obstetrics.

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*Diseases of the Mind and Nervous System.*—Professor Charles L. Dana, M. D., Graeme M. Hammond, M. D.

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W. H. SIMPSON, PH. G., Examiner in Chemistry.

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