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 REVIEW OF CANADIAN MEDICAL LITERATURE,
 SANITARY NOTES, CORRESPONDENCE,
 ITEMS, BOOK NOTICES, Etc.,

IN THE

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JANUARY TO JUNE, 1894.

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EDITORS:

W. H. B. AIKINS, M.D.

W. B. NESBITT, B.A., M.D.,

WITH THE ACTIVE COLLABORATION OF

A. B. ATHERTON, M.D.

J. J. CASSIDY, M.D.

A. A. MACDONALD, M.D.

J. H. BURNS, M.D.

J. FERGUSON, M.D.

G. S. RYERSON, M.D.

A. H. FERGUSON, M.D., WINNIPEG, MAN.

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[No. I.]

ORIGINAL ARTICLES.

(No paper published or to be published elsewhere as original, will be accepted in this department.)

CASE OF INHERITED FRAGILITY OF BONES—FOUR FRACTURES OF THE OLECRANON WITHIN SEVEN MONTHS.*

BY A. B. ATHERTON, M.D., L.R.C.P. AND S. EDINBURGH.

F. D., aged 13. Family History.—Nothing of note on maternal side. Paternal grandfather sustained at least three or four fractures. Paternal grandmother frequently broke her limbs. They say that she scarcely ever seemed to have her arm out of a sling. The patient's father and paternal uncles have all frequently suffered from broken bones. The former has had at least six fractures at different times. The last was one of both bones of the legs, got by a tumble on his office floor.

One of the boy's father's brothers has fractured his bones over and over again. Once he broke a finger by suddenly seizing hold of a female bather in order to rescue her from drowning. Patient has two sisters older than himself who have so far escaped fractures.

Previous History.—When two and a half years of age, had some acute inflammatory affection of the brain, from which he recovered well. The forehead especially, and the head generally, seem wider than in ordinary children.

With the exception of the above-mentioned illness, he has enjoyed a fair degree of health. He never broke a bone till March 21st of the present year, when, while sky-larking with one of his sisters, he fell on the floor and fractured his right olecranon. The fracture was treated by a long anterior splint—a small pad being applied to the upper fragment, with a strip of adhesive plaster over it, so as to bring it down as near as possible to the lower fragment; also, a short poro-plastic splint was placed posteriorly

* Read before Toronto Clinical Society.

so as to steady the broken fragments more effectually. The splints were removed in four weeks, no motion having been allowed in the joint during this period. The bone was found firmly united without the intervention of any fibrous tissue, and he could at once flex the elbow to nearly, if not quite, a right angle. In a week or two the movements of the joint were perfect, and that without any assistance from me.

On the 9th of May, exactly seven weeks from the first fracture, he slipped on the oiled floor, striking his left elbow against the end of a bedstead, thus fracturing the left olecranon, and when he fell to the floor also produced a refracture of the right bone. On this occasion a large amount of blood was found poured out over the back and sides of the right elbow.

These fractures were treated in much the same way as the previous one, and the splints were removed in four weeks as before. Both fractures were united by bone, and after two or three weeks almost perfect flexion was obtained.

After this experience the boy took the greatest care to avoid any further accident, and succeeded in doing so until October 6th. At this date, while he was sitting on a bench apart from his school-mates, who were at play on the school-grounds, two or three of them rushed in his direction, and he threw up his left arm to ward them off. In doing so he felt the bone break again, and when I saw him about two hours afterwards I found a very large extravasation of blood already showing distinctly through the skin over the fractured olecranon, and making it difficult to detect the fracture.

Again the usual anterior straight splint was applied, but only a wad of cotton wool posteriorly, as I feared to make any firm pressure by pad or splint there, because of the effused blood. After about ten days I found the swelling sufficiently reduced to use a pad and adhesive plaster to the upper fragment of the olecranon. On November 5th, the splint and other appliances were left off. On examination, I felt a furrow about one-fourth of an inch wide at the side of the fracture. At the base of this furrow I found what appeared to be bone uniting the olecranon with the ulna.

The patient has since November 5th been allowed moderate and careful use of the arm, and you will observe that the movements of the elbow are nearly perfect. You will also see that the motions of the right elbow are quite normal, and the bone seems little or not at all deformed. It may possibly be that the uniting medium in the left elbow is a broad, short and firm band of ligamentous tissue, but I can detect no decided movement of the upper fragment upon the lower.

REMARKS.

It may be a question whether this case should have been reported as one of fractures of the olecranon or of separations of that epiphysis. Bone is said to begin to form in the olecranon process at ten years of age, and union with the ulna to take place at sixteen years. Whatever may have been the true nature of the injuries, it is, at all events, certain that in three, if not in all four, fractures (or separations of the epiphysis), the parts were reunited by bone or cartilage, and not by ligamentous tissue.

Hamilton says, in his work on fractures and dislocations, that he never saw but one case of separation of this epiphysis, and that occurred in a boy of seven years, while he was trying to break up some adhesions in the elbow joint. He had met with seventeen fractures of the olecranon, and out of these he got bony union in five.

Hulke states, in "Holmes' System of Surgery," that fracture of the olecranon is almost unknown before fifteen, and that union is generally fibrous.

I think, therefore, that I may congratulate myself on the result in this case. No doubt, had it not been for the extensive extravasation of blood in and about the joint in the last accident, we should have obtained a better union than we did, but the members of the Society will see, by examining the limb, that the patient has a perfectly useful arm.

I attribute the speedy attainment of good motion in the joints largely to the fact that complete and continuous rest was maintained until all inflammation had time to subside. I think it is a great mistake for a surgeon to begin passive motion in an injured joint before ample time has been given for nature to repair the injury done. All forcible movement of an inflamed joint can only defeat the very object that we have in view. When a fracture complicates such an injury, it is quite time enough to begin to move the joint when the bone has become united. In former times, surgeons were often over anxious to commence passive motion, and did so before all active inflammation had subsided. This was the cause of much unnecessary pain, and also retarded complete recovery.

The large amount of blood poured out in the case of both the second fractures was doubtless due to the increased vascularity of the parts, resulting from the repair of the preceding ones.

INFANTILE SPASTIC PARALYSIS.*

BY JOHN FERGUSON, M.A., M.D., TORONTO.

This is a disease that has for its anatomical basis several conditions. In one there is the occlusion of a cerebral vessel—vein or artery—by a thrombosis; in another there is the plugging of an artery by an embolism; in another there is a hæmorrhage; and in yet another form there is an encephalitis. These anatomical and morbid changes occurring in certain portions of the brain of the child, affect the cerebro-spinal nerve mechanism, and a paralysis of the spastic type is the result. These paralyzes may be monoplegic, hemiplegic or diplegic in form.

The history of the disease is very interesting. The first observations of an extensive nature were made by Little in 1853. Within more recent years the work of Strümpell, McNutt, Sachs, Osler and Gowers deserves special notice. In the *American Journal of Obstetrics and Diseases of Women and Children*, No. 8, 1891, I published the report of an extremely typical case of the diplegic form. In this case I traced the degeneration from the cerebral cortex down through capsule, the crista, the pyramids and the lateral tracts of the cord. So far as I have been able to ascertain, my case is the first on record where this degeneration was traced from the brain downwards in those cerebral palsies of children.

While it may be admitted that the view of Strümpell is possible, namely, that the cerebral palsy is due to polio-encephalitis, it must be held that this cause is an extremely infrequent one. The views put forth by Osler, Gowers, Sachs, McNutt and Hirt, that the palsy is due to either an embolism, a thrombosis or a hæmorrhage, must be accepted for the great majority of the cases. Gowers holds that the thrombosis is often formed in a cerebral vein, and extends into the adjoining sinus. In the case of an embolism it must be an artery that is involved, and is not infrequently a complication of some cardiac lesion. Hirt holds that many of these cases are of an infectious

* Read before the Clinical Society of Toronto.

origin, as exemplified by the occurrence of cerebral palsy in children in connection with scarlet fever, measles, whooping cough, etc. In cases where the palsy is due to a hæmorrhage, it is almost certain to be of a traumatic origin, either at birth or later on in life.

In the case to which I have already referred, as published in the *American Journal of Obstetrics and Diseases of Women and Children*, the lesion was evidently caused at birth, and was of the nature of a meningeal hæmorrhage, involving the leg centres. In another case, which I had under treatment some years ago, the child, three years of age, fell from the table. There was subsequently developed a typical case of spastic hemiplegia, involving the arm more than the leg. No doubt, in this case, there was a meningeal hæmorrhage. In the case which I exhibit here to-night, it seems to me that the diagnosis is that of a thrombosis, involving the veins and longitudinal sinus, so as to affect the motor areas on both hemispheres.

The later pathological anatomy found in these cases varies a good deal. They can, however, be grouped under two heads: (1) atrophic sclerosis, and (2) parencephalus. Embolism or thrombosis of a fair-sized artery could give rise to necrotic changes in the brain, and, later on, to cystic degeneration or parencephalia. In like manner, a blood clot by its pressure would arrest the development of cerebral convulsions, and after the clot had disappeared, would leave a cavity. Sclerosis and atrophy would arise from embolisms, thrombi or hæmorrhages, where these produced inflammations and irritative changes. But all the exact primary conditions of atrophic sclerosis have not yet been determined.

The case which I present to-night took ill on the 22nd August, 1893. For three or four days he complained of headache and loss of appetite, with slight fever. My attention was directed more to the possible existence of typhoid fever than anything else. On making a visit to another patient in the house, I was informed that the boy had been complaining of spasms in his left arm. On examining it I found it to be spastically paralyzed. Next day the left leg was also spastic. The day following the patient was unconscious; the four extremities paralyzed and spastic; the neck quite rigid; the eyes strabismic, and marked trismus. I noticed an angry-looking sore on his heel, which I was informed was due to a burn. While I was attending him first, and while he was conscious he was quite positive that he had not been hurt.

I suspected that some infection had entered the system and had given rise to tetanus. The temperature was 105° F. The wound was cleansed and properly dressed. The patient suffered very much from tetanic spasms of the muscles, though not from actual convulsions. An ice bag was applied to the head, and the body sponged with tepid to cold water. A bromide and chloral mixture was ordered for the spasms; but hypodermic injections of morphia acted much better. The patient was in a condition of perfect unconsciousness for one month.

I have already stated that I regarded this case as one of veno-sinus thrombosis. There was no history of injury to lead one to suspect meningeal hæmorrhage. The heart was perfectly normal, so that it was not likely that there had been an embolism. Thrombosis occurs in connection with scarlet fever, whooping cough and other conditions, where there is some infection in the system, but not such an infection as necessarily leads to suppuration. It is quite possible that some infection had entered the system from the burn above mentioned, and yet not such as to produce an abscess, but such as to give rise to a thrombus, as in scarlatina cases. On this point, however, I am not dogmatic.

The mental condition of the child is improving slowly, but I have grave doubts if the restoration in this respect will be perfect. The condition of the muscular system is very bad. Both upper extremities are very much involved, and, no doubt, in spite of all efforts there is going to be considerable deformity. The lower extremities are not so seriously implicated as the upper. The somatic muscles are also affected, and the neck is still stiff. I have noticed, occasionally, some indications of athetoid movements. The condition mentioned by S. Weir Mitchell of lead pipe paralysis is exceedingly well shown in this case. Flex or extend either of the upper extremities, and it remains in the new position. This is true, to a lesser degree, of the legs. The reflexes are increased, but the spastos is so marked as to interfere with the exhibition of the myotatic contractions.

As to the prognosis, I might very appropriately quote the words of Hirt, that "*quoad validitatem* it is absolutely bad. Complete recovery is impossible." Certain important sections of the brain are irretrievably ruined. The direct consequence of this is that the perverted muscular phenomena must persist.

The case is so clearly one of cerebral palsy that I refrain from making any differential diagnosis between it and the spinal type of spastic paralysis in a child where the lateral tracts are diseased, without any accompanying lesion in the brain.

To what is the spastic condition of the muscles due? This is an easy question to ask, but by no means an easy one to answer. J. Hughlings Jackson and H. Charlton Bastian have held and taught for some time that if the dorsal part of the cord is completely destroyed in its transverse axis, there will be no reflexes in the parts of the body supplied by nerves coming off from the cord below the injury or disease. They hold that the cerebrum inhibits the deep reflexes, and that the cerebellum increases them. When the motor path anywhere in the cerebro-spinal portion is destroyed, the controlling power of the cerebrum is lost, while the cerebellar influx, still going on, produces the spastic condition. In support of this view, cases are cited where there were complete transverse lesions of the cord, in the upper region, with absolute loss of the knee jerk.

Against this view we must range such men as Gowers, Buzzard, Bristowe, Hirt, etc. W. R. Gowers shows that in cases of injury to the dorsal part of the cord, with loss of muscular reflex, there is also loss of skin reflex, and also muscular atrophy, with the electrical reaction of degeneration. His view of these cases is that, in injury to the cord in the dorsal region, the degeneration that ensues is of an irritative character; and, when it descends to the lumbar region, it excites into activity changes that destroy the roots of the lumbar nerves, and in this way differs from those cases of descending degeneration where the reflexes are increased, instead of being lost. There are heavy arguments in favour of both views. In my papers on the knee jerk, which appeared some time ago in the *New York Medical Record*, several cases were reported that would seem to uphold the opinions of Jackson and Bastian. We must wait patiently for pathological investigation on these cases, as the clinical evidence alone is not sufficient. If the view of Gowers should be finally proven correct that, in all cases of injury of the cord, in the dorsal region, where the knee jerk is lost, there is a descending irritative change in the cord, as well as a descending degeneration, we must regard the cord as a chain of reflex centres, and that these centres pass into a condition of abnormal activity when the influence of the cerebrum is cut off. The final settlement of this vexed problem will be of great value in diagnosis and prognosis, and will do much to throw light upon the normal physiological functions of the human spinal cord.

UTERINE FIBROIDS—TREATMENT AND REPORTS OF
RECENT CASES.*

BY ALBERT A. MACDONALD, M.D., TORONTO.

Treatment of this diseased condition has been, and is still undergoing very great changes. It seems like only a few years since, owing to the marvellous results claimed by Hildebrant, patients were filled with ergot. Time has shown that in some cases it will promptly control hæmorrhage, and that by producing powerful uterine contractions it will often produce a temporary diminution of size. This action is most marked at or about the time of the menopause, and in small interstitial tumours it may at this time be useful.

Hydrastis *Canadensis* seems to act chiefly upon the small vessels of the uterine mucosa, and is of use in some cases of bleeding fibroids. It acts as a palliative only; as do other drugs.

Uterine fibroids, not being necessarily fatal, differ from other uterine and ovarian diseases, and give greater scope for palliative measures. We must not be carried away however, by the thought that such tumours diminish, as a *sure sequel to the menopause*, or our less radical modes of treatment. Each case must be studied by itself. A small interstitial fibroid may be arrested by drugs, whilst the same means would do harm in a subperitoneal tumour.

Some eight years ago electricity was brought to our notice with a great flourish, and, following the enthusiastic opinions expressed by Apostoli and others, we were inclined to think that no man was up to the times unless he was fully equipped with a sixty-cell battery, and electrodes, milliamperes, etc., with which he could dose his patients with the subtle remedies flowing between the positive and negative poles. The doses were accurately measured and given according to scientific principles. What have the results been? In my hands I have only one symptomatic cure to report:

Miss S., æt. 33 (who had always been healthy with the exception of two attacks of acute rheumatism), applied for treatment. She had pain and hæmorrhage at irregular intervals, and was in consequence prevented from attending to her household duties. On examination, I found a retroflexed uterus with an interstitial fibroid, about the size of an orange, in the posterior wall. She could only stand comparatively small doses of the galvanic current, but under treatment for three months, the tumour became smaller, her pains ceased, and her condition was very much improved.

In some cases I found temporary lessening of pain and hæmorrhage.

But on the subject of electricity I am not competent to speak from my own experience. It has been given extensive trials, and we may safely rely upon reports such as were made to the Berlin Gynæcological Society, where 143 cases were presented by men of undoubted reputation and experience. In this series of cases, one only was cured. It was a tumour the size of the fist. Treated by P. Brase. Sixty or seventy per cent. of this series were relieved. Thirty or forty per cent. were either not relieved or made worse. From this and our own experience we learn that, though electricity has not been proved to be the powerful and subtle remedial agent which we

* Read before Toronto Clinical Society.

were at first led to hope it might be, it is of benefit in properly selected cases. In small interstitial fibroids and subperitoneal growths the pain may be relieved and hæmorrhage may be so brought under control that the patient is tided over the menopause, when in many cases a beneficial change takes place. In large tumours, in pedunculated tumours, œdematous, submucous, or in fibrocystic tumours, nothing but harm would follow treatment by large doses of electricity.

Electro-puncture I consider to be quite as dangerous as radical treatment, and I have not seen it productive of any good; whilst on the other hand it has been productive of serious harm.

Both poles of the galvanic battery are caustic as well as electro-chemical in their action. The positive pole is more intensely caustic than the negative, and upon this intra-uterine chemico-caustic action of the positive pole we rely, though to the mysterious interpolar electrolytic action, causing blanching at one pole and congestion at the other, may be attributed its share of whatever beneficial results follow. The relief of pain is said to be due to the interpolar action of the galvanic current.

The electro-caustic destruction of diseased uterine mucosa may, however, be the chief factor in relieving the pain.

Briefly I will refer to a patient who had been under observation for about fifteen years, and who died recently under my care, untreated for her tumour:

Miss B., æt. 52, coloured; when young she was strong and healthy. The tumour appeared when she was aged between 30 and 40 years. It gave little trouble at first. It was multilocular and increased until after the menopause, when for a few years it was quiescent. Then a discharge commenced which gradually became putrescent, sapped her vital powers, made her unbearable to herself and others, and she died in great pain, from peritonitis and la grippe. She always refused treatment for the tumour—which at an early date could have been easily removed. No case of uterine tumour should remain untreated.

Palliative treatment should be employed where more suitable means are declined by the patient. Semi-radical means are still advocated by a large number of successful men, who are bold operators.

We have removal of the ovaries and tubes, as advocated so strongly by many, and the tying of the vessels of supply as first practised by F. Martin.

Oöphorectomy is opposed by some on the ground that it does not give complete and uniform success. It will, however, remain as a recognized operation on account of its perfect safety and the fairly good results which we know follow in most cases.

Ligation of the vessels of supply seems to be based on scientific grounds. It is still on trial and we must await results before pronouncing upon it. It has the merit of being safe for the patient and easy for the operator. It would be applicable at an early stage of the disease, and in cases where the patient could not bear the shock of complete removal.

A patient now under my care presents rather typical symptoms of those for whom oöphorectomy is suitable:

Mrs. M., æt. 35, married, had a healthy child seven years ago. She herself has always been healthy, though her mother was under my care for fibro-cystic tumour of the uterus, for which she refused operation. Three years ago she noticed metrorrhagia with great weakness and general debility. Her medical attendant tried various remedies without giving benefit.

Examination revealed enlarged, softened and retroverted uterus. Considerable

pain and bleeding. Under chloroform I dilated the cervix, curetted the endometrium and swabbed out with iodine. Relief from bleeding and pain followed, but the tumour continued to grow.

I therefore removed both ovaries and tubes, this being a perfectly safe operation in such a case, and giving promise of good results. During the month following the operation, the uterus had decreased in size to an appreciable extent, and the general condition of the patient has improved to such a degree that she looks well and pronounces herself to be feeling better than she has for three years. It is too early for me to foreshadow the actual result, but sufficient gain has been made to enable me to hope for a cure.

There is one question which such a case forces prominently upon us at this time, and that is, what is the operation of election? We look at the opinions of the strong advocates of complete extirpation, and compare their opinions and results with those held and expressed a few years ago. In 1880, Knowsby Thornton, in reporting some successful cases of operation to the London Obstetrical Society, says that he believes that "the removal of uterine fibroids by laparotomy is not only justifiable, but is an operation with a position in the immediate future in no way second to that held by ovariectomy." Thornton at that time had reported ten cases with six recoveries; at the present time results are much more favourable. I have not seen Thornton's latest reports, but J. M. Baldy, in the discussion on a recent paper, says: "Undoubtedly, by a skilful surgeon the uterus can be removed as safely as the appendages alone." When, *if ever*, this view is accepted by the profession, we will have for the relief of uterine fibroids an ideal operation. Our batteries may be laid aside, and when the earlier symptoms appear, the uterus with its appendages will be removed, before they contract adhesions, and render the operation difficult for the surgeon and dangerous to the life of the woman.

PHARYNGEAL SYPHILIS AND ITS LOCAL TREATMENT.

BY MURRAY M'FARLANE, M.D.,

Late Clinical Assistant, New York Polyclinic; Rhinologist, etc., St. Michael's Hospital, Toronto.

During the past couple of years I have been struck by the fact that syphilis is either becoming much milder than formerly, or that the local treatment of the secondary manifestations in the mouth and pharynx exercises a great influence in lessening the severity of the skin and other lesions seen in this disease. From the nature of my present practice, I see the disease in its secondary and tertiary stages as it attacks the throat, the patient in many cases being in ignorance of the true nature of his malady, only seeking relief from the sore throat of which he complains. It is a fact well known to all, that in the great majority of cases of constitutional syphilis, the mouth and pharynx has a greater predilection to become attacked by the manifestations of the disease than any other portion of the body, excepting the vulva and anus; for, according to Martellière (*De l'Angine syphilitique Thèse de Paris*), fully 75 per cent. of all cases of syphilis present pharyngeal and buccal lesions.

It has also been ascertained that the mucous patches and other secondary eruption in the throat contain a virus second only to the primary lesions in power of contagion,

and it may be possible that much of the severity of the disease results from an absorption of this poison into the system in a manner analogous to the absorption of pus from the pustule, causing the well-known secondary fever of variola.

One thing is certain, that in fifteen cases of secondary syphilis, seen by me in the past two years, whether the result of chance, mildness of attack, or thoroughness of local treatment of the pharyngeal lesions, the skin and other symptoms usually seen were of an exceedingly mild character; in fact, after the healing of the mucous patches, the only indications of the disease were a few transient papules, while in three cases there was a slight falling out of the hair.

I am aware that many say that you may have severe throat symptoms with very slight lesions in other parts of the body, yet this very severity of the pharyngeal attack draws decided attention to the throat, and local treatment is very apt to be thoroughly carried out, with the result of preventing further systemic poisoning.

While in Hot Springs, Arkansas, I found that a number of the medical men there had noticed this beneficial result of local treatment, and the throat and mouth medications are applied with rigid care daily while the baths are being taken. They don't trust the waters alone by any means.

Sir Morell Mackenzie went so far as to say that he seldom employed any specific treatment for adults, using local treatment entirely, and added that "I have rarely met with tertiary phenomena in the throat amongst those whom I previously treated for the earlier manifestations." ("Pharynx, Larynx and Trachea," p. 69.)

Few, of course, are willing to go so far as to leave out constitutional treatment by the usual remedies employed, but I do feel assured that those who are thorough and careful in the local treatment of the throat lesions in syphilis, will find themselves amply repaid for their pains by the subsequent immunity of the patient from many of the severer symptoms of the disease. As to the methods of local treatment, I find that Churchill's tincture of iodine, carefully applied to all visible patches, after carefully drying them by means of a cotton holder, using cocaine, if preferred, on a nervous patient, to ease the smarting pain of the iodine, has given me the best results. This may be done every second day, acrolozone or peroxide of hydrogen being employed in the interval.

The patient may be given a mouth wash for home use, containing "Listerine," or similar mild antiseptic, to be used night and morning. I sometimes employ a solution of argenti nitras, grs. xxx. ad \bar{z} i., in place of the tincture of iodine, and find it very efficacious.

Correspondence.

The Editors are not responsible for any views expressed by correspondents. Correspondents are requested to be as brief as possible.

'LODGE PRACTICE,' OR RATHER, 'CONTRACT PRACTICE.'

EDITOR DOMINION MEDICAL MONTHLY :

SIR,—The facts given in your editorial are about the first that I have seen ; most of the correspondence seems to be random opinions. If Dr. Kidd, who claims to have found practice with his lodge remunerative, will give us the figures, it will add something of value to the discussion.

I have no facts from personal experience, but ask leave to present the case as it appears to me, more particularly after reading an article in the September *Forum*. There it is stated that private benefit and burial societies have been a part of the industrial life of Germany for centuries. It was found that the strong and fortunate—that is, those who least needed them—were taking advantage of these societies. The Government stepped in some few years ago, and passed a compulsory insurance law whereby one and a-half per cent. of the normal wage of a labourer is contributed (one-third by employer, two-thirds by employed) to a fund "to remove fear of positive want and suffering." Out of this fund the labourer receives free medical care and all appliances, besides an amount equal to one-half his wage as sick money for thirteen weeks. In south-west Germany the Trade Association finds it to its advantage to secure specialists of first rank from Heidelberg, Mannheim and Freiburg.

In one instance 51,000 persons were insured ; there were 305,000 cases of sickness cared for by physicians at a cost of \$350,000, with an average of five visits from the doctor for each case.

This insurance shows us "the new principle that whatever adds hopefulness

and a sense of security to those on the verge of poverty will be far more certain to inspire in them the active energies of self-help than any motive which springs from fear and disgrace." The poor in Great Britain can always get bread and medical attendance at the poor-house, but it is considered a disgrace to be so poor. There is at present a movement on foot to appoint a qualified medical man as parish doctor with a fixed salary, and this to me is a recognition of the fact that no matter how poor, if a man is sick, he should have the opportunity of regaining his health. Under "contract practice" we have ship, army, poor-house, hospital, etc., doctors, and these cannot be done away with. It appears to me that the right of a medical man to contract for the use of his time and abilities cannot practically be interfered with. The only possible improvement is to raise the fees of the members of the lodges, or, what would be more equitable to all parties concerned, have an actuary determine from year to year what fees should be paid by each lodge, taking the facts of age, employment, condition, etc., into consideration. If this were done, the doctor could sign the contract without loss of dignity and respect, because he would be contracting to do an amount of work estimated on the facts of the case, and there would not be any underbidding, because the amount would be fixed by the actuary for all comers.

NORMAN WALKER, M.D.

Toronto, Jan. 15th, 1894.

IS ALCOHOL A SEDATIVE AND STIMULANT?

EDITOR DOMINION MEDICAL MONTHLY :

SIR,—I have read Dr. Harrison's reply to my criticisms in your last issue with great interest. Like the writer, it is fair, liberal, and manifests only a desire for

truth. From it I learn that he has much less confidence in the stimulant and restorative powers of alcohol than I had inferred from his paper. He says, "I do not use it very frequently in my practice." And again, "I have never expected it, as a stimulant, to have more than a temporary effect." What length of time the stimulant effect lasts, and whether the resulting depression does not more than counterbalance the stimulant effect, he does not say. But I respectfully submit that the Doctor's practice does not harmonize with his theory. For if alcohol be a stimulant of any value, a man of such extensive experience must have found frequent, very frequent, uses for it. I claim that the average practice of to-day is not, as the Doctor does, to prescribe it for a "short time" only, but that it is prescribed frequently, and for days and even weeks at a time, and several bottles of brandy are sometimes consumed by a single patient.

Dr. Sloan's letter, in the same issue, shows this. He says, "Wherever waste exceeds repair, wherever the powers of assimilation are defective, alcohol rationally given affords fuel to feed the lamp of life." That is the stimulant theory in a nutshell, and I ask how could anyone holding such views fail to prescribe it frequently? How many acute diseases are there in which, at some stage, waste does not exceed repair; or how many in which the powers of assimilation are not defective? I consider it a proof of the skill and acumen of Dr. Harrison that his practice has been in advance of his theory. The Doctor says that I seem to have prescribed alcohol indiscriminately. Allow me to say that when I believed alcohol to be a stimulant, I acted up to my theory, and anyone who believes in that theory must find frequent uses for it. He will allow few patients, especially acute cases, to die without prescribing alcohol in the

hope of keeping them up till a favourable turn may take place.

Now that I believe that alcohol is a sedative, I prescribe it where a sedative is called for, and find that I can make my practice and my theory agree much better than before. The stimulant theory cannot be reconciled with the uses to which it is applied. On the other hand, every effect, beneficial or otherwise, can be explained by the sedative theory. If alcohol be a stimulant, why do we so frequently prescribe it to assist in procuring sleep? Why is it such an excellent antispasmodic? and why is it so frequently prescribed to allay nervous disturbance? If alcohol be a stimulant, why is it not useful in short but severe trials of strength? Why does "one small glass destroy a man's usefulness for the day" in the arctic regions? And finally, if alcohol be a stimulant, why do the most eminent men in the Old Country say that it is a sedative?

I have no desire any more than Dr. Harrison to enter into a controversy on this subject, and if it degenerated to that level I would drop out. So far, however, I consider it a pleasure to exchange views with such men as have written in your last issue.

H. ARNOTT.

London, Jan. 10th, '94.

SANITARY NOTES.

AGAINST THE SPREAD OF DIPHTHERIA. —At the meeting of the Academy of Medicine (Paris) October 31, Mr. Nocard presented a report showing conclusively the happy results of an intelligent and rigorous application of sanitary measures against the spread of diphtheria.

In the islands St. Pierre and Miquelon, diphtheria has for a long time caused great loss of life. One epidemic in particular which lasted from May 1st, 1890, to September 1st, 1891, caused sixty-three deaths. The authorities resolved to adopt

rigorous measures of protection, and under the skilful direction of the governor, Mr. Feillet, practical application of the rules followed swiftly on the resolutions taken. It was made obligatory on physicians to report all cases of diphtheria in their practice to the director of the Sanitary Service. A sanitary corps was organized to see to the scrupulous application of the rules of isolation and disinfection.

It was made obligatory that after the recovery or death of the patient, everything which had been directly or indirectly in contact with him had to be disinfected, and entrance to the infected place was forbidden until complete disinfection had taken place. All these measures were done gratuitously, the expenses of the same having been met by a grant of money voted unanimously by the general council.

The happy effects of these reforms soon appeared; during the ensuing twenty-one months only twenty-three deaths occurred from diphtheria, which makes a decrease of eighty per cent. in the mortality.

DISINFECTION OF APARTMENTS. — A committee composed of Messrs. Bucquoy, Herard and Grancher, was appointed by the Academy of Medicine to report on the desirability of asking the public authorities to oblige hotel-keepers and proprietors of sanatoria to disinfect rooms which had been inhabited by consumptives after the death or departure of these persons. — *La Tribune Medicale*.

MUMPS. — At a meeting (October 13) of the Societe Medicalc des Hopitaux, Mr. Catrin presented a report of 159 cases of mumps, which he had treated at the Val de Grace Hospital from November, 1892, to May, 1893. There were 128 cases of double mumps; in twenty-nine cases the disease was confined to one side, and in two the only sign of the disease was orchitis. Mumps rarely begin on both sides at once, but they appear on the right side as often as the left; generally

the swelling appears on the second side from twelve to forty-eight hours after the first side is attacked; sometimes the interval may be from four to five days.

Mr. Catrin noticed prodromes in 102 cases. They consist of malaise, headache, chills, nose-bleed, earache, pains in the joints, etc., or more frequently one of these symptoms predominates. He says, "One of the most frequent symptoms is pharyngitis, with or without tonsillitis. Seven times out of seventeen in the month of April I observed the jutting out of the orifice of Stinson's duct, and regretted that I did not look for it sooner. Pyrexia seems to me the principal cause of the dryness of the mouth, for it is one of the most common symptoms. I have found it on 111 occasions, temperatures oscillating between 100 $\frac{2}{3}$ and 105 $\frac{1}{3}$ F. It exists, probably, in all cases. Several of the patients did not enter the hospital until the third, fourth or fifth day of the disease. There is no correlation between the bulk of the swelling and the gravity of the disease.

In some cases, the parotid gland alone is affected; in others, it lies buried in a gelatinous œdematous mass of peri-glandular tissue. The submaxillary glands often participate in the inflammation, and sometimes the sublingual glands. The mean duration of the disease is twenty-nine days. This is a higher figure than what is generally quoted, but I consider it exact, because I have seen men discharged as cured re-enter hospital some days afterwards with an orchitis, an arthritis or a nephritis; besides, after fifteen or twenty days I found the micrococcus of mumps still present in the blood of patients.

Out of 19,458 men having had mumps in the course of several epidemics, there was only one case of death, and as the patient died at his own house, it is difficult to state the exact cause of his death.

I have observed a coincidence between an epidemic of mumps and one of measles.

Recurrences are not so exceptional as is generally believed. Cases are reported by authors, of patients who have had them five times. The most frequent complications are orchitis and albuminuria. I do not consider a simple congestion of the testes as an orchitis, as no simple congestion of these organs is followed by atrophy. Cases of orchitis appearing at the outset of the disease, appear to me of doubtful origin.

Mr. Antony, who was associated with Mr. Catrin on the report, thought that the dryness of the mouth was only noticeable when both parotid glands were affected. He thought this symptom was due to the inflammation of the salivary glands and not to the fever.

DISEASES WHICH MUST BE REPORTED IN FRANCE.—The French Academy of Medicine has adopted the following list of contagious diseases, which physicians are obliged to report: Cholera and choleraic diseases, yellow fever, the plague, variola and varioloid, scarlatina, the sweating sickness, diphtheria, typhoid-fever, typhus fever, dysentery, puerperal infections, ophthalmia of newly-born babes.

HYGIENE IN RUSSIA.—(*La France Médicale*.) Venereal diseases, especially syphilis, appear to have become a regular plague in the Caucasus as well as the Southern and Eastern parts of Russia. During the harvest season thousands of farm labourers of both sexes assemble in these regions, and live together in a condition of surprising promiscuity. These peasants, after their return, infect their neighbours. For instance, in four months' time twenty-three persons were syphilized by one and the same individual.

To stop this plague, the governmental

measures adopted are: providing prostitutes with cards and subjecting them to regular inspection; periodical examination of men working in factories and other commercial establishments, also of soldiers and labourers returning to their homes; examination in villages at the request of the inhabitants of every suspected person, isolation and treatment of venereal cases in general or special hospitals, and the distribution of pamphlets explaining the infectious character of venereal diseases, and the necessity there is of being treated for the same.

Certainly these measures appear strongly opposed to personal liberty, the hobby to which some hygienists attach a great deal of importance.

In Russia in Europe, there is one hospital bed for a population of 1,600 persons; in the Caucasus, one for 12,500; in Siberia, one for 3,000; and in Central Asia, one for 16,000.

The number of physicians is in the same proportions. One for 9,200 in Russia in Europe; one in 11,600 in the Caucasus, and one in 48,500 in Siberia!!

In addition to regular physicians, civil and military, there are 11,959 male and female Feldschers, or irregular physicians, who have received some medical education, and have attended a hospital service for four years. There are, however, many districts in which there is not even a Feldscher. In Russia there are only three sewered cities—Warsaw, Odessa, and Yalta. Elsewhere, privy pits are in general use. In addition, the water supply in towns is extremely defective; out of 86 central towns there are only 46 provided with water works, and of the 46, 31 supply an inferior or very impure water. This condition of affairs probably explains the formidable epidemics of cholera which prevail in Russia.

J. J. C.

Dominion Medical Monthly.

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TORONTO, JANUARY, 1894.

TORONTO WATER SUPPLY.

The daily press and a great many citizens assume as a fact that the water of Lake Ontario, close to the city, is pure, and that everyone ought to be satisfied if it is delivered at the pumping-house in the same condition in which it exists near the intake pipe. This assumption is open to two formidable objections. Toronto is certainly fortunate in being able to discharge her sewage into a bay, instead of pouring it directly into the lake from which her water supply is taken. The island, lying between the city and Lake Ontario, intercepts a considerable amount of organic matter, or at least prevents it from commingling with the pure water of the lake. But not all. A good deal of filth is borne lakewards from the bay through the eastern gap when the wind blows from the west, and through the western gap when it blows from the east.

Bacteriological examination of the water proves that sewage-tainted water, with a very slight diminution of the bacteria, is regularly borne into dangerous proximity to the intake.

These bacteriological examinations were made by the Provincial Board of Health in July, 1891, when only ordinary bay sewage would be wafted in and out of the island gap, according to the direction of

the wind. In spring or after a freshet, such as we have had recently, immense quantities of filth are liberated and added to the sum of ordinary sewage. This soon finds its way to the intake pipe by running out through the eastern and western gaps. We do not, therefore, think that a water tunnel would be a guarantee that our lake water would be always good. It would certainly be better than the present supply, which receives a liberal dose of bay sewage *in transitu*, but might at times contain sewage for the reasons already given, and in the spring and after a freshet would certainly contain a good deal of filth.

If Toronto sewage were intercepted by a trunk sewer and treated at the outfall, so that a purified effluent would be discharged into the lake or Ashbridge's Bay, the special germs of typhoid fever could be destroyed and their re-introduction, by means of the water supply, prevented. The Don might also be diverted into Ashbridge's Bay and another source of pollution removed from proximity to our water supply. The discharge from the Humber would always be more or less of a menace.

If a trunk sewer with a proper system of disposal of excreta at the outfall were provided, we do not think a water tunnel would be required. The reasons are obvious. As excremental sewage would no longer be discharged into Toronto Bay, the introduction of bay water into the intake pipe would be of slight moment. The expense of constructing a trunk sewer would be about the same as that required for building a water tunnel, which would extend a suitable distance into the lake, viz., about \$1,500,000.

The respective merits of the two schemes may be summed up thus :

A trunk sewer—water free from excremental sewage delivered through the present pipe ; a clean, pleasant bay, and an improved water front.

A water tunnel—water clean or foul, according to the season; no change in the bay, and an ever-present menace from excremental sewage to our water supply.

If the citizens, for excellent financial reasons, are unprepared to go on with either of these sanitary works, the cheapest and safest plan for obtaining a clean water supply is to filter what we have. It is a pity that the necessity for the boiling process should occur so soon again after our experience of last winter. It is true that boiling kills the pathogenic germs of disease, but it does not remove the filth from the water which contains them.

The people are incapable of taking the initiative in such a matter, and those of them at least who do not consider all sanitarians as "cranks," look to their health officer for guidance. It is, therefore, the duty of the city Medical Health Officer to advise his municipality as to the safest and withal the cheapest means of removing this constantly recurring impurity from our city water supply. The distinguished Prof. Koch, of Berlin, has recently demonstrated that the use of filtered water in Altona and Wandsbeck, both suburbs of Hamburg, has resulted in a great saving of life in these cities. While the mortality from cholera was large in Hamburg, which used the water taken unfiltered from the river Elbe, it was very small in Altona, in which the river water was filtered (*vide The Sanitarian*, September number, p. 246). It seems reasonable to conclude, therefore, that until we are prepared to construct a trunk sewer, which would remove all town sewage from proximity to our water intake, we should filter our present water supply and thus reduce to a minimum the dangers of having it contaminated with pathogenic and ordinary filth bacteria.

We commend these considerations, made in no dogmatic spirit, to the Toronto Board of Health.

Economy is the watchword: economy, with sanitary efficiency, is what we are endeavouring to advocate.

THE HEATING OF COLLEGE RESIDENCES.

It is admitted by the best of authorities that the proper temperature for a sitting-room, such as a student is intended to work in, should range from 60° to 65°F.; and that it should run from 50° to 55°F. during the hours of sleep. In some residence colleges we very much fear such a temperature is not maintained.

It is the custom, we believe, with some college authorities to have the steam turned off about 10 p.m., or 10.30 at the latest. The result is that the students' rooms soon become cold. We are well informed that, in some instances, they have to put on their overcoats, or wrap bed comforters around themselves. This is neither good for health nor study.

When the heating is turned off the students resort to the habit of closing doors and windows in order to maintain as much warmth in their rooms as possible. This, of course, means studying and sleeping in a badly vitiated atmosphere. Take a room of moderate size, with two or three students in it, with as many lamps or gas lights burning, with the doors and windows closed, and one can readily imagine the condition of the atmosphere in such a room in a very short time.

A very small extra cost would keep all college residences up to proper bed-room temperature. Were such the case, the student would not be afraid to let in a little fresh air, without running the risk of being frozen before morning. When water will freeze in a college bed-room, where young men are intended to study and sleep, we think it is time to write about this matter, and we trust that those in fault will soon correct the evil.

MOVABLE KIDNEY.

Palpation of the kidney is an important means of establishing the diagnosis of the condition in question. It ought to be practised with both hands, the patient having been placed in different positions (vertical, dorsal-lateral, genu-pectoral). To palpate the right kidney, the attendant places himself on the right side of his patient, his left hand under the lumbar region below the last rib, whilst his right hand, placed a little above and to the right of the navel, keeps up a steady pressure. In this manner one may often take a kidney between the fingers and examine it in a detached fashion. When this method fails, the patient should be placed in a horizontal position, lying on the side opposite to the kidney which is to be examined. According to the degree of mobility of the kidney, Paul Hilbert has made the following classification:

1st degree.—The lower half and end of the kidney may be felt: palpable kidney.

2nd degree.—The whole kidney may be taken between the fingers: movable kidney.

3rd degree.—The whole kidney may be examined and pushed inwards and backwards: displaced kidney.

Movable kidney is much more common among women than men. The same observation applies to the merely palpable kidney.

In one woman out of five the kidney may be palpated. Palpation should be practised in the manner indicated above, and the person examined should breathe deeply. The kidney rises in expiration and falls during inspiration, this to and fro movement enabling the attendant to recognize the kidney.

Israel thinks that this displacement of the kidney by the respiratory act is a physiological movement. He has demonstrated it in a male patient after the kidney had been exposed by an incision in the

loins. Hilbert has made the same observation in a rabbit after opening its abdominal cavity. Besides, the situation of the upper end of the kidney reposing on the crura of the diaphragm explains very naturally why this mobility occurs, and also why it increases during deep respiration.

Movable kidney occurs most frequently at from 30 to 40 years of age; it occurs also pretty frequently at from 20 to 30 years. It is found most frequently in childless women. Repeated pregnancies do not exercise any considerable influence in producing the lesion. In Hiller's statistic, in one instance the patient had strained herself in lifting a too heavy load; in another the displacement of the kidney seemed to be due to spinal curvature; in twelve cases there was prolapse of the liver; in two, inguinal hernias; in one, a prolapse of the vagina. In some cases all the viscera were prolapsed (enteroptosis of Glenard).

Küttner, in 89 cases of movable kidney, examined in order to ascertain the influence of this lesion on the stomach, found in 79 cases a dilated or prolapsed stomach. In his 100 cases, Hilbert found these conditions only 17 times.

According to Hiller, it appears that displacement of the kidney is accompanied by, or may induce, secretory troubles of the urinary organs, which may eventually bring on albuminuria.

In one of his cases (movable right kidney, left one simply palpable), Hiller found an acute nephritis, with large albuminuria, cylindrical casts and hæmaturia. Neither during the course of the disease nor afterwards did he discover any change in the shape or consistency of the kidneys. Out of 100 cases, Hiller found 15 who complained of symptoms directly due to movable kidney. He considers a merely palpable or slightly movable kidney as normal and requiring no treatment.

Cases of very movable kidney are re-

quired to wear a special form of bandage or abdominal supporter, not with the expectation of keeping the kidney reduced, but to limit its mobility and prevent the painful, twitching movements. In grave cases, which do not yield to medical treatment, the performance of a nephrorrhaphy must be considered by the surgeon.

EARACHE.—Dr. J. A. Thompson, of Cincinnati (*Cincinnati Lancet Clinic*, Dec. 2nd, 1893), reviews the causes of earache: 1. This may be due to furuncles in the external auditory canal. Remove any irritation, apply dry heat locally and give opiates internally. 2. Syphilitic ulcers and gummata may form in the external meatus. The treatment for syphilis is called for. 3. Diseases of the nose, such as hypertrophic rhinitis. The nasal disease must be treated. 4. Foreign bodies are often the cause of severe earache. They should be removed under the concave mirror by means of a small hook or pair of forceps, or by means of the syringe. 5. Acute inflammation of the membrana tympani is sometimes very severe. A five per cent. solution of cocaine, or a one per cent. solution of atropine should be dropped into the ear. Any abscess should be opened and treated with antiseptic douches. 6. Acute otitis media is greatly relieved in the early stage by means of cupping or leeching in front of the tragus. The hot douche gently used is also helpful. If the cavity is full of mucus, you can relieve the tension by the incision of the tympanic membrane, and the use of warm antiseptic douches. Sometimes the mucus can be evacuated by the Politzer bag. 7. Chronic catarrh of the middle ear, with adhesion bands, may cause great pain. In some of these cases the membrane and ossicles must be removed. 8. Chronic purulent-otitis media is sometimes painful. Polypi, granulations, etc., must be treated. The thickened membrane, as a rule,

must be removed. 9. Chronic suppurative inflammation of the mastoid cells must be treated by freely opening into the diseased cavities. The operation should not be too long postponed. 10. Disease in the teeth is sometimes a cause of severe earache. The eruption of the milk teeth may cause earache; and teeth improperly treated by the dentist.

ASEPTIC SURGERY FOR THE COUNTRY PRACTITIONER.—Dr. James B. Bullitt (*American Practitioner and News*), makes the following observations:

1. Coats and cuffs should be removed; a clean apron or towel fastened over the front; hands and arms are scrubbed in hot soap and water; special care is to be given to the nails; the hands are then rinsed in boiled water or alcohol.
2. The field of operation is rendered aseptic by being thoroughly washed with soap and warm water, any hair being shaved. This followed by alcohol or ether.
3. Sheets, towels, aprons, &c., can be completely sterilized by being scrubbed and then boiled in a five-per-cent. solution of washing soda.
4. Ordinary cheese or butter-cloth makes an excellent gauze, and can be sterilized by being placed in a steam sterilizer for an hour. It is then put in a jar that had been boiled and tightly stoppered. Iodoform can be sprinkled over it when needed.
5. The best sponges are cotton-wool tied in butter-cloth and placed for an hour in the steam sterilizer. Sterilized heavy linen make good substitutes for large flat sponges in abdominal operations.
6. Silk for sutures is sterilized by being boiled for fifteen minutes in the soda solution. It is then dried in the sterilizer and placed in sterilized, stoppered bottles, containing a five-per-cent. carbolic acid solution.
7. For flushing out a cavity, nothing is better than boiled water, or a physiological saline solution that has been boiled.

PHENOSALYL.—Dr. J. De Christmas (in *New England Medical Monthly*, Nov., 1893) states that phenosalyl, a clear syrupy liquid, consists of a mixture of carbolic, salicylic and benzoic acids, melted together and dissolved in lactic acid. This crystallizes at low temperatures, but a small quantity of glycerine prevents this.

Bacteriological tests have been very satisfactory with this compound. One in one thousand will destroy the spirals of cholera. A one per cent. solution will destroy the staphylococcus aureus, one of the most resistant of germs.

With regard to instruments, a two per cent. solution in water will completely sterilize them.

For clinical purposes, for the hands and for irrigation a one per cent. solution is used. It does not irritate.

A one or two per cent. solution is very valuable in cystitis. This is injected into the bladder and allowed to remain there for a few minutes, when it is removed by the catheter or voided spontaneously.

Two to ten per cent. pencils are of much value in the treatment of endometritis and urethritis.

In ophthalmia, in the form of an ointment, one part in one hundred or more of vaseline, or as an irrigation in the strength of 0.2 or 0.4 per cent., phenosalyl has been of signal service in inflammation of the conjunctiva, and of the margin of the eyelids.

HYSTERICAL AMBLYOPIA.—Dr. S. C. Ayres, of Cincinnati (*American Journal of Ophthalmology*, Nov. '93), reports five cases of hysterical amblyopia:

In Case I. by means of cross cylinders the vision of the right eye was brought up to .5 and the left to .1. The ophthalmoscope showed that there was no disease of the fundi oculorum. A course of treatment of rest, electricity, massage and tonics restored her to a normal condition,

both as to the field and acuity of vision.

Case II.—This case had been fitted with glasses. Shortly after this she came back in great alarm. The acuity of vision had changed from .9 to .1. There was no sign of disease in the fundus. In a short time, under judicious treatment, the scotoma disappeared and she recovered normal vision.

Case III.—This case was very amblyopic. The sight of the right eye was practically gone. While making the test for refraction the amblyopia suddenly disappeared.

Case IV.—When first seen her right eye had a vision of .9 and the left of .3. Homatropine was used and the case tested. The right had H. of 1D and the left increased from .3 to 1. While making the final test the amblyopia entirely disappeared.

Case V.—In this case there was extreme photophobia. The indications were that it was of hysterical origin. A strong spring speculum was inserted between the lids. The second morning she consented with reluctance to have this done, and complained of the pain. On the third morning she walked into the office saying that she was quite well, and would not require any further treatment.

Dr. Harlan, of Philadelphia, had a case of amblyopia of one eye for ten years in a young man, that disappeared under the refraction test. Dr. Moore, of New York, has also reported some interesting cases of amblyopia in men, that made good recoveries under proper treatment.

LATENT DIABETES.—At a meeting of the Academy of Medicine, Paris, 5th of December, Mr. Vorns presented the result of some new researches upon the subject of latent diabetes. (*La Tribune Medicale*.) He examined the urine of 600 men, all of the working class, without finding signs in a single instance.

He examined the urine of 100 persons

belonging to a higher social class and found sugar seven times. Well-to-do people are, therefore, particularly liable to be affected by diabetes.

These chronic cases may be considered under three heads:

1. Reducible form: 10-15 grains of sugar a day; treatment causes the sugar to disappear.

2. Irreducible form: Larger amount of sugar; does not yield to treatment.

3. Transitory form; large amount of sugar which disappears, and reappears without cause.

Mr. Worms has obtained good results in combining with a regulated diet the use of quinine, repeated purgatives and cold lotions to the head morning and evening.

TIC DOULEUREUX.—Dr. Jarre presented a report on the causation and treatment of tic douleureux of the face. His conclusions are as follows (*La Tribune Medicale*):

1. The disease known as spasmodic neuralgia, epileptiform neuralgia, tic douleureux of the face, etc., is due to a peripheral lesion seated in the terminal extremities of the fifth pair.

2. The exact and invariable seat of this lesion is a more or less extensive portion of the alveolar border of the upper or lower jaw, which is the seat of a cicatrix consecutive to former accidents of different kinds.

3. The intracatrical location of the original lesion brings tic douleureux into the same category as the neuralgia of the toothless, and the neuralgia affecting the stumps of amputated limbs, both of which are also of cicatricial origin.

4. The rational treatment of tic, therefore, ought to consist purely and simply of the ablation of that portion of the alveolar border comprising the original seat of the disease.

5. The ablation is done by first incas-

ing the soft parts with the galvano-cautery knife, removing the alveolar border by the bone forceps or saw, and subsequently rasping the wound in the bone.

6. The operation is not at all grave: the wound dressed antiseptically heals, ordinarily, in a few weeks without complications.

7. The results so far obtained give reason to hope that we are now in possession of a simple, rapid and harmless means of curing tic douleureux, a disease which, up to the present, has been classed with incurable diseases.

THE USE OF THE CURETTE.—Dr. Fancourt Barnes (in *The Medical Week*, November 24, 1893) reminds his readers that curetting the uterus is a grave operation and must not be lightly undertaken. 1. It is essential that the cervix be well dilated. He prefers the gradual method with tents to the rapid plan. He condemns sponge tents. 2. When the cervix is well dilated, the patient is brought under the influence of an anæsthetic and placed in either dorsal or lateral positions. 3. There are two forms of curette, the sharp and the blunt. Great care must be taken in using the sharp curette as a perforation may easily result. It is particularly useful in curcinomatous and sarcomatous conditions. The most useful form of blunt curette is that designed by Gaillard Thomas. It is passed into the uterine cavity and made to traverse every part of the interior. In passing it over the surface, certain parts may be noticed to be rough by the thrill imparted to the instrument. Special care should be given to these portions. The uterine cavity is then washed out with tr. iodi ζ i. or ζ ii. to the pint. An elastic catheter attached to a Higginson's syringe is employed for this purpose. An iodoform pessary and a dry tampon is then applied to absorb the discharges. 4. The complications likely to occur are perforations of the

uterine walls. Troublesome hæmorrhage comes on a few hours after the operation. This can be readily met by the application of hæmostatics. The most serious complications are inflammatory troubles. Pelvic cellulitis and peritonitis have been frequently observed. Strict regard to antiseptic precautions is the safeguard against these.

THE TREATMENT OF MORPHINE POISONING.—Dr. H. T. Penny, of Sand Coulee, Montana (in *Medical Sentinel* for November, 1893), records his experience with nineteen cases of morphine poisoning. As the result of this experience he concludes as follows:

1. Use the Faradic battery for hours if required; one pole on the side of the neck, the other over the diaphragm.
2. Next in value comes artificial respiration.
3. A hypodermic of apomorphine is better than either the stomach pump or emetics by the mouth.
4. Give belladonna, but cease its use as soon as the pupils dilate.
5. Ether, spirits ammonia arom., or caffeine, given hypodermically, are very helpful.
6. Flagellation is too fatiguing to the patient.

DEAFNESS AND SYPHILIS.—Dr. A. F. Plicque (*Gazette des Hopitaux*, November 14, 1893), remarks that in acquired syphilis the symptoms of aural trouble are diminution in the acuteness of hearing; vertigo; painful hyper-acuteness of hearing; severe auricular neuralgia, becoming worse at night; an intense neuralgia in the ear that yields to the iodides.

In the case of hereditary syphilis, the auricular troubles begin most frequently about puberty. There are often vertigo and nausea, without loss of consciousness, and without pain. The two leading symptoms are: 1. The bilateral loss of the

hearing. 2. The disproportion between the hearing through the air, which is relatively preserved, and the hearing through the tuning fork applied to the bones of the head, which is absolutely lost.

The prognosis in syphilis of the ear depends above everything else on the promptness with which the diagnosis is made and specific treatment instituted. In the gravest cases, the deafness is so acute, so lightning in character, that there is no time to act. These cases appear in the hereditary as well as in the acquired forms of the disease.

In these very acute cases the treatment at first should consist of hypodermic injections of strychnine and pilocarpine, with mercurial inunctions pushed rapidly to salivation. As salivation occurs the mercury should give place to the iodides of potassium, which in turn must be administered freely.

THE INDUCTION OF PREMATURE LABOUR.—Dr. John O. Polak, of New York (in November *Post Graduate*), claims good results for the following method of inducing premature labour: He takes two ounces of glycerine in a clean bottle. This is loosely corked with a V-shaped nick in the cork. The bottle is placed in boiling water for thirty minutes. This sterilizes the glycerine. The bottle is then tightly corked. The syringe, which has a long, flexible catheter end, is rendered aseptic by being washed internally and externally with perchloride 1-1000, and then washed in the same way with boiling water to remove all the mercury. The patient is thoroughly cleansed with green soap and warm water. The vagina is douched with a two-per-cent. solution of creolin. Half the aseptic hand is introduced into the vagina and the anterior lip of the uterus fixed with bullet forceps. The bougie is introduced on the side away from the placenta. Care should be taken to have the glycerine

welling out of the bougie, so as to expel all air. Of the glycerine 1½ ounces are slowly injected between the uterus and the membranes. Withdraw the catheter about half an inch and turn it round, then tampon the vagina with iodoform gauze.

TREATMENT OF NEURASTHENIA. — We take the following notes from an editorial in *Le Monde Medical*, for October, 1893. For the constipation which is so troublesome in these cases, give a pill of aloes and myrrh. For the flatulence and anorexia, a mixture of nux vomica, cascara sagrada, cardamoms and gentian gives good results. Against the anæmia, a pill composed of arsenic, aloes, nux vomica and reduced iron should be ordered. As a palliative to produce sleep and equalise the circulation, potassium bromide is very helpful. Granulated kola is indicated, along with other remedies, for the anæmia, dyspepsia and nervous phenomena.

COLD BATHS IN THE TREATMENT OF BRONCHO-PNEUMONIA AND PNEUMONIA. — In a leading article in *Le Monde Médicale* for November, 1893, the valuable therapeutic uses of the cold bath in these affections are discussed. The author says:

The cold bath acts on the temperature, the circulation, the nervous system and the secretions. The temperature is lowered. This is a fact of observation. The lowering of the temperature by the cold bath is much more desirable than by the use of chemicals, as antipyrine, etc. The temperature can be reduced one, two, or three degrees.

The cold bath acts very favorably on the circulation. There is a contraction of the peripheral arteries and an increase in the pressure in the left side of the heart.

On the nervous system the action of the cold bath is very marked. It lessens

the depression, moderates the excitement, and produces a calmness in the symptoms.

On the secretions the action is equally good. There is an increase in the flow of urine. The skin acts more freely. The toxins are thrown out of the system more freely, while their formation is greatly retarded.

Thus the cold bath lowers the temperature, modifies the pulse, regulates the circulation, calms the nervous phenomena, augments the secretions, increases combustion, and favours elimination.

PULMONARY ANTHROCOISIS. — Dr. E. Lancereau read before the Academy of Medicine, Paris (*La France Médicale*, November 24, 1893), a very interesting paper on this subject. He dealt with some cases of anthrocoisis that came under his observation among the polishers of carbon for electric apparatus. In one case the left lung was almost a solid mass of carbon. The pleura was thick and indurated. The lobes of the lung were obliterated. In the left lung there were several cavities, the size of a prune. Tubercles and the bacilli could be found in the cavities. The pleura was thick and brilliant. The large bronchi were dilated and the mucous membrane brown. He advises that the rooms where these carbons are polished should be thoroughly ventilated so as to carry away the dust.

TOXÆMIA IN TUBERCULOSIS. — Dr. W. Osler (*The Medical News*, December 2, 1893) remarks that the symptoms of profound toxæmia in tuberculosis, are met with under three conditions: 1. In rare cases, most commonly children, in which death may take place with symptoms of profound toxæmia before there are any extensive localised foci of disease. 2. In acute miliary tuberculosis there is often found toxic features, giving to many of the cases the clinical features of severe typhoid fever. 3. In chronic tuberculosis

there may develop, with or without fever, a profound toxæmia, with dry tongue, delirium, rapid pulse, and signs of intense intoxication. The author then reports a case where the temperature ran up to 105°. The *post mortem* revealed only a few tubercular glands in the neck; and a few tubercles in the liver and spleen.

MERCURIAL POISONING.—Dr. William Moser (in December number *Brooklyn Medical Journal*) remarks that so long as mercury is used in obstetric practice, even as weak as 1-3000 or 1-2000, cases of poisoning will occur. The clinical manifestations much resemble those of dysentery. The colon is the seat of important changes. A diphtheritic membrane is formed in this part of the intestinal tract. It is usually localized in the colon, but many extend into the ileum. This is the "colitis diphtheritica" of Virchow. The lungs, liver, heart and spleen show nothing characteristic. The stomach also is rarely affected. There are important changes in the kidneys. There is a deposit of phosphate of calcium in the epithelium, with fatty degeneration.

Items, Etc.

An International Food Exposition is to be held in Vienna next spring.

The fourth annual meeting of the Maritime Medical Association will be held in St. John in July next.

Dr. J. Russell Reynolds has been elected to succeed Sir Andrew Clark as President of the Royal College of Physicians.

At the regular quarterly meeting of the Niagara District Medical Association, held in St. Catharines on the 10th inst., Dr. Armour was presented with a requisition, signed by a considerable majority of the electors of the division, requesting him to be a candidate for the Medical Council.

Dr. A. H. Ferguson, of Winnipeg, Professor of Surgery in the Manitoba Medical College, has been elected Professor of Surgery in the Chicago Post-Graduate College. Dr. Ferguson will shortly take up his residence in Chicago. We congratulate the doctor and also the Chicago school upon having made so judicious a selection.

Book Notices.

Duties of Coroners. A Practical Treatise on the Office and Duties of Coroners Ontario and the other Provinces, and the Territories of Canada, and in the Colony of Newfoundland, with Schedules of Fees, and an Appendix of Forms. Third edition. By WILLIAM FULLER ALVES BOYS, LL.B., Junior County Court Judge, County of Simcoe, Ontario. Cloth, \$3.50; half-calf, \$4. On receipt of price this work will be sent, express charges prepaid, to any part of Canada. Address The Carswell Co. (Ltd.), Law Publishers, etc., 30 Adelaide Street East, Toronto, Ont.

"Changes in the law, and the exhaustion of the previous editions of this work, have made a third edition necessary. The former editions were intended for use in the Province of Ontario only, but this one is adapted to all the Provinces and Territories of the Dominion of Canada, and to the Colony of Newfoundland. The Coroners' Law in all these places has been brought down to the present time, and it is hoped the work will be found as reliable and useful in its extended field, as apparently it has hitherto been so found in the Province of Ontario.

"Upon the suggestion of a coroner, a new chapter has been added containing a programme of the ordinary proceedings at an inquest in consecutive order, with many of the forms required as the inquest proceeds, printed in their proper places, and the others referred to by their numbers in the appendix. With the chapter

open before him, while holding an inquest, no coroner need ever be at a loss to know what next to do, and it is believed this programme will be found a convenient and valuable addition to the book.

"The general arrangement and much of the text, as in the former editions, is taken from the well-known English work on the same subject by the late Chief Justice Jervis; and the medico-legal portions have been largely taken *verbatim et literatim* from the authors referred to in the notes."

This work is one of great value to the coroners of this country, and we have no hesitation in advising every coroner who attends to the duties of the office to procure a copy. It is full of most valuable information and is a safe guide.

We note that the form of oath of a Scotch witness, or one who swears with the uplifted hand, is given. We hope the unseemly practice of "kissing the book" may soon be entirely done away with.

The Uses of Water in Modern Medicine.

By SIMON BARUCH, M.D., Attending Physician to the Manhattan General Hospital and New York Juvenile Asylum. George S. Davis, Detroit, Mich.

The author of these two volumes of the Physicians' Leisure Library has long been known as an authority on the uses of water in health and disease. These two volumes now bring the therapeutic uses of water within the ready reach of every busy physician. We take it as a matter of course that every medical man ought to be fully posted on how to use water in every form in health and in acute and chronic diseases. It would be difficult, indeed, to fancy how any physician would attempt to carry on his profession without a knowledge of hydrotherapy. To the pages of Dr. Baruch's two handy little volumes he can turn with perfect confidence that he will find full and reliable

information for his guidance. The volumes of the Physician's Leisure Library are issued every month. They are from the pens of the best known writers. The set of twelve volumes is published in handsome form for the very moderate sum of \$2.50 a year.

Impotence and Sexual Weakness in the Male and Female. By EDWARD MARTIN, A.M., M.D., Surgeon to Howard Hospital, Clinical Professor of Genito-Urinary Surgery, University of Pennsylvania. George S. Davis, Detroit, Mich. 1893.

This little book of 102 pages constitutes one of the well-known series, published by George S. Davis, of Detroit, as the Physicians' Leisure Library. The subject is treated of under four headings: impotence and sexual weakness, postastorrhœa, involuntary seminal emissions, and impotence of the female. The style of writing is clear and direct. The matter is good. The rules laid down for the treatment of the different forms sound. We can heartily recommend the work to all who desire to make themselves familiar with the views of one who has given much study to this important subject. The work appears in the very neat style of the well-known publisher, George S. Davis. The paper, type and cuts are excellent.

The Popular Science Monthly. Edited by WILLIAM JAY YOUNG. New York: D. Appleton & Co., 1 Bond Street. Toronto Agency: N. G. Morang, 63 Yonge Street.

The January number contains many valuable and interesting papers, such as "Evolution: Prof. Huxley," by St. George Mivart; "Emotions and Infections," by M. Ch. Féré; "Surgical Methods: Biology," by Frank Cramen; "Legal Preventives of Alcoholism," by M. J. Bergeron, etc., etc

Progress of Medical Science.

THE GREAT MEDICAL ERROR OF THE DAY.*

BY DR. WILLIAM GOODELL, PHILADELPHIA.

In the treatment of the diseases of women at the present time there seems to me to be a tendency to lay too much stress upon lesions of the reproductive organs. Too little heed is therefore given to the nerve element of women's diseases, and as a natural sequence the surgical feelers and antennæ of the medical profession, always too keenly sensitive, vibrate vehemently at the approach of an ailing woman. This trend of the profession, to appeal to the knife as the great panacea for woman's diseases, is seen everywhere. It prevails alike in city, town, village, and hamlet. It asserts itself in every medical discussion, and stands out in bold relief upon the pages of every medical journal. It has caused many needless sexual mutilations and unnecessary operations, and it is, in my opinion, the great medical error of the day.

It comes, not so much from the glamour surrounding surgery, nor from the greed of gold, but from errors of judgment and from mistaken diagnosis. These arise from the fact that woman, through her sensitive and emotional organization, is a bundle of contradictions. More pitiful than man, and more long-suffering, her anger is more cruel, and her jealousy more relentless. Feebler than man, an appeal to her affection will make her surpass him in sheer muscular endurance. Who can nurse her kin so untiringly and with so little rest as even a frail woman can? What father can equal a mother in fondling and soothing a sick and fretful child through the weary night watches? What man can undergo the sheer fatigue,

the strain and stress that a woman will for those she loves? Even in her pleasures, her physical amusements, she will, through keen enjoyment, often outtire the strongest man. In one word, she is a creature of impulse and of emotion. But all nerve strains, whether arising from the emotions, from the affections, or from the passions, have their reactions, and very strange and very misleading reflexes come from the loss of brain control over inordinate lower nerve centres. For what is hysteria but nerve misrule and the panic of the brain at incompetent control? The secret and sanctity of woman's inner life lies in her affections, and what disturbs them disturbs the nerves, and through them their environment of flesh and blood. These unruly nerve lights, flashing and fading at their own will, and without control in the different organs of the body, the most careless observer may sometimes plainly see, for the clew is then as secure as the steps of a geometrical problem. But then again the symptoms are more frequently obscure. Often they are as misleading as the lapwing's flight. To construe such symptoms, to unfold their sense, and to paraphrase them, so as to gain a true conception of their character, often demands a deep acquaintance with human life and a keen insight into the most secret springs of its action.

Nerve strain, or nerve exhaustion, comes largely from the frets, the griefs, the jealousies, the worries, the bustles, the cares and cares of life. Yet, strangely enough, the most common symptoms of this form of nerve disorder in women are the very ones which lay tradition and dogmatic empiricism attribute to ailments of the womb. They are, in the usual order of their frequency, *great weariness*, and more or less of *nervousness*, and of *wakefulness*; inability to walk any distance and a bearing down feeling; then headache, napeache, and backache. Next comes scant or painful, or delayed or

* Extract from *University Medical Magazine*, January, 1894.

suppressed, menstruation; cold feet and an irritable bladder; general spinal and pelvic soreness and *pain in one ovary*, usually the left, or in both ovaries. The sense of exhaustion is a remarkable one; the woman is always tired; she spends the day tired, she goes to bed tired, and she wakes up tired—often, indeed, more tired than when she fell asleep. She sighs a great deal, she has low spirits, and she often fancies that she will lose her mind. Her arms and legs become numb so frequently that she fears palsy or paralysis. Nor does the skin escape the general sympathy. It becomes dry, harsh, and scurfy, and pigmentary deposits appear under the eyes, around the nipples, and on the chin and forehead. Blondes are likely to get a mottled complexion, and brunettes to be disfigured by brown patches or by general bronzing. Sometimes the whole complexion changes to a darker hue, and an abnormal and a disfiguring growth of hair appears on the face. There are many other symptoms of nerve strain, but since they are not so distinctly uterine in expression, and therefore not so misleading, I shall not enumerate them.

Now, let a nervous woman, with some of the foregoing symptoms, recount them to a female friend, and she will be told she has 'womb disease.' Let her consult a physician, and he, especially if she has backache, bearing down feelings, an irritable bladder, and pain in the ovaries, will assert the same thing, and will diligently hunt for some uterine lesion. If one be found, no matter how trifling, he will attach to it undue importance, and treat it heroically as the erring organ. If no visible or tangible disease of the sexual organs be discoverable, he will lay the blame on the invisible endometrium, or on the unseeable ovaries, and continue the local treatment. In any event, whatever the inlook or the outlook, a local treatment more or less severe is bound to be the issue.

Yet these very exacting symptoms may be due *wholly* to nerve strain, or (what is synonymous) to loss of brain control over the lower nerve centres, and not to direct or to reflex action from some supposed uterine disorder. Neither, for the matter of that, may it come from some real, tangible, and visible uterine lesion which positively exists. Thus it happens that a harmless antelexion, a trifling leucorrhœa, a slight displacement of the womb, a small tear of the cervix, an insignificant rent of the perinæum, or what is always present, an ovarian ache, each plays the part of the will-o'-the-wisp to allure the physician from the bottom factor. To these paltry lesions—because they are visible, palpable and ponderable, and because he has, by education and by tradition, a uterine bias—he attributes all his patient's troubles; whereas a greater and subtler force—the invisible, the impalpable, and the imponderable nervous system—may be the sole delinquent. The sufferer may be a jilted maiden, a bereaved mother, a grieving widow, or a neglected wife, and all her uterine symptoms—yes, every one of them—may be the outcome of her sorrows, and not the outcome of her local lesions. She is suffering from a sore brain, and not from a sore womb.

Strange as it may seem, the coccygeal joint is very liable to play the barometer to any kind of mental worry. The serious surgical blunder is, therefore, not infrequently made of extirpating, for sheer hysterical coccygodynia, this important bone—important from its muscular origins and insertions. I have known coccygodynia to attack a lady after the death of her mother. Every kind of treatment failed, but it was finally abruptly cured by her great resentment at the second marriage of her father.

I must confess to becoming far less inclined than formerly to operate on trifling lesions of the reproductive organs, and especially on small tears of the perinæum,

the repair of which is painful, unnerving and generally of doubtful expediency. I have become very skeptical of the influence of such lesions upon the general health, and have come to the belief that, even in bad cases, it is greatly overrated. In my experience, the mistake usually made in these cases is that of attributing to the lacerations the mock uterine symptoms of nerve prostration. About this there can be no error, for I have over and over again, without any surgical treatment whatever, cured of all their ailments, patients who had been sent to me for the very purpose of undergoing some operation on the womb, on the perinæum, or even on the ovaries themselves.

Just as headache does not necessarily mean brain disease, so ovary ache, groin-ache and backache do not necessarily mean ovarian disease. Nerve strain and these aches are, it is true, correlatives, but the middle term which connects them is merely a disturbance in the circulation. Yet time and again—and I say this deliberately—have ladies been sent to me to have their ovaries taken out, when the whole mischief had started from some mental worry. Their ovaries were sound, but their nerves were not, and no operation was needed for their recovery. The physician of the present day is too apt to jump from any distinctly female ache to an ovarian conclusion without the delay of any misgivings. The ache is in the back, then, he argues, it probably is ovarian; it is in the groin, then, of course, it is ovarian; it is in the head, but extremes meet, and surely it comes from the ovaries. I, indeed, have seen a painful nose, and also a red one, attributed to the ovaries and treated canonically by the hot vaginal douche and uterine applications. From this widespread bias and pernicious haste the removal of the ovaries has degenerated into a busy industry by which, in city and in country, very many women have been and are

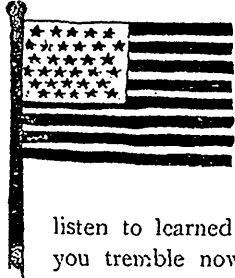
being mutilated, both needlessly and on the slightest provocation.

So misleading, indeed, are the symptoms of a jaded brain or of other nerve strain, under the uterine guise in which they often masquerade, that when a jilted girl, a bereaved mother, or a grieving wife consults a physician, he, unless on his guard, will be more likely to minister to a womb diseased than to a mind diseased. Such cases, even when associated with actual uterine disease, are not bettered by a merely local treatment. Nor are medicines by themselves of much avail. What they need are the incantations of the rest cure: viz., massage, electricity, and strict seclusion. Hope should be infused into every case, and, above all, there should be imported into it the personality of the physician. The riper my experience, the more am I convinced that, in the treatment of woman's diseases, the possibility of a nerve origin or of a nerve complication should be the *fore*-thought and not the *hind*-thought of the physician.

DR. SUNDBERG IN BAGDAD.*

*U. S. Consular Mansion,
BAGDAD, TURKEY IN ASIA,
June 7th, 1893.*

*President and Fellow-Members of the
San Francisco County Medical Society:*



During my seven years' membership of this society I have abstained from inflicting on you the painful ordeal of having to listen to learned papers; nor need you tremble now, for I shall only serve you a dish of hodge-podge of questionable ingredients, and badly cooked. Indeed, I should have maintained golden silence—it would perhaps

*Read before the San Francisco County Medical Society, Aug. 8th, 1893, by Dr. D. W. Montgomery, and published in the *Pacific Record*.

have been best—but the thought came to me this evening, the forty-eighth anniversary of my good-for-nothing vagabondage on this planet, that I would like to have you all with me, from the distinguished pioneer in the new specialism of mucous-membranology, the erudite neurotecto-nists, and other great men, down to the humble plodder who goes about quietly fighting off the death angel, or smoothing the passage for those whose time has come, and then says no more about it.

If you could sit with me now on the roof of my lowly dwelling (no, beg pardon, palatial residence), surrounded as I am by all the luxuries and barbaric splendours of the Orient—for *I have wealthy neighbours*—viewing the graceful domes and lofty minarets pointing skyward out of the fresh-green palm groves of “The City of Peace,” “The Queen of the Desert,” “The Home of the Caliphs,” the Tigris which washes the walls beneath with the melted snows of Mount Ararat, the famous bridge of boats, and on the opposite shore a long line of quaint-looking houses and beautiful gardens, all delicately coloured by the rays of the setting sun, you would surely exclaim with me, “A Painter’s Dream.” Then again, passing out of my residence with me through the massive gate on which a cannon ball would hardly make an impression, into the narrow, crooked, inconceivably filthy streets, where, being, jostled every moment up against the walls of the houses by the Bagdad Water Works (sheepskin bags on donkeys’ backs), you would have to tread your way cautiously to avoid stepping on fresh human excrement, while fine dust consisting of the dried ordure of both asses and men fills our nose and throat; or walk with me through the bazaars, where food covered with flies and dirt is exposed for sale, while alongside of the bread, meat, or fruit, lie children with purulent ophthalmia, whose faces you cannot see for the flies that are feast-

ing on the pus oozing from their eyes, and on ash heaps near by half a dozen half-starved vagrant dogs are dozing, covered with sores from head to foot—excellent material for a skin clinic—with not enough life in them to even fight over the fish heads, sheep entrails and other offal strewn about; or, examine with me cess-pits, wells and cellars which fill with water whenever the river rises, and are emptied by percolation through the porous soil, and just as surely would you groan under “A Sanitarian’s Nightmare.”

I treat, *gratis*, from sixty to eighty indigent sick daily and my universal prescription—for like most quacks I have one—is, “wash and be clean.” If a patient comes dirty a second time, I have scrubbing brush, soap and water ready, and apply the brush myself so effectually that I have never had to repeat the operation a second time. For the want of a suitable place to operate aseptically I have had to turn away many cases which I could benefit, as to operate in the house of the poor—and even of the rich, for diamonds and dirt are found together—is out of the question.

The practice of medicine is in a degraded state, and patients are constantly bargaining with the physician for a cure, and refuse to pay for advice pure and simple or for an examination, no matter how much skill or time it may involve. When a wealthy person gets sick all the doctors and magicians in the city are sent for an hour or two apart, and without each other’s knowledge, and their advice is followed or not, as it suits the fancy of the women neighbours, who always try to pump the doctor by fair means and foul. If a prescription is sent to the drug store it will probably be put up in an old unwashed cod-liver oil bottle that has lain perhaps for months in some dirty corner, and then an old rag and some paper is made to do service as a cork. This is not overdrawn. Sometimes the prescrip-

tion may be put up in a cup without any cover at all. The percentage on-prescription system has here been developed and refined as nowhere else. There are benevolent societies whose secretary receives as salary a certain amount on every prescription he has to settle for, and then he and the doctor agree that a new prescription shall be written for every dose!

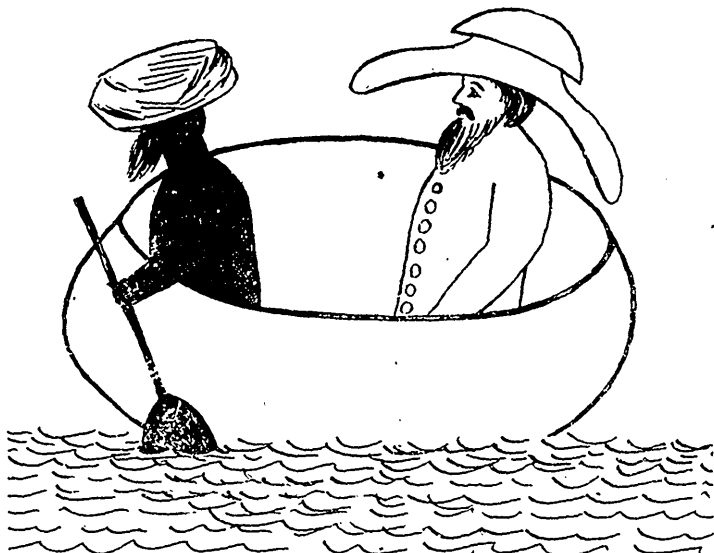
I go to see my patients, if they live far away, either on horseback or in a "coofa" (Tigris boat, round as a wash tub).

Voila, the Hakim on professional visits.

In my professional capacity I have visited the harem of the Nakib, a hereditary saint, whose saintship dates back forty or fifty generations. I was permitted to see his wives' faces and examine their



RIDING THROUGH THE PALM GROVES OF MESOPOTAMIA ON A NOBLE ARAB STEED.



IN A COOFA.

I could record many amusing incidents, thus: One day I was called to see a wealthy lady, highly educated, spoke French correctly and without the least foreign accent (thanks to the French sisters). I requested her to send me some of her urine and next morning a servant came to my office carrying a large chamber brim full!

tongues only by creeping under the robes which cover them from head to foot.

I am preparing a paper on the Climatology and Demography of Mesopotamia for the Pan American Medical Congress. Briefly stated, the summers here are as "hot as hell" and as "dry as a drunkard's throat in the morning." But this year the eastern bank of the Euphrates has given

way and the desert is twelve feet under water, communication by boat being established between the two rivers. A couple of days ago I crossed the Tigris and walked a quarter of an hour back from the river, where all further progress, except by swimming, was impossible. Towards the setting sun not a trace of land was visible and the horizon was clear and distinct, while on the left were here and there little islands marking ancient mounds. I stood some time by the tomb of Sit Zobeida (Harun-al-Rashid's wife) admiring the view, which was grand. The air this summer is of course more humid than usual, and we may expect an epidemic of fevers and mosquitoes.

But Bagdad is a healthy city withal, and is famous as a summer health resort for the entire Persian Gulf region. "The air and water of Bagdad are good" is an old chestnut; I have heard it now fifteen thousand times, and what *tout le monde* says must contain some truth. I should say: "The desert air of Mesopotamia and the Tigris water five miles above Bagdad are good."

I should like to tell you something of my journey from California to Mesopotamia were I not afraid of wearying you. I visited the U. S. Naval Hospital at Yokohama and found it, like everything else in Japan, clean. It also looked to me as if it were empty, but the surgeon in charge assured me that there were two doctors, and also a couple of chronic cases kept as seed to justify the presence of the two naval surgeons there. Therefore the hospital was not, as I at first thought, empty.

China is a land where industry and poverty are twins. I visited Canton, and found the wharfs and landing places almost as disgracefully dilapidated, dirty and foul-smelling as those of San Francisco. On my arrival at Calcutta I had completed my tour around the world in fourteen years—Nellie Bly, George Francis

Train and other idiots have done it in less time. What seemed very strange to me was that during my absence distances seemed to have greatly magnified; in other words, the distance between two given points was twice or thrice as great as fourteen years ago. Why? There have been many sanitary improvements during my absence. Dead bodies no longer come floating down the river and back again with the flood tide as before; urinals have been erected in various parts, and one does not see men urinating all along the street, anywhere, quite as often as before. The sewers are fairly good and the water excellent.

India is suffering from too much western civilization. One day on Dalhousie Square I was accosted by a well-dressed Baboo,* who delivered the following speech:

"It would seem presumption on the part of this miserable worm, myself, to intrude my presence on your Highness' valuable time, but if your Excellency would condescend to listen to the pitiful tale of this miserable wretch, who has been educated in the Benares University, and passed with high honours in Sanscrit, but who rests at present without employment, perhaps, by the influence of your noble presence, he might be saved from an ignominious death by starvation," etc.

"My young friend," said I "go to America and my Uncle Samuel will give you a farm."

"Thanks, my noble benefactor," said he, "and may all the blessings of Heaven fall on your head, and on that of your eminent uncle, but I have not the wherewithal to go to America, and moreover, being a Brahmin, I cannot cross the ocean."

I visited Dr. Cunningham's bacteriological laboratory. Dr. C. has made experiments with comma bacilli, and says

*Baboo, a term in Calcutta and in Lower Bengal for a Hindoo gentleman, or a gentleman of pure Oriental descent.—Worcester's Dictionary.

there are many kinds of them. He showed me different cultures. But he has lost his faith in the creature and thinks him a humbug, and not at all the cause—at least not the sole cause of cholera. He said the prisoners in the House of Correction understand how to produce in themselves a diarrhoea—not cholera—though the orthodox comma bacillus was found in the discharges. Neither by threats nor rewards had he succeeded in getting at the secret of producing artificial cholera.

I saw an excellent smoke-self-consuming garbage incinerator in operation, which I could conscientiously recommend for San Francisco.

In Persia we touched at three ports, Bandar Abbas (near the Isle of Hormuz), Linjah and Bushir. It is from Bushir one gets the best attar of roses, and it is said that the road from Shiraz to Bushir is impregnated with the odour, as the perfume leaks through the skins in which it is brought on camels to the coast. But other odours than that of roses greet one's nose on landing.

The Garden of Eden (where the Euphrates and Tigris unite) is a veritable Paradise. Other interesting points on the river are Ezra's tomb, and the ruins of Ctesiphon, where one sees the largest arch in the world. On the opposite bank are mounds covering Seleucia.

Bagdad has about 200,000 inhabitants (5,000 Christians, 50,000 Jews and the rest Mahomedans). There is neither a saloon, gambling house, or brothel in the city, though there are said to be some clandestine prostitutes. Murders are rare; suicides unknown. The people are dirty, lazy, good-natured, independent, and not at all servile like the inhabitants of Bengal and Japan. They do not always tell the truth; in fact, the lower classes never do if they can help it. The higher classes—at least some of these I know—are models of probity and goodness. The people

here are not dark, and, though dark eyes and hair prevail, extremely blonde types, light blue eyes and yellow or even red hair, are common. The women are stately and often beautiful. The dress of the native Christians (both men and women) is becoming, but European civilization has introduced high-heeled boots and corsets, and the izar may be doomed. I shall be sorry to see it go.

This is a rich country, and all are anxious to get a slice of Turkey when the carving takes place. I should myself like to get a few corner lots in Babylon.

I should have mentioned that my house here is a fortress with burglar-proof gates and iron-barred windows.

Street cars, carriages, telephones, gas, electric lights, etc., are unknown here. At night the streets are deserted except during the Ramadan.

This region is great for creeping things of all kinds, from lizards to lice. The steamer I came up the Persian Gulf in was so full of cockroaches that one could leave nothing loose in the cabin. They devoured the ship surgeon's boots and one of my Arabic dictionaries, and came near eating my spectacles—at least they made a meal of the case. An entomologist's paradise that.

No other consul but myself ever goes out without an armed body-guard (from three to twelve), but I have been defying all rules and traditions, except when making official visits. Let Bagdad's poor be my guard, if I need one, though, judging from the way physicians were attacked by mobs in Spain and Russia during recent cholera epidemics, I do not know to what extent I ought to trust a lot of half-savage fanatics.

Now, farewell for the present. Next time I come to California I may possibly have something of interest to communicate.

JOHN C. SUNDBERG.