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EDITORIAL.

AN HONORARY DEGREE FOR DR. J. L. BRAY.

AT the Arts Convention of April 27th last, the Honorary Degree of LL.D. was conferred upon Dr. J. L. Bray of Chatham. The presentation of Dr. Bray to the Chancellor was made by the Dean. The reply of Dr. Bray will be of interest to many of our readers and we, therefore, print it in full. Dr. Bray graduated in medicine at Queen's University in 1863 and has been in practice in Chatham ever since. For twenty-five years he has been territorial representative from his district on the Ontario Medical Council and his services in behalf of medical education have been unremitting.

Dr. Bray replied as follows :

Mr. Chancellor, Principal Gordon, Ladies and Gentlemen :—

I am at a loss to find words in which to express my gratification, for the high honor my Alma Mater has conferred on me, and I desire to thank the Senate and all concerned, most heartily for their kind and generous gift. When I consider it is the highest degree in the power of the University to bestow, and when only two weeks ago, Earl Grey, the Governor-General of this great Dominion, and Lord Strathcona, our High Commissioner in England, whom every Canadian loves and reveres, were the recipients at your hands of the same honor, only serves to make it more valuable in my eyes.

We all know that Queen's is not prodigal in the disposal of her honors, therefore they are to be the more highly appreciated, and I can assure you that no one on whom you have conferred the degree of LL.D., can feel more grateful than myself, particularly as it comes to me at this time and as a pleasant surprise. Little did I think when I entered the Medical Department of Queen's University forty-six years ago, a mere lad and quite unknown, that I should receive at her hands the supreme honor I have had given me today, and when I look back at her in her infancy as she then was, and compare her with the Queen's of the present, I am amazed; and it is in a great measure due to the energy, devotion and self sacrifice of that noble man now gathered to his Father's, Principal Grant, that she occupies the proud position among Universities of the world that she now enjoys. I say it without fear of successful contradiction, that no University in this or any other land, has made such giant strides from so small a beginning, or done so much for the youth of any country as our own beloved Queen's, she has known no creed, sex or color, nor has she shut her doors against the poor and humble, but always welcomed those who have tried to help themselves.

There is a bond of union between students, graduates and professors that is entirely unknown in any other University on this continent, and what is the result of this union? It is the great love of Alma Mater that exists in all her Alumni, no matter in what country they may be located, and wherever they may be, you will find them occupying positions of trust, and always using their best efforts to advance the interests of their fellow men, and the grand old University of which we are all so proud.

At the present moment there are no less than seven graduates of Queen's in the Medical Council out of a possible twenty-four, a far greater number than any other University can boast of, and the President of the body is the Hon. Dr. Sullivan of this city so long connected with the Medical Faculty of this institution.

I do not wish to detain you longer, and only say in conclusion that the honor you have conferred on me is the one above all others I would have chosen had I the choice, coming

to me as it does in my declining years after nearly a life-time spent in our noble profession, it is a legacy I shall be proud to leave to my sons. It should also be a lesson, and act as an incentive to every young man now entering on his collegiate course, to do his best and thus reflect credit on himself, his teachers and his Alma Mater, for who can tell which of you in years to come shall receive the same honor from the grand old Queen's that has been conferred on me this day.

THE ONTARIO MEDICAL ASSOCIATION.

The recent meeting of the Ontario Medical Association was probably a greater success than usual. Yet, neither the effectiveness of this Association nor its influence on the medical life of this Province is certainly not what it should be. This is an institution capable of doing an infinite amount of good. That it has accomplished practically nothing is due mainly to the fact that it has been altogether too narrow in its administration and in its work. The officers, members, the place of meeting, reading of papers, the general life of the Association has been confined nearly all together to the City of Toronto.

This is not uttered in any antagonistic spirit, merely with a view of pointing out a defect. Might we beg to suggest that the Ontario Medical Association should broaden out just a little. Its officers might be selected from various parts of the Province. The reading of papers should follow the same general plan. And by all means, if the profession of the Province of Ontario is to be interested in the Society's work, then its meetings should follow the plan of the British Medical Association and take a different city each year.

There is no doubt whatever, but that the success of the B. M. A. has been in a great measure due to this fact.

Let those having in charge the guidance of the Ontario Medical Association bear this in mind. What better site could be selected for next meeting than the City of Kingston.

SPASMODIC TORTICOLLIS.

CONDITIONS which are met less than half a dozen times, in a moderately busy general practice, during a quarter of a century may justly be considered rare.

In that time I have come across two cases of Spasmodic Torticollis, short accounts of which may be of interest.

Mr. H. H. O., of Barrie, Ont., age 32 years, tinsmith for seventeen years, healthy until this illness, was the first.

In December, 1880, he worked very hard, putting a furnace in a school-house seven miles in the country, driving back and forth, the weather being very cold.

In January, 1881, he had what was called lumbago, which, in spite of a variety of treatments, became more and more painful. Pain was increased by movements.

In March the first symptoms of torticollis commenced with slight twitching.

In a few weeks this had increased in severity, until violent spasms of the right sterno-cleido-mastoid were almost constant.

In July he came to me with a letter from the late Dr. Wm. A. Hammond, a well-known neurologist of New York, who had the patient under observation for ten days. The rarity of these cases is exemplified by Dr. Hammond's statement, that he had seen only twelve cases, including this one.

At this time the spasmodic rotation of the head was so violent that the patient could walk only with difficulty, and by a strong side pull upon his nose with his hand. The nose was much deflected by this. Besides the sterno-cleido-mastoid of the right side, the trachelo-mastoid, inferior oblique, and other muscles having a rotary action on the left side were affected.

He spent most of the time lying on his back, in which position there was little spasm except on making some voluntary muscular effort.

Previous to consulting Dr. Hammond he had passed through the hands of several good doctors. Counter irritants, anti-rheumatics alteratives, electricity, massage, suggestion, all had been used, but with no marked effect. Occasionally here was slight temporary improvement.

The treatment he received in New York, and which I continued for some time, consisted of zinc bromide, atropia hypodermically, electricity, tonics and rest.

Though there was some improvement he was still bad in October, when the patient went to Montreal and consulted Dr. Roddick. Shortly afterwards he was taken ill with typhoid fever and was in bed several weeks. When he was able to be up the torticollis had nearly disappeared.

He was practically well until 1896, when there was a return following unusual hard work and anxiety. Prolonged rest in bed restored him to comparative health. At present he has only a slight tremor of the head.

March, 1901, Mrs. T. E. consulted me for an involuntary twisting of the head. The condition was so much like the preceding case that even a short description would be tedious.

The accompanying photograph shows the prominent sterno-cleido-mastoid (left side in this case), and the blurred outline of the face, caused by the tremor.

With severe counter irritation over upper cervical vertebrae, potassium iodide and rest, there was much improvement. Prolonged rest in bed being impracticable, she derived much comfort from a chair with adjustable head rest. The spasms are of much less force than during the first year. Touching her hat rim against a chair back, or one finger at the chin, is strong enough restraint to keep the head straight.

To avoid prolixity, instead of any compilation from the meagre literature upon Spasmodic Torticollis, I shall mention a few ideas, the result of studies in connection with these cases.

Pathology.—The close similarity of symptoms in all cases and the lack of analogous affections (co-ordinated spasms) in other situations, prompt one to inquire if the course of the spinal accessory nerve, in through the foramen magnum, out through the foramen lacerum post., piercing the sterno-cleido-mastoid, may not peculiarly expose the nerve to irritation from rheumatic or other swelling. In connection with this, the relief afforded by the recumbent position is to be considered.

Prognosis.—No tendency to other nervous troubles. Complete cure rare. Amelioration of symptoms probable.

Treatment.—Rest in bed, counter irritation, bromides, iodides, suggestions. Efficient mechanical restraint mentioned in connection with the second case illustrates the effect of suggestion. As soon as the patient sits in the chair the spasms are decidedly less, as if the knowledge that the head could not turn strengthened the inhibitory power. Division of muscles and of nerves has not given good results and frequently has done harm.

G. C. TREMAINE WARD.

Napanee, July, 1905.

A CLINICAL STUDY OF ABSCESS OF THE LUNG.

WE find the first recorded history of lung abscess in the works of the father of medicine, and Hippocrates, in his aphorism, "when empyæma is treated either by the cautery or incision, if pure and white pus flow from the wound, the patients recover, but if mixed with blood, slimy and fetid, they die," seems to have been the monitor to the medical world for many centuries. Not until 1664 do we find record of any physician exhibiting a deliberate purpose of opening a thorax evacuate an empyæma, and that honor belongs to Baglivi, who thus drained an abscess following a sabre thrust in the lung.

However, it was not until Gluck, Biondi and Schmidt (in 1882) showed by experiments on animals that operations on lung tissues were well borne that surgeons felt justified in undertaking extensive operations in this region. Since that time the subject has received a great deal of attention, and much has been written, and many instructive cases reported. Among those most active in the field have been Bull, Park, Tuffier, Quincke, Murphy, Godlee, and Runeberg.

Empyæma of the lung frequently differs from abscess elsewhere in the body, in that the parts surrounding the tissues to be expelled are usually normal in other organs, while in the lung a large portion, often an entire lobe, may be the seat of another disease, the abscess being formed later in the infected

part. Clinically, therefore, it is well to distinguish between abscesses occurring in inflamed tissue and those that develop in previously healthy tissue. As examples of the first variety we have those that occur in lobar pneumonia and acute desquamative pneumonia. Here the exudation of leucocytes at certain points, or in a single circumscribed area, are not confined to the alveoli, but also affects the inter-alveolar tissue, total softening and separation of the tissue may take place, and an abscess formed.

Other varieties of pulmonary empyæma develop in previously healthy lung tissue. In this class we have those resulting from infected thrombus, from the veins in the abdomen or lower extremities before carried into the lungs through circulation. Aspiration of foreign bodies or fluids not infrequently cause this lesion. Pus from the abdominal cavity may burrow upwards through the diaphragm into the lung, there causing an abscess. These are known as perforating abscesses, and arise from abscess of the liver, subphrenic abscess, disease of the appendix or pus formed from perforation of the stomach or intestines, or as the result of malignant disease. Empyæma of the pleural cavity may perforate into the lung and carries of a rib or spine, or suppuration of bronchial glands may cause an abscess that will seek drainage through the lung. Once the lung tissue is invaded by pus, or commences to break down, the fluid increases, the air cells are destroyed or compressed, leucocytes are thrown out in the surrounding lung tissue, there is proliferation of the cells in the inter-alveolar tissue, interstitial thickening fibrosis, forming after a little time a strong, firm abscess wall. Whether the fluid originates from a pneumonia or a pulmonary embolus with its infarct; or from pus burrowing into the lung, it must find some way of escape from the thorax, or cause the death of the patient. Nature here, as elsewhere, sometimes affords the all-important relief, but only imperfectly. Should the pus rupture into a bronchial tube, and the abscess small and favorably situated, the drainage may be sufficient to bring about a complete cure if the cavity can contract down on to the bronchial opening.

But just here comes in the difficulty. Frequently lung tissue gives way with surprising rapidity, and a large abscess

may be formed in a very few days. If it finally ruptures into a bronchial tube, it can not contract sufficiently to close the cavity, consequently we have a bronchiectasis with thick firm walls. While the patient has escaped the immediate peril, the constant irritation of the bronchial tube by the escaping pus subjects him to an exhausting disease and great discomfort.

The space left in the thorax must be filled up. In part this is done by drawing in of the lung, separating it from the chest wall or parietal pleura, by drawing up the diaphragm, by drawing over the heart and mediastinum, and by producing over-distension (hypertrophous emphysema) in any air cells in the surrounding tissue capable of being inflated. But in yet another way (and this is the more serious matter) the space is filled by drawing outward the walls of the bronchial tubes, and thus producing a further bronchiectasis.

The organisms concerned in the pus formation are the pneumococcus, the streptococcus, the colon bacillus, the influenza bacillus, and Friedlander's pneumonia organism. It is well to bear in mind that some of these may produce either gangrene or abscess, and it is said that influenza bacillus produces gangrene of the lung in seven per cent. of the cases of pneumonia from that cause.

Of the cases of abscess or gangrene (which is extremely liable to break down or form an abscess) from all causes, about eighty per cent. occur in the middle of lower lobe of the lung.

The classification of these lesions as given by "Quincke";

- Acute Simple Abscess.

- Acute Gangrenous Abscess.

- Chronic Simple Abscess.

- Chronic Putrid Abscess, with bronchiectasis, is practical and agrees closely with the clinical characteristics of the different cases.

The symptoms of pulmonary empyæma will of course vary with the cause. In those resulting from pneumonia we have the history of that disease. Usually there is an apparent crisis, the temperature falls for a day or so, but the physical signs do not much improve. The temperature will probably again rise and the curve be less characteristic of pneumonia. Should the abscess be large, the respirations become quickened and the

effort in breathing becomes more voluntary, the face taking on the expression of one who has undergone physical exertion for some time. The cough becomes more fatiguing from day to day, and sleep is much broken by it, but unless there is a developing gangrene there is very little expectoration. On percussing the chest, the area of dullness will not have diminished perceptibly, and if the abscess be anywhere near the surface the percussion note may become quite flat. With the stethoscope we usually find diminished breathing everywhere near the diseased area, and the sounds are those of bronchovesicular or bronchial breathing, which may become metallic in character, and a few coarse râles. Should the abscess be small or situated deep in the lung the physical signs become less satisfactory; but patient examination from day to day, finding continued absence of normal respiratory sounds in the suspected area, should strongly fortify one's suspicions of an abscess.

Occasionally the percussion note will change from time to time. An abscess may rupture into a bronchial tube and partly drain away, thus changing dullness to hyperresonance, or the air cells around the cavity may become inflated, as in hypertrophous emphyæma, but heavy and light percussion will in a measure eliminate this source of error. The vocal resonance will be increased in the congested area, but lost over the location of the fluid. Sometimes the restriction of the respiratory movements over the affected side is most marked. Pain is usually not severe, even though the pleura be involved, because of the restricted movements of the lung and the local character of the pleurisy.

In all cases there is emaciation, anorexia and rapid decline in strength. If the expectoration becomes profuse and the odor disagreeable there can be little doubt we have to do with a gangrene or a lung abscess.

In diagnosis the history of the case is of the greatest importance, especially if pneumonia has preceded the onset of gangrene or abscess. Should gangrene of the lung develop, the expectoration becomes profuse and separates in three layers on standing in a receptacle. The odor is particularly offensive. The spit contains some elastic fibers and a few small blood clots,

or the fluid may be streaked with blood. If there is a pulmonary abscess developing, there is not much increase in the quantity of expectoration, and it contains numerous elastic fibers. When the pus ruptures into a bronchial tube the expectoration is suddenly profuse and *gushing* in character, and contains small particles of gangrenous lung tissue with some small blood clots. The odor is so intensely disagreeable as in the case of gangrene. In bronchiectasis we have the history of cough with profuse expectoration that has lasted for some time and a history of an acute illness, either a pneumonia or an empyæma having preceded it by several weeks. The spit is not so offensive as in gangrene or abscess, but has a musty odor, more or less perceptible as the disease progresses.

A tubercular lung may have much the same physical signs especially in the acute pulmonary tuberculosis, but the presence of the bacillus of the disease and the greater frequency of tuberculosis in the upper part of the lung will greatly aid in eliminating it from consideration.

In the second variety of lung abscesses, or that occasioned by pus penetrating the lung from its outer surface, we have the history of a disease elsewhere that has been recognized and run a course of some little duration. Perhaps we should exempt from this statement subphrenic abscess and suppuration of the bronchial glands. In either locality pus may form without occasioning any symptoms that a patient might observe and the first evidence of the disease would be the onset of pulmonary symptoms.

As I have mentioned, abscesses may be single or multiple, and about eighty per cent. of them form in the lower part of the lung. Many may be near the pleural surface of the lung, or indeed, complicated with pleurisy and empyæma in the pleural cavity. Should this be so it would be impossible to differentiate between such an empyæma and a lung abscess. It is my belief that the outer wall of the inflamed lung surrounding the pus is seldom far from reaching the pleura, and so often involves it that the pleural cavity corresponding to the diseased area in the lung very frequently contains a small quantity of fluid that is walled off by the adhesions between the lung and parietal pleura. In one case that came under my observation there

were two separate abscesses in the same lung ; one in the lower lobe and the other in the upper lobe, and each of which had a well walled cavity that contained very little fluid.

As an aid in clearing up the diagnosis in the lung empyæma we may use the X-ray, but it is not entirely to be depended upon, for, unless the tube is directly over the abscess the shadow on the plate may be misleading. Should the abscess have ruptured and the cavity contracted and the heart drawn over, the X-ray could be of little service and it would be quite as misleading in the case of an aneurism of the aorta. If the clinical evidence of an abscess persists, there can be little harm in excising a piece of rib and undertaking a systematic search for it with an aspirating needle.

There can be no doubt some cases recover with medical treatment, but it is seldom that the drainage through the bronchial tube is sufficient, or sufficiently prompt, to avoid the extensive destruction of the lung tissue. We then have on the one hand the rapid breaking down of the soft lung tissue, or, on the other, with the delayed evacuation of the fluid, a thickened, fibrous abscess wall that is slow to contract. It is clear, therefore, that the pus should be evacuated after a diagnosis can be satisfactorily made.

It is unfortunate that we have no statistics of the results from medical treatment alone, but it is not difficult to imagine the fate of a majority of cases left to time and good Dame Nature. Of the cases surgically treated, we have now the compilation of some statistics that are very instructive and lend abundant encouragement to those who would be watchful and operate early. The statistics of results after operation as given by Quincke, Tuffier and Eisendrath are as follows :

QUINCKE.

	<i>Recovered.</i>	<i>Imp.</i>	<i>Died.</i>	<i>Per Cent.</i>
Acute simple abscess	6	..	1	85-15
Acute gangrenous abscess.....	7	..	6	53-47
Chronic simple abscess and bronchiectasis	1	5	2	12-60-24
Chronic putrid abscess and bronchiectasis	4	7	8	21-36

TUFFIER.

	<i>Recovered.</i>	<i>Imp.</i>	<i>Died.</i>	<i>Per Cent.</i>
Acute simple abscess	14	..	4	77-23
Acute gangrenous abscess	39	..	15	70-30
Chronic simple abscess	3	..	2	60-40
Chronic putrid abscess with bronch- iectasis	1	.	3	25-75

EISENDRATH.

	<i>Recovered.</i>	<i>Imp.</i>	<i>Died.</i>	<i>Per Cent.</i>
Acute simple abscess	24	1		96-4-0
Acute gangrenous abscess	20	2	6	71-7-22
Chronic simple abscess	6	8	5	43-21-36
Chronic putrid abscess with bronch- iectasis	13	4	9	50-15-35

The cases reported by Eisendrath all followed pneumonia, and were collected during the past few years, and show a marked increase in the percentage of recovery.

The efforts to combat gangrene of the lung and the formation of abscess by carbolic acid and other antiseptic inhalations, and intralaryngeal injections, do not seem to have been rewarded with much success. It would seem reasonable to suppose that the increased respiratory effort in the non-diseased portion of the lung would draw the antiseptics away from the inflamed area rather than in that direction. Then if we are to resort to operation, how long shall we delay after the nature of the disease has been definitely made out?

This must somewhat depend on the size and location of the abscess and the condition of the patient. If the fluid is in the upper part and deep in the lung, the abscess be small, and the patient in fairly good condition, then waiting for three or four weeks would be justifiable. But if the pus is in the middle or lower part of the lung where drainage would be more favorable, operative procedures should be promptly undertaken.

In performing thoracotomy and pneumotomy, two objects should be kept in mind; the first to remove sufficient of the rib to enable you to explore the pleura and get free drainage, and the second to make your opening in the lung, if possible, in such a position that the cavity in the lung may be explored after the pus is evacuated. This is an important point, for frequently there is a sequestrum of gangrenous lung in the abscess cavity, which, unless it is removed, will cause the discharge of pus to continue for several weeks, and so convert an

acute case into a chronic one. In draining a chronic abscess, it is necessary to remove a part (three inches) of a sufficient number of ribs to allow the chest wall to collapse on to the lung, else it will be difficult to introduce your drain into the lung, as it recedes from the parietal opening.

As the pleural cavity over the site of the inflammation is very frequently walled off, little attention need be given to it, so long as your drainage is well established. Should there be no adhesions of the pleural surfaces, I believe it is quite sufficient to gently pack iodoform gauze around the opening you purpose making in the lung. Some advise suturing the pleural surfaces before opening the lung, while others resort to caustic application to the pleural surfaces to bring about adhesions before the lung is opened. This I believe is quite unnecessary. After we have established drainage, the question of irrigating the cavity is to be considered. If the abscess contains considerable pus, and is of large size, there is always the possibility that a bronchial tube may communicate with it, in which case irrigation would be dangerous. The irrigating fluid may be drawn into bronchial tubes, and from there aspirated into the air cells, setting up septic pneumonia. By waiting a few days, until the cavity can contract down, it ought to be fairly safe to employ irrigation.

In acute cases the choice of an anesthetic and the technique of operating may vary with different surgeons, but it is well to remember that with a little courage on the part of the patient, thoracotomy can be rapidly done by blocking the nerves with cocaine, and the pain quite easily borne. In pleurotomy and a pneumotomy there is very little pain; and by avoiding the use of gas or a general anesthetic, after an exhausting disease, such as pneumonia, the dangers of the operation are very materially diminished, both by avoiding the anesthetic and from the possibility of pneumothorax. By this method of procedure the pus can be evacuated, the cavity and pleura rendered clean, the patient's strength restored for a later general anesthetic, when an accurate estimate of the extent of rib resection necessary to allow the chest wall to collapse on to the lung, and so obliterate the lung and pleural cavity. A point of considerable import-

ance is getting these cases sitting up and out of bed as soon as the heart will stand the strain of the sitting position.

Finally, it is well to keep in mind that by a timely operation we shorten the period of illness, increase the patient's chance of recovery, avoid the formation of bronchiectasis and the displacement of the thoracic contents.

W. H. RANKIN, M.D.

INTESTINAL SURGERY.

IT has been stated by an eminent authority that no surgeon should enter the human peritoneal cavity until he is proficient in the art of intestinal anastomosis.

While this may be somewhat stringent, nevertheless one cannot help feeling that many lives might possibly have been saved had our abdominal surgeons been as adept at anastomosis of the intestinal tube as they are at excising an ovary or removing an appendix.

Review the case reports in our hospitals and find how small the percentage of recovery in cases requiring intestinal resection and anastomosis.

The case is a serious one, it is true, which requires such procedure. But what makes it serious?

In the past, before abdominal diagnosis was as carefully taught, before modern technique made the surgeon as bold, many cases came to the surgeon only in the hour of extremis. In these cases the fault was not to be laid so readily at the surgeon's door, should the shock of a prolonged operation and a resection of several feet of intestine speedily close the scene.

Now, however, our general practitioners everywhere are thoroughly alive to the importance of early exploratory incisions in severe abdominal injuries.

They diagnose readily cases of intussusception and of volvulus. They know the symptoms of obstruction, due to adhesions following a recent laparotomy. They recognize when

a perforation has occurred in typhoid fever or ulcerative gastritis and the surgeon is hastily summoned.

Why, then, are these cases so frequently fatal? Is the collapse any greater than in ruptured tubal pregnancy? Is the infection so much more virulent than in fulminating appendicitis with perforation? Is the direct shock to the nervous system any greater than in an amputation of the thigh?

If these cases are expected to, and do so often recover, why should we be so fearful of our results in an uncomplicated case of intussusception or of volvulus, requiring resection and anastomosis? The intestinal canal, unlike the appendix, the ovary, the uterus, or the gall bladder, is a vital necessity; and to a great or lesser extent is constantly performing its physiological functions. Any repair of its lumen must be undertaken with due regard to this fact, and must necessarily be as perfect as possible. As to the mortality in these cases, we must admit that apart from the fact that many are in very young subjects, where mortality is necessarily high, there is a peculiar tendency to shock, even in adults, where section of the intestinal canal is involved.

There is the infection of the bacillus coli communis added, especially in cases of several hours standing. But another factor which adds to the gravity of the situation, and the one on which I wish particularly to dwell, is the inexperience and oftentimes incompetence of the operator in this particular line of surgery.

While doing post-graduate work last year, the writer had the pleasure of observing the work of many operators, and while we were much pleased with most of the great American surgeons, the magic genius of Dr. John B. Deaver, of the German Hospital, Philadelphia, seemed to transform the most difficult of cases into the simplest, and after witnessing him do ten operations, most of them major, in a little over three hours, one went away wondering where was the secret, and why it should have taken some others almost as long to do one.

It can readily be inferred that the element of shock can in a large measure be excluded, and be accounted for, in a great measure, by this great surgeon's excellent statistics.

We make this reference to more forcibly impress the great

need for rapid accurate work, and this opens up the question of how to attain this proficiency.

Although Celsus in A.D. 20 mentioned intestinal suture, the first definite writings on the subject are in the middle ages by some Italian surgeons, who used the trachea of a goose to keep the lumen of the bowel open, while they stitched the bowel together with four sutures, a method classically known as the "Four Masters."

Various other stitches and methods were advised and adopted, but it was not until 1825, when Lembert published his method of union of serous surfaces, that any decided progress was made.

This revolutionized intestinal surgery and his views are still recognized as the basis of all modern methods. These may be divided into three classes.

1. Union by invagination.
2. Union by mechanical aids.
3. Union by simple suture, either interrupted or continuous.

1. Maunsell (American Journal of the Medical Sciences, March, 1892,) adopted successfully the invagination method, bringing both ends of the divided bowel through a lateral incision and stitching them with an interrupted suture which left the knot within the lumen. He afterwards reduced the invagination and placed Lembert sutures in the longitudinal incision. This proved to be a fairly safe and accurate method, and still has its advocates.

2. In the same year J. B. Murphy, of Chicago, invented the well-known button which bears his name. While this has been condemned by most surgeons, even Murphy himself admitting it has its faults, yet we find all guilty of using the same little contrivance on many occasions. Its greatest advantage is the rapidity which it permits, and its great disadvantage the fact that it requires to be passed by rectum later, a little feat it does not always perform.

Again, in the same year, 1892, Mayo Robson produced the decalcified bone bobbin, which he still uses. Senn shortly after introduced his bone plates. Since that time many forms of anastomosis forceps have been invented, well known among

them being the Laplace model (Annals of Surgery, March, 1899.) The latest contrivance, perhaps, is that of Harrington & Gould (Annals of Surgery, Nov., 1904,) which consist of a collapsable segmented ring.

3. While these may all be excellent in the hands of those who have learned how to use them, as Mayo Robson says, (Med. Annual, 1904,) "the general trend of opinion is now to rely on simple suture, with or without any mechanical support." Although the Lembert stitch is still largely in use, various modifications of this suture method have been devised. It has been found of late that the danger of leakage and of infection from the through and through stitch is not nearly as great as theoretically it would seem, and many operators of the present day are including all coats of the bowel without any reinforcing.

M. E. Connell (N. Y. Med. Record, Sept., 1892,) devised a through and through continuous stitch, adapting the serous surfaces, but his method did not become popular.

F. G. Connell (Journal of the American Med. Ass., Oct. 12, 1901,) describes a very easy and safe procedure, which has been well received and is proving satisfactory. He uses a Halsted mattress suture arranged so as to bring all the knots within the bowel. It is easy of performance and I can vouch for its success.

J. Shelton Horsley (Annals of Surgery, November, 1903,) modified Connell's method, and removes a crescentic piece of bowel, thus enlarging the lumen at the line of suture and leaves little or no shelving ring. Two methods used at the present time for gastro-intestinal anastomosis by some of the surgical experts are well worthy of consideration, viz., the McGraw elastic ligature and the Maury twine triangular stitch. The latter method is graphically described in Annals of Surgery, Vol. XLI, June, 1905. But the secret of success in any method is practice, without which all are difficult and entail much time.

While at Johns Hopkins in May, 1904, the writer had the opportunity of a post graduate course in intestinal surgery under the personal instruction of Dr. Harvey Cushing, a most delightful tutor and one of the most skilful of surgeons. Our

subjects were dogs and we did our own work. The class was limited to eight, and we used two dogs per day. We were divided into groups of four, which made two full operating staffs, and each in turn performed a part of the operation or assisted. Antiseptic and aseptic technique were carefully carried out, and we aimed at having our animals recover. We were very carefully and sometimes severely criticised in our technique and methods. Our instruments and appliances consisted of a straight No. 7 cambric needle and iron dyed silk. The course covered all the recognized operations on the prima via, from the cardiac end of the stomach to the lower portion of the descending colon, including most excellent discourses on the latest and most improved methods, with descriptive drawings and criticisms.

Not the least instructive feature was the second operation on the same subject from three to eight days later, when we could observe the marvellous attempts of nature at protecting the line of suture and resolving the parts to their normal condition. With such a mighty agent as our ally one could not fail to be inspired with a holy desire to study her ways and render her every possible assistance. As to after treatment little may be said in addition to that laid down for other abdominal operations, except, perhaps, to direct the attention to the inadvisability of drainage of the line of sutures which at one time was recognized as proper. This has been found inexpedient in most cases, as it only thwarted nature's better methods of protection by plastic lymph and the ubiquitous omentum.

While the above mentioned course in intestinal surgery was conducted under the wing of the great Johns Hopkins Hospital, there should be nothing to hinder any surgeon, desirous of becoming proficient in this work, performing these various operations over and over again without spending much money and valuable time in some distant city.

Indeed now that gastro-enterostomy has become recognized as such a valuable procedure in gastric ulcer, and even in malignant as well as benign pyloric stenosis, it behooves every abdominal surgeon to become expert in this special operation that he may be able to go in and get out of an abdo-

men in from twenty to thirty minutes and feel confident of his results.

If Johns Hopkins Medical School can and does include such a course for its students, why should our Canadian Medical Schools not do likewise? Make it optional if you will, but give the aspiring young surgeon an opportunity to become proficient in one of the most difficult lines of modern surgery, or, better still, prove to him his total incapacity for surgical work.

Would that many of us did discover this latter early in our career, and thus save the country from much bad surgery, and perhaps give to the world some great masters in medicine.

E. B. ECHLIN, M.D.,

*Surgeon to County of Carleton General Protestant Hospital,
Ottawa, Canada.*

SOME OBSERVATIONS ON DIABETES MILLETUS.

DURING the last two years there have been a great many cases of Diabetes throughout the country, and many of them of a fatal character. It is generally considered a very serious malady, and as yet but little is known of its true nature and etiology. Osler says "We are ignorant of the nature of the disease," and just so long as we are in this state of ignorance will our efforts at treatment be like groping in the dark.

Many theories have been advanced to account for the presence of sugar in the urine. The rich and well-to-do seem to be more commonly affected than the poor. This fact naturally induces us to conclude that excessive eating and drinking have much to do in its production. After having had considerable experience with diabetic patients, it appears to me that first and foremost among all the causes of diabetes is severe and continued mental and physical strain. In this age of fast living and getting, when the accumulation of wealth seems to be the prime object of ambitious people, it is easy to understand why

there is so much mental worry and anxiety. The standard by which a man's success in life is estimated in this age is almost entirely gauged by the amount of wealth he accumulates. In all branches of business in the commercial world, as also in the professions, competition is keen, and the person who amasses wealth must be "up and doing", hence the wear and tear of active life is very great. There is, indeed, not much wonder that nature should rebel in some way against such treatment, and she does rebel in a most emphatic way oftentimes. It would be a great boon to humanity if some one discovered the secret of this disease. It would be tiresome to mention in detail the various theories advanced to explain the nature of diabetes milletus. Physiology teaches us that the carbohydrate part of our food is converted into sugar by the action of the different digestive fluids of the mouth, stomach and intestines. This sugar is absorbed into the blood and carried by the portal system to the liver.

In some unknown manner the liver cell has the power of converting the sugar into glycogen and storing it up to be drawn upon as required by the system. Then again the liver has the power of re-converting glycogen into sugar, which is again absorbed into the blood and re-carried by the general circulation to the various tissues of the body. This process is called the glycogenic function of the liver. The sugar thus formed from glycogen and carried by the blood to the tissues is wholly consumed and is not eliminated from the body by the kidneys or otherwise in health.

In diabetes milletus a varying quantity of sugar is always found in the urine and is usually proportionate to the amount of hydrocarbons taken in the diet. It would seem, then, that when sugar is present in the urine the glycogenic function of the liver is at fault. If this were always the case, the treatment of diabetes would be quite simple, *i.e.*, cut out the hydrocarbons from the diet and give albuminous food instead.

Unfortunately, there is a more serious form of diabetes, one in which sugar continues in the urine when an exclusive diet of proteids is taken. This latter form is but little influenced by drugs of any kind.

By cutting out all starchy and sugary food, in the severe.

form, will lessen the amount of sugar in the urine, as also some of the other symptoms, as excessive thirst and polyuria, but the disease goes steadily on and the patient gradually emaciates, weakens and dies. In some cases, especially in the young, this form of diabetes runs a very rapid course, but, usually, a year or two passes before death takes place. I remember one case, that of a thin, delicate looking man of thirty years, in whom the disease ran its course in six weeks, ending in diabetic coma and death.

Codein, a drug much spoken of in the treatment of diabetes, is practically of no use in the severe forms of the disease. I have given as high as eight grains per day without any effect, except to make the patient feel stupid and sleepy. Morphia also has no beneficial effect, but rather the opposite in my hands, making the patient feel sick, deranging the stomach and constipating the bowels. Indeed it is difficult to know whether a drug does good in either the mild or severe form of diabetes, as the mild form improves anyway when carbohydrates are taken from the diet.

Claude Bernard long ago advanced the theory that the blood in health always contains a certain amount of sugar, which is taken up in the tissues and used in the production of heat and force, being finally eliminated from the body as carbonic acid and water. Again, it has been suggested that in the severe form of diabetes there is failure on the part of the blood or tissues, or both, to break up the sugar in the blood.

The pancreas has been made the scapegoat by some observers, who claim that when in a healthy, normal state the pancreas secretes a fluid which has the power of breaking up the sugar in the blood. No satisfactory theory has been yet advanced to explain the nature of diabetes. The form of diabetes which is benefited by eliminating the carbohydrates from the diet is of a much less serious character, and as a rule this class of patients, with care, will maintain very fair health. Patients of this class are generally fat and well nourished. They do not have the great appetite, thirst and polyuria. Those affected with the grave form are thin, have a ravenous appetite, great thirst, dry skin, pass large quantities of urine, and emaciate and get weak very rapidly. Phthisis sometimes

supervenes and ends the scene in this class of patients. It is quite possible, also, that the mild form of diabetes may merge into the severe form. It is very necessary for anyone who has had sugar in the urine and other mild symptoms of diabetes to be on his guard and not look upon his case too lightly. Many remedies have from time to time been advocated for the cure of diabetes mellitus, chief among which are the alkalies, salicylic acid, pot. bromide, arsenic, opium, or its derivatives, codein and heroin, antipyrine, &c. As stated before, none of them are of any apparent benefit in the severe forms of the disease. In the mild form, by aiding nutrition and toning up the run down system, some of them, such as arsenic, may be of benefit. The chief treatment in all cases is change of diet, that is, the cutting out of all starchy and sugary foods, rest, for a time at least, from both physical and mental work, fresh air and change of surroundings. It is a great hardship for some people to do entirely without some starchy food. Gluten bread, with some, is a poor substitute for the ordinary bread. Probably a moderate amount of potatoes is the least objectionable form of starchy food that may be allowed. In fact it is well to watch your patient closely and observe how he gets on with his proteid diet. If failing in strength and losing flesh, it is not best to be too strict about diet, and will not make matters worse to allow some starchy food. A diabetic patient should sleep in a well ventilated room, should spend much of his time out of doors, and wear woolen underclothing at all seasons of the year. All diabetic patients drink an abnormal quantity of water, and those affected with the grave form drink excessive quantities. Thirst is said to be due to the sugar in the blood, and the more sugar the greater the thirst. It is a very noticeable fact that when the diet of a diabetic patient is changed, the thirst is materially diminished. It is well to encourage the drinking quite freely of water when the patient is placed upon an exclusive proteid diet. The reason for this is quite plain and patients will tell you they feel better when allowed to drink a moderate amount of water.

Some mineral waters are said to be of service, particularly Carlsbad. Salines, such as effervescing magnesium sulphate or phosphate of soda, to be taken in the morning, are of de-

cided benefit, especially if there is constipation. It should be constantly borne in mind that diabetic patients bear any inter-current disease badly, especially those of a pulmonary character. Open air exercise is necessary and beneficial, but not to the extent of producing fatigue. I dare say to spend the winter in a warm climate would also be of benefit, but, unfortunately, the financial condition of many will not allow of this. I sincerely hope the time is not far distant when the medical profession will be able to treat this disease more intelligently and thus save more of our diabetic patients from premature death.

W. M. MATHER, M.D.

Tweed, June 2nd, 1905.

CLINICAL CASES IN HOTEL DIEU.

PRIMARY CARCINOMA OF THE LIVER.

MRS. B., aged 48, Marmora, was admitted to the hospital on April 11th, 1903. She was the mother of several children and her previous health had been good. Her family history was excellent. About one month before her admission while lifting a heavy weight, in her own words, she "felt something give way in her right side." Shortly afterwards a lump made its appearance below the right costal margin. There was a sense of weight and dragging, accompanied by slight discomfort, but at no time was there any distinct pain. When she first came under observation she was a healthy, well nourished woman, no cachexia. The liver was very much enlarged. To the right of the umbilicus and in the mammary line a distinct globular tumor was projecting. From the history of the case and from the physical signs of the projecting tumor, I felt I had to deal with a case of hydatids of the liver. On April 25th I made an incision over the projecting mass. When exposed the tumor projected well below the margin of the liver and certainly had a cystic appearance. It was only

upon opening that its malignant nature was discovered. The patient died of exhaustion on July 10th following. The autopsy was performed by Dr. W. T. Connell who reports :

The abdomen and lower extremities were markedly oedematous. The abdomen was distended with a large solid mass just below the right costal margin and in the epigastric region. On opening the abdomen and removal of dropsical fluid the liver was found reaching an inch below the umbilicus and extending to the left as far as the spleen. The other viscera in the abdomen were examined and found quite normal. Some of the glands in the portal fissure and along the coeliac axis were enlarged. The right lung was shoved up as far as the third rib, but was otherwise normal, so with the left lung and heart. Liver weighed $11\frac{1}{2}$ pounds. It was filled with a huge mass of growth which breaks out on the surface in large orange shaped nodules. The left lobe lateral portion is the only part not affected by large central nodules, but it contains small secondary nodules. The growth itself was very soft and fatty looking. Microscopic sections from the edge show typical encephaloid carcinoma the cells being large and packed in small alveoli. In the centre the sections are simply a mass of degenerated cells.

Two points about this case are worthy of notice : the rapid growth of the mass and the tumor like projections which were certainly very deceptive.

MAMMARY HYPERTROPHY.

Lottie B., aged 18, came to the hospital in July, 1904. Her mother was an Indian woman, her father a half-breed. The family history was excellent. Until the time of puberty her health had been good. From that time on her breasts gave her trouble, being subject to occasional attacks of pain and swelling. In April 1904, her breasts began to increase rapidly in size and when she first came under my observation in July they were enormously enlarged. The nipples had disappeared under the tension. There was little or no tenderness. Treatment was begun at once, strapping, local applications and internal administration of iodide of potash. The treatment had absolutely no effect and as the patient refused to submit to

operation she left the hospital three weeks from the time of entering. She returned on October 15th following, her condition being practically unchanged. She was now prepared to undergo operative treatment. On October 17th the left breast was removed. The gland on amputation measured 25 inches in circumference, $9\frac{1}{2}$ inches in long diameter, $3\frac{3}{4}$ inches in short diameter and weighed 10 pounds 4 ounces. On November 25th the right breast was removed. It measured 25 inches in circumference, 9 inches in long diameter, $3\frac{1}{4}$ inches in short diameter and weighed 9 pounds 2 ounces. The patient herself weighed 95 pounds upon her recovery. During the operation venus sinuses were encountered some fully one quarter of an inch in diameter and the haemorrhage at times was very difficult to control. The gland tissue would not hold a forceps and the best control of haemorrhage was obtained by hot towels and pressure. In fact towards the end of the operation I abandoned any attempt to stop bleeding and shelled the breast out quickly when the bleeding ceased at once. I am sure this method was a decided gain. The patient's recovery was uneventful, the wounds healing rapidly, and the patient left the hospital before the end of December.

Pathological report by Dr. W. T. Connell: Mammary Hypertrophy. Microscopically: shows distinct lobular grouping. The lobules consist of irregular alveoli with single or double epithelial lining: the cells being spheroidal or cubical. A distinct lumen was present in most but not all the alveoli. There was no active secretion, nor any evidence of cyst formation. The specimen seems to approximate closely to that of ordinary actively growing, but now secretive breast tissue.

NEPHRECTOMY FOR HYDRONEPHROSIS.

Mrs. McN., aged 48, was referred to me on July 14th by Dr. Cooper of South Brenton.

She was the mother of a large family, had an excellent family history and her previous health was good. For about four months before her admission to the hospital she had been troubled with attacks of painful and frequent micturition. There was a large well defined tumor situated in the right hyochondriac epigastric and umbilical regions. The tumor diminished in

size upon brisk purgation. There were frequent attacks of intense pain referred mostly to the umbilical region. The urine was normal in quality and quantity. A hydronephrotic kidney was diagnosed and operation decided upon. The lumbar incision was used. It proved too small and was carried freely along the crest of the ilium and the kidney with the attached mass was removed. There were few adhesions and no great difficulty experienced after the opening was enlarged. The wound healed without incident and the patient left the hospital on September 11th. She has since enjoyed excellent health.

Upon two points in connection with this case I would beg to offer comment, namely, the difficulty of diagnosis and the method of operation. The situation of the tumor, the extent and seat of pain were confusing. The lumbar region gave little assistance. There was no appreciable increase of dulness, nothing at all like what one meets with in a cancerous or tuberculous kidney. The bladder trouble was suggestive, yet the symptoms were not more pronounced than those ordinarily met with in cases of abdominal tumors. The one really diagnostic feature was the partial disappearance of the tumor upon brisk purgation though no copious flow of urine at that period was detected.

The proposed methods of treatment are various, friction paracentesis, injection of irritants, nephrotomy, nephrotomy with subsequent nephrectomy, and nephrectomy. The operation of nephrectomy seems the only rational cure. The other methods of treatment appear to be but expedients not without danger and rendering the radical cure in the end more difficult. To stitch to the integument the cyst wall or the remnant of kidney with the subsequent inconvenience and danger of fistula or sepsis does not appear to be in the spirit of modern surgery. As to the kidney or rather the shell remnant, I think its economical value is of little account. The fluid it secretes is not urine and therefore its emunctory duty is of little value. As a primary operation nephrectomy presents no great difficulty. As a secondary operation with adhesions formed, and in a field soiled with discharges, I am not sure it would pass off so easily.

SUCCESSFUL CASE OF TALMA'S OPERATION FOR CIRRHOSIS OF LIVER.

JAS. K., aet 23, bartender by trade, consulted me in June, 1902. He was emaciated, slightly jaundiced, sclerotics, and abdomen protuberant. He had been ailing for about a year and treated by a number of medical men. The protuberant abdomen, I might say, was noticed first a month or two before consulting me. On examination I at once concluded the abdominal cavity was full of fluid. The liver was somewhat enlarged, and I advised him to go to St. Joseph's Hospital, so I could more closely keep him under observation. I wished to tap him to remove the fluid, which procedure he was averse to, preferring the use of drugs, if possible, to remove it. I put him upon diuretics and morning salines, and endeavored to keep his skin performing its excretory functions as well; but I found his skin was quite dry and it was almost impossible to make him perspire. In fact, before he came to me he had tried the hot vapour baths, but could not be made to sweat. However, by keeping the kidneys working freely and the use of the morning saline, I succeeded in apparently removing a considerable quantity of the fluid for a time, which rapidly returned in any let up of the treatment; so finally he consented to allow me to tap him. This was done and a large quantity of fluid removed, and he apparently felt much better for a time; but in a very few weeks it was necessary to tap him again, and his abdomen rapidly refilled. I then had a consultation to discuss the advisability of performing a Talma's operation for the purpose of relieving the obstructed portal circulation and allowing part of it to pass through the vessels of the abdominal wall. My consultants agreed with me that it was well worth the trial, although, I think, at the time there had been only a very few successful cases.

On August 12th, assisted by Doctors Cockburn and Gillrie, I made an incision in the median line extending about 3 inches upward from just above the umbilicus. Considerable fluid had formed again since the last tapping, which took a little time to get out on account of the valve-like tendency of the bowels to hold it in the lower part of the abdomen. How-

ever, after sufficient was removed, so as not to interfere with the field of operation, I made an incision in the parietal peritoneum about an inch from the margin of the wound on the left side, and another incision about an inch farther external (both parallel with incision in abdominal wall). Then I separated the peritoneum from the abdominal wall, between the two incisions, leaving it attached above and below. Then did the same on the other side. I drew up the great omentum and took a vascular loop from each lower external corner and looped it in between the separated parietal peritoneum and abdominal wall from within outwards, and after getting it in place stitched it to the abdominal wall to prevent it slipping out before adhesion had formed to hold it in position. Then I did the same on the other side. Before doing this I took a piece of gauze and rubbed over the outer surface of the liver to endeavour to cause a certain amount of irritation of the peritoneal surfaces, with the possible formation of some adhesions and circulation from the liver to the intercostal vessels. Then after stitching up the abdominal wound the patient made a good recovery from the operation. About three weeks after the operation he had to be tapped again, and about five weeks later on I tapped him again for the last time. It is now almost three years since the operation. He has had no return, when I looked him up a few days ago. He is following his usual avocation, and feels in perfect health. He occasionally takes drinking spells—of course, contrary to my instructions. He has no bad effects, except when he drinks he must always vomit in the morning. He says he can vomit any time he wishes. He has also a large varix of the long saphenous vein on the right side, extending from the ankle to the saphenous opening, which he says dated from or shortly after the operation. He is now enjoying excellent health, and on account of his age the liver cells must have almost returned to their normal condition and perform their proper functions. His kidneys were in good condition. This with his age made him a good subject for operation. I have never had a case since that I considered suitable for operation but one; he was a considerably older man, about 50, with a good deal of ascitis, necessitating frequent tapping; but he could not make up his mind to the

operation, and he died inside of a year.

This patient (Jas. K.) was a gin-drinker, starting when only a boy. His employer told me in the mornings he has seen him take a drink of raw gin, of about two wine-glasses, on an empty stomach. The liver at the time of operation, I believe, was passing from the hypertrophic condition to the atrophic; but it was still larger than normal. I think that this successful operation goes to prove that the liver cells, no doubt damaged and their functions interfered with by the increased connective tissue in the organ, which increase must have been considerable judging from the amount of obstruction of the portal circulation and consequent ascites, do recover their proper functions to a large extent.

From the complete success in this case I would recommend operation in almost any case of cirrhosis, if the other organs—kidneys, &c. — are in a healthy state, and I think the outlook would be good.

THOS. H. BALFE.

225 James Street N., Hamilton.

THE MEDICAL COUNCIL.

THE Medical Council of the College of Physicians and Surgeons of Ontario met the 4th day of July, 1905. Dr. A. A. McDonald was elected President, Dr. Moorehouse, Vice-President; Dr. R. A. Pyne, Registrar; Dr. H. W. Aikins, Treasurer; Dr. J. C. Patton, Auditor; and Chas. Ross, Prosecutor.

COMMITTEES.

Registration—Drs. Campbell, Sullivan, Klotz, MacArthur, Stuart, Thornton.

Rules and Regulations—Drs. Lane, Bascom, Adams, Hillier, Spankie.

Finance—Drs. Henderson, King, Griffin, Brock, Bascom.

Printing—Drs. King, Stuart, Temple, Hardy, Hillier.

Education—Drs. Spankie, Henry, Luton, Gibson, Ryan, Temple, Robertson, Britton Bray.

Property—Drs. Johnston, Britton, Thornton, Sullivan, Campbell.

Complaints—Drs. Griffin, Hardy, Glasgow, Mearns, Johnston.

Moved by Dr. Spankie, seconded by Dr. Ryan, that this Council take the first opportunity to express its regret at the death of the late John Herald, who so ably represented Queen's University in this Council, and at the loss this Council has sustained through his death. We wish to tender to his bereaved family, our sincere and heartfelt sympathy. And that a copy of this resolution be sent to Mrs. Herald.

Moved by Dr. Moorehouse, seconded by Dr. Bray, that this Council present its congratulations to Hon. Dr. Pyne upon his promotion to the position of Minister of Education.

Moved by Dr. Britton, seconded by Dr. Robertson—Inasmuch as Dr. J. L. Bray and Dr. G. Henderson have been members of this Legislative body continuously for a quarter of a century during which long period they have shown intense interest in the welfare of this Council and the advancement of the profession, it is hereby moved that a committee be appointed to draft a suitable address to be engrossed and presented to Dr. Bray and Dr. Henderson.

EXAMINERS.

1. *Anatomy, Descriptive*—Dr. T. W. G. McKay, Oshawa.
2. *Theory and Practice of Medicine*—Dr. Geo. Hodge, London.
3. *Clinical Medicine*—Dr. H. R. Duff, Kingston
4. *Midwifery, Operative and other than Operative and Puerperal Diseases*—Dr. J. R. McCabe, Strathroy.
5. *Physiology and Histology*—Dr. R. D. Rudolf, Toronto.
6. *Surgery, Operative and other than Operative*—Dr. W. T. Parke, Woodstock
7. *Clinical Surgery*—Dr. J. S. McCullough, Alliston.
8. *Medical and Surgical Anatomy*—Dr. T. H. Middleboro, Owen Sound.

9. *Chemistry, Theoretical and Practical, and Toxicology*—Dr. A. R. Pyne, Toronto.
10. *Materia Medica and Pharmacology*—J. S. Sprague, Stirling.
11. *Medical Jurisprudence and Sanitary Science*—Dr. D. J. Sinclair.
12. *Diseases of Women*—Dr. R. E. Webster, Ottawa.
13. *Diseases of Children*—Dr. J. Newell, Watford.
14. *Pathology, Therapeutics and Bacteriology*—Dr. Isaac Wood, Kingston.
15. *Homeopathic Examiner*—Dr. W. A. McFall, Peterboro.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

THE following students of the Medical Faculty, Queen's University, were successful at the recent Examinations of the Medical Council (June, 1905):

PRIMARY.

B. Asselstine, Wilton; H. M. Bowen, Gananoque; W. J. Geddes, Kingston; H. E. Gage, Kingston; J. Johnston, Combermere; S. J. Keyes, Kingston; F. J. Keeley, Railton; J. R. Losee, Collinsbay; A. T. Munroe, Moose Creek; A. E. Mahood, Kingston; S. McCallum, Brewer's Mills; J. P. McNamara, Stratford; P. A. McIntosh, Dundela; R. D. Paul, Selby; J. P. Quigley, Kingston; M. Reynolds, Kemptville; R. G. Reid, Kingston; W. A. Smith, Kingston; A. T. Spankie, Wolfe Island; H. J. Sullivan, Peterboro; J. F. Sparks, Kingston; F. H. Trousdale, Hartington; M. J. O. Walker, Kingston; R. Wightman, Lancaster; W. L. Yule, Gananoque.

INTERMEDIATE,

M. E. Grimshaw, Wolfe Island; H. E. Gage, Kingston; J. T. Hogan, Perth; R. W. Halladay, Elgin; R. E. Hughes,

Ottawa ; M. Locke, Brinston's Corners ; A. J. Lalonde, Kingston ; I. D. Macgillivray, Kingston ; A. T. Munroe, Moose Creek ; J. W. Presault, Verner ; W. M. Robb, Lunenburg ; F. Sheffield, Peterboro ; J. T. Sparks and H. J. Williamson, Kingston.

FINAL.

J. C. Caskey, Tweed ; F. J. Ellis, Ellisville ; H. E. Gage, Kingston ; Wm. Gibson, Emerald ; J. V. Gallivan, Kingston ; R. W. Halladay, Elgin ; J. L. Kane, Gananoque ; A. J. Lalonde, Kingston ; A. T. Munroe, Moose Creek ; T. D. Macgillivray, Kingston ; Geo. McGhie, Elgin ; C. C. McCullough, Gananoque ; J. W. Presault, Verner ; J. F. Sparks, Kingston ; E. Sheffield, Peterboro ; H. J. Williamson, Kingston.

 BOOK REVIEW.

A TEXT-BOOK ON OBSTETRICS. By Adam H. Wright, Prof. of Obstetrics in the Medical Faculty of the University of Toronto ; ex-President of the American Association of Obstetrics and Gynaecology. Cloth. Price \$4.50.

SEVENTEEN years experience as Professor of Obstetrics, a large general and consulting practice in Obstetrics, and unusual gifts as a teacher and writer, are some of the qualifications which have rendered this book on Obstetrics valuable.

We believe it will be found eminently adapted for general use and aid in difficult cases. No difficulty in which the student or practitioner may find themselves is omitted, but all are fully dealt with, while the whole book is a record of the most valuable clinical experience.

The author has availed himself of the results of a comprehensive study of the literature of Obstetrics, but at the same time his methods of treatment and his opinions are his own and are presented with convincing clearness and careful detail.

The chapter on Ectopic Gestation is particularly good. No one can read this chapter without feeling that he has ac-

quired a most useful and practical knowledge of the subject. Embryology will be found to have been presented in an interesting, concise and practical form.

We would call particular attention to the chapter on Tuberculosis and Cardiac Disease in Pregnancy. Clinical facts are here at hand, which can only be presented after careful investigation for a number of years. Every practical point arising in the management of cases in general practice is dealt with in the most common-sense manner. The subject of Eclampsia is accurate and complete. The section devoted to the management and treatment of this condition is most valuable.

The style in which the book is written is unusually direct, interesting and forcible.

The personality of the author appeals to the reader, not only by showing a wide and varied knowledge, not of the subject alone, but also of its relations to successful professional life and work.

Every part of the book is in line with the most recent investigations.

This comprehensive work at the modest price of \$4.50 in cloth binding will, we believe, receive a favorable reception by the general practitioner and student.

The Messrs. D. Appleton & Co. are publishers, and Messrs. Morang & Company, Limited, are Canadian agents.

TREATMENT OF FELONS.

Felons are classed as minor surgery, and yet many a finger has been lost through their careless treatment: Antiphlogistine is a specific in incipient cases. Apply hot, change every six or eight hours; resolution will as a rule occur without the formation of pus. If pus has already formed, incise deeply and freely. Thoroughness is essential. Evacuate and cleanse with a suitable antiseptic. Insert a drainage tube. Surround the finger with Antiphlogistine. Cut the drainage tube one-quarter of an inch above the surface of the Antiphlogistine. Cover all with absorbent cotton and a bandage. The results will be satisfactory.

The New York Post Graduate Medical School has just inaugurated a separate and distinct department to be known as a School of Anatomy.

This most important branch of medical science will henceforth be handled elaborately and with detail in all its branches. The managers of the Post Graduate School have long believed that insufficient attention is generally given to anatomy, and have awaited the psychological hour for this new departure. A separate building has been secured for the work, adjoining the established school and hospital buildings. Dr. Neil MacPhatter, the former Adjunct Professor of Surgery, has been placed in full charge. A representative of the Associated Medical Press interviewed Dr. D. B. St. John Roosa, President of the New York Post Graduate School, who gave out the following statement :

“Our institution has finally achieved its long desired object in the establishment of a separate School of Anatomy, where doctors may obtain special instruction in this branch of medical science.

The School has been separately endowed and will be given fullest facilities for study of Anatomy in any or all of its departments.

Heretofore doctors, when desiring to make a special study of anatomical subjects, have been obliged to attend under graduate colleges, which are generally very much overcrowded. Physicians and surgeons prefer to carry on their advanced work in a post graduate school. It is our ambition to establish in this country a school similar to the great School of Anatomy in Edinburgh.

Dr. Neil MacPhatter has been placed at the head of this department and will have five competent assistants to aid him in this work.”

AN EXCELLENT GERMICIDE AND INTESTINAL ANTISEPTIC FOR TREATMENT OF TYPHOID FEVER, DYSENTERY, DIARRHOEAS AND OTHER DISEASES OF BACTERIAL ORIGIN.

That ACETOZONE is a valuable germicide is demonstrated by its effects upon typhoid bacili and cholera vibrios in river water. In their experimental work Freer and Novy (contributions to Medical Research, p. 107,) made the following tests: (a) A cylindrical glass-wool filter was prepared, and on it was placed a layer of Acetozone crystals, about three cm. thick. A bouillon suspension of typhoid bacili passed once through this filter yielded a sterile filtrate, while control tubes gave the usual abundant growth. (b) A liter of tap-water was sterilized by heat, and when cool a suspension of cholera or typhoid germs added, the experiment being repeated several times. Ten to twenty milligrams (one-sixth to one-third grains of Acetozone was added, and after thorough shaking portions of the liquid were taken out and planted in bouillon and agar which was plated. In each instance the cholera germs were destroyed completely in five minutes, and the typhoid germs in fifteen minutes, by the extremely small quantity of Acetozone used. From the above experiments the authors draw the conclusion that pathogenic organisms are destroyed by extremely small amounts of Acetozone. Therapeutically Acetozone is being very widely and successfully used in the treatment of typhoid fever, intestinal diseases, notably diarrhoea, dysentery, cholera, in gonorrhoea, suppurating wounds and infectious processes generally. It is prescribed in the saturated aqueous solution which is prepared by adding fifteen grains of Acetozone to a quart of water, shaking thoroughly and setting aside for a couple of hours to hydrolyze. Messrs. Parke, Davis & Co., who prepare Acetozone, are sending out printed matter to physicians containing reports of very gratifying results from the use of this interesting compound. Any physician who has not received a brochure can obtain one on request.

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