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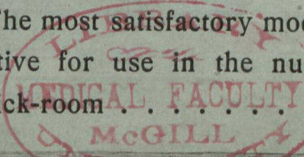

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Dominion Medical Monthly

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VOL. XXVII. TORONTO, JULY, 1906. No. 1.

Original Articles.

THE WEIR MITCHELL TREATMENT OF ANEMIA.*

BY J. N. GUNN, M.D., CLINTON, ONT.

Perhaps some of you will remember two years ago, when I presented here five cases of pernicious anemia, which we then had under observation. It may be of interest here to mention that of that number three are now dead, and that the other two have had recurrences.

This brief sketch is a part of the sequel to one case of pernicious anemia, which is a primary anemia—to-day I propose taking up the secondary anemias. I will not enter into etiology, blood changes, symptoms, with treatment, but confine myself to results which we have obtained in the hospital and practice in a number of cases of secondary anemia due to various causes. I will first recount the results in a few cases, and then briefly outline the routine treatment, which is practically the Weir Mitchell, with slight transformation in individual cases.

Mrs. T.—For several months had been nursing a sick friend. Came in complaining of nervous exhaustion and palpitation of heart, anemia, tired all the time; pains in different parts of her body; appetite poor; does not sleep well. On examination a well-marked systolic murmur over the base. On entering the hospital on February 26th, hemoglobin 38 per cent.; March 12th, 56 per cent.; March 27th, 70 per cent.; April 23rd, 87 per cent.; May 29th, 95 per cent. Total increase, 57 per cent. Murmur dropped.

*Read at regular meeting of Huron Medical Association.

Mr. T.—Had pneumonia in winter; did not regain his normal condition; felt poorly; was anemic, irritable and discouraged. April 23rd, B.T. 50 per cent.; May 2nd, 65 per cent.; May 8th, 80 per cent.; May 15th, 86 per cent; May 22nd, 92 per cent.; May 29th, 96 per cent. Total rise in five weeks of hemoglobin, 46 per cent. Weight from 119 to 130 pounds.

Mrs. E.—Aged 65 years. A thin, anemic, nervous, sleepless individual, always tired in the morning on rising; had severe pains in different parts of the body; had tried several changes of climate for health. Her symptoms were so severe at first one would suspect some severe organic disorder; but examination revealed none, except a reduction in the body weight, and in the hemoglobin. She was under treatment for six weeks, and in that time all her symptoms had entirely disappeared. The hemoglobin increased from 70 to 100 per cent., and she exceeded her usual weight.

Miss K.—A very marked case of exophthalmic goitre. The heart was very rapid and irritable, 140 to 150, and marked exophthalmos and tremor; very much emaciated and anemic. When the patient left the hospital the symptoms of the disease had entirely disappeared, except some prominence of the eye. The hemoglobin increased from 65 to 100 per cent.; weight from 75 to 125—50 pounds.

Other cases I might mention are anemia following parturition, 27 to 90 per cent.; bleeding piles, from 35 to 100 per cent.; another at present under treatment, brought on by long nervous strain, with marked hysterical symptoms and anemic condition, gradually improving.

The Weir Mitchell methods can be applied to a great variety of cases, and there are some that cannot be cured by any other form of treatment.

In this class may be placed those exasperating cases which come complaining of nervous exhaustion. She has aches and pains and tender points; eats and sleeps poorly, and awakes unrefreshed; has various uterine and ovarian troubles, and is always tired, and takes little interest in anything. She ultimately becomes, as Holmes describes it, the vampire, who sucks the blood from healthy people about her.

Other favorable cases are:

1. Certain forms of mental disturbance, such as melancholia.
2. Cases where convalescence is slow from fevers, pneumonia, etc.
3. In early stages of tuberculosis.
4. In exophthalmic goitre cures may be effected.

5. In various forms of uterine and ovarian disorders.

6. It is also very beneficial in cases of chronic dyspepsia who are kept thin and anemic by the disease.

7. In early stages of Bright's and in floating kidney of recent date.

8. In heart disease, with failing compensation, especially if combined with Schott resistive movements and baths.

Weir Mitchell describes the treatment as a certain method of renewing the vitality of feeble people by a combination of entire rest and excessive feeding, made possible by passive exercise obtained through the steady use of massage and electricity.

The first step in the treatment is isolation. Isolation is necessary, and the patient should be removed to a hospital or sanitarium, away from familiar scenes. Home treatment does not succeed well. If circumstances compel the patient to remain at home, her room should be changed. Weir Mitchell states that if you once separate the patient from the moral and physical surroundings which have become part of her life of sickness, you will have made a change which will be in itself beneficial, and will enormously aid in the treatment that is to follow. This isolation is not as imperative where the symptoms are brought on by distinct causes, such as blood losses, dyspepsia, etc. The room should be bright, airy and comfortable, while the nurse should, if possible, be an entire stranger. Patient is put to bed and kept there from three to six weeks, as may be necessary, and during a part of this time allowed to see no one, except the nurse and the doctor. To take the place of ordinary exercise, two measures are employed—massage and electricity. By the kneading and rubbing of the muscles and skin, the liquids in the tissues are absorbed and poured into the lymph spaces, and a healthy flush is brought to the skin. This passive exercise should last from one-half to one hour, and may be used either in the morning or afternoon. If the massage is used in the morning, the electricity should be used in the afternoon.

Every part of the body should be gone over, even the face and scalp. In the afternoon each muscle should be passively exercised by electricity, each muscle being made to contract by the application of the poles of the battery to its motor point.

Both of these forms of exercise do not call for any expenditure of nerve force, and they keep up the general nutrition.

To outline a day's programme: At 7.30 a.m., a glass of milk, either hot or cold; 8 a.m., sponge with tepid water, following with rough towel friction; 8.30 a.m., breakfast, either boiled,

poached or scrambled eggs, milk, toast, fish, etc., tender meat or chicken. At 10 a.m., massage; at 11, milk in egg-nog; at 12, reading for one hour; 1 p.m., dinner, small piece of steak, rare roast; beef soups; easily digested vegetables; 3 p.m., electricity; 4.30 p.m., glass of milk or egg-nog; 6.30, supper time, no tea or coffee, but toast, and butter, milk custard, eggs or junket; 9.30 p.m., glass of milk or egg-nog. The amount of milk and the number of eggs should be slightly increased.

With a programme like the foregoing, the day is well filled, and the time does not drag as heavily as one might expect. In order to get good results, certain rules should be laid down, and each individual case is not lost sight of for a single hour.

TWO CASES OF ECTOPIC PREGNANCY: OPERATION, RECOVERY.*

By J. P. Kennedy, M.D., Wingham.

Mr. President and Gentlemen,—Ectopic pregnancy, I believe, does not occur very frequently in the practice of the general practitioner. During the last twelve years in Wingham it has been my fortune, or ill-fortune, to meet with at least four cases which I recognized as such. The first case, which I reported at this association some years ago, died two days after operation. The second case, which I met some four or five years ago, was in collapse when I was called, and died before I could get preparations made for operation. A subsequent post-mortem, however, demonstrated that her death was due to internal hemorrhage, following the rupture of a tubal gestation. I might add that this patient was a bleeder, the family giving the history of serious, in fact they claim almost fatal, hemorrhage in her case from the extraction of a tooth some years previously.

The first case which I wish to report to-day occurred in the practice of Dr. D. M. Gordon, of Lucknow. On June 26th last Dr. Gordon telephoned me to go to Lucknow the following day to operate on a case of hematocele. I went over early the next morning, and found patient with the following history, as furnished me by Dr. Gordon:

*Read at regular meeting of Huron Medical Association.

R. F., aged 26; primipara, first seen by Dr. Gordon, May 24th; examination then revealed slight uterine enlargement and discharge, no pains, nausea, browned skin, tympany, and abdominal tenderness over whole area, which eased off and on for two weeks, with temperature running from normal to 100½°, remaining normal for a few days, then followed by a severe attack of vomiting. On June 11th, 12th and 13th patient felt much relieved. On June 14th a sudden collapse occurred, when patient became pulseless for three or four hours, apparent death impending, followed by swelling in Douglas' cul-de-sac, and dulness over lower and left side of abdomen. Patient began to rally, and twelve hours afterwards temperature was 96°, pulse 180. Temperature raised to normal second day, following with varying temperature for 100° to 101½° for next eight days; pulse, 100 to 140 for four days, dropping to 110 to 124; next three days, temperature became erratic, running from 101° to 102½°; suspicious of septic condition.

Upon examination, I found patient with a temperature of 102°; pulse, 120. A large mass, which was clearly to be seen in the left inguinal region, with tenderness over the whole of the lower abdomen, particularly on the right side.

After the usual preliminary preparations, assisted by Drs. Gordon and Spence, of Lucknow, I opened the abdomen in the middle line, when the first thing to attract our attention was an enlarged, elongated gangrenous appendix adherent across the lower bowel, about six or seven inches in length, the tip reaching over to the bladder and uterus on the right side. The appendix was so rotten that it broke twice before I succeeded in freeing it from adhesions and removing it. I then packed right side of abdomen around end of the stump of appendix with some dry gauze pads, and proceeded to examination of the mass on the left side. This I found adherent to the intestines surrounding it, and also to the peritoneum of the abdominal wall. With some difficulty, by aid of the fingers and gauze pads I was able to separate these adhesions and free the mass down to the broad ligament. This I then transfixed with a pedicle needle, and tied with a Staffordshire knot. The mass, which I here present to you, was then cut away, and contained, as you will see, a well-developed fetus of probably two and one-half months. Below the mass, in the pelvis, was a large quantity of old blood clots, which I scooped out with my hand, sufficient to fill a small granite wash-basin. I then washed out the abdomen with gallons of plain sterile water, removed gauze pads from around

the stump of appendix, and dried out cavity thoroughly. On account of condition of appendix, I thought it wise to drain. I therefore packed plain sterile gauze about the end of the stump, and also in the pelvis down behind the uterus. This packing was brought out through the lower end of the wound, and the balance of the abdominal wound was closed with interrupted, through-and-through, silkworm gut ligatures. As may be imagined, this patient had a very stormy convalescence, and her eventual recovery is no doubt largely due to Dr. Gordon's careful after treatment. Dr. Gordon reports that her temperature moderated for a few days, 100½° to 101 2-5°; pulse running 110. July 3rd, 4th and 5th, temperature became more erratic, from 101 7-8° to 102 3-5°; pulse, 112 to 118. On the morning of July 6th, temperature was 101°; pulse, 110. In the evening it suddenly jumped to 105 2-5°; pulse, 145. Active purgation baths, etc., brought temperature down to 103° on the morning of the 7th. On the evening of the 7th, temperature was 103 2-5°; pulse, 130; bowels were moved eight or nine times during the afternoon. That evening, about ten or twelve ounces of pus were passed per rectum. The next two days there were bloody stools, ceasing on the third day. This was followed by a rapid convalescence. By the middle of August, patient was able to move around; gained rapidly in weight, showing ever since in appearance and feeling unequalled robustness. The opening in the abdomen was packed eight times during the after treatment to ensure drainage to appendix stump.

The second case I have to report occurred also in Dr. Gordon's practice, and the doctor, I think, deserves great credit for his early diagnosis in the case. On October 9th last Dr. Gordon telephoned me to go to Lucknow and operate for what he had diagnosed extra uterine pregnancy. Dr. Gordon gave me the following history of case:

Mrs. McK., aged 28; had on September 12th symptoms of miscarriage. On September 13th, placenta not having been discharged, examination of uterus failed to find it; had pains; suspicion of tubal pregnancy. Examination showed enlargement of uterus, and revealed a small tumor on the right side; tender to the touch, with slight uterine discharge. On October 7th, the pains were quite severe, and upon examination increased enlargement. Advised immediate operation. On October 8th, assisted by Drs. Gordon and Spence, of Lucknow, I opened abdomen, and found a mass on the right side, which was easily separated from adhesions. When loosened down to

the broad ligament, I clamped it with forceps and removed it. No fetus was found, but specimen shows an extruded mole from within layers of broad ligament. I removed about two tablespoonfuls of clotted blood, showing that tube had ruptured into the broad ligament. The anterior and posterior layers of broad ligament were united by a continuous catgut ligature. The abdomen was mopped out with dry sterilized pads. The peritoneum was united by a continuous catgut ligature; the aponeurosis and muscles united by catgut, and the skin closed by a continuous horse-hair suture.

Patient had an uneventful convalescence. Temperature, 99½° on the second day. Stitches removed on tenth day. Union by first intention.

Both cases are interesting from the fact that they were both primiparæ. I might add, too, that the second case I mentioned as dying from hemorrhage was also a primipara. The first case reported to-day is particularly interesting to me, on account of the gangrenous appendix, and also from the fact of the fetus being found.

THE CLINICAL SIGNIFICANCE OF TRACHEAL BREATHING.*

By A. F. McKenzie, M.D., Monkton, Ont.

Mr. President and Members of the Huron Medical Association,—During normal respiration there is no noticeable movement of the larynx. By the term tracheal breathing, as used in this paper, is meant that form in which the respirations are accompanied by up-and-down movements of the larynx, and with it, of course, the trachea. My attention was first called to this subject by a short paper, which appeared in some medical journal a good many years ago, soon after I commenced to practice. I am sorry to say that at present I am not able to give the name of the author of the article nor the journal in which it appeared. So far as my memory serves me, I think the subject of the paper was "Signs of Approaching Death," and, after enumerating the ordinary signs by which we are usually guided in forming an estimate as to the probable outcome of any serious case of acute illness, the author spoke of tracheal breathing as

*Read at regular meeting of Huron Medical Association.

being an almost certain indication of a fatal termination. I am not quite sure whether the term tracheal was applied by the writer to this form of breathing; but in the meantime, until something more appropriate is suggested, it appears to be a convenient term to use, particularly as the term "tracheal tugging" has been applied to somewhat similar movements of the windpipe, accompanying, however, the cardiac pulsations instead of the respirations.

As you are no doubt aware, tracheal tugging is one of the diagnostic points of aneurism of the arch of the aorta, and depends upon the fact that in passing from the trachea to the lung the left bronchus lies just below the arch of the aorta, and consequently each time the aorta is distended, the aneurism (if on the under side of the arch) pushes the bronchus downwards before it, and the latter drags in turn upon the trachea, causing it to descend with each beat of the heart. To obtain this sign it is generally necessary to put the trachea on the stretch. The respiratory movements of the larynx and trachea, to which I wish to call your attention to-day, are easily perceived both by touch and sight. The range of movement varies from about a quarter of an inch up to half or possibly three-quarters of an inch. The slighter degrees of movement are, perhaps, more easily detected by touch than by sight.

In the literature at my command I am able to find very little on the subject of movements of the larynx during respiration. In "Clinical Methods," by Hutchison and Raney, p. 35, it is said that "movements of the laryngeal box are sometimes conspicuous, and may call for explanation," but nothing further is stated as to the conditions in which we may expect to find these movements.

Jakob, in his "Atlas of Internal Medicine and Clinical Diagnosis," p. 37, says: "In cases of dyspnea depending upon stenosis of the larynx this organ makes wide respiratory excursions, and the head is thrown backwards, while in cases of stenosis below the larynx this organ remains still, and the head is bent forwards."

My limited opportunities for observation have led me to form the following provisional conclusions regarding this sign:

1. While a person is in a normal condition there are no up-and-down movements of the larynx during respiration.

2. Tracheal breathing does not occur in ordinary cases of illness, nor in those diseases in which there is a certain amount of dyspnea, but where we ordinarily look for recovery—such as

asthma, pneumonia, spasmodic croup and mild attacks due to cardiac and renal disease. The onset of tracheal breathing in these troubles makes the prognosis of the case much more serious.

3. Tracheal breathing does occur in diseases of the larynx attended by obstruction.

4. It is liable to occur during the course of any illness, and when it does, particularly if the movements are well marked, generally indicates a fatal termination.

5. The amount of danger appears to be in direct relation with the extent of the movements, the larger the movement the greater the danger.

6. When the sign occurs in connection with diseases of the lungs, such as pneumonia, bronchitis, pleurisy, etc., it is probably not of such grave significance as when occurring in cases where the respiratory tract is sound or only secondarily involved. The few cases I have seen recover, and the cases where death has been delayed for long periods, have mostly been in connection with respiratory troubles.

7. This sign may indicate a serious state of affairs when other symptoms by which we are ordinarily guided, such as the state of the pulse, condition of consciousness, etc., do not appear alarming.

8. Although occasionally other symptoms may point to a speedy fatal termination before the onset of tracheal breathing, yet, so far as my observation goes, death is always preceded for a longer or shorter period by this sign, the period ranging, as a rule, from a few hours to three or four days, occasionally to a few weeks, and in one case, to which I shall refer later, to a year or more.

In illustration of this subject, short sketches of the following cases may be of some interest:

1. A lady about forty-five years of age had for years been subject to bad attacks of asthma. I was called to see her in what was supposed to be one of her ordinary spells. Besides the usual dyspnea, she complained of pain in the right side of the chest, due, no doubt, to pleurisy. I saw her again in about thirty-six hours. Her pulse was about 120, and weak. Her intellect was perfectly clear. There was considerable dyspnea, and she complained greatly of the pain in the side. To relieve this I gave a hypodermic injection of one-eighth of a grain of morphia. I told her husband that her heart was weak, and that she might not get better, but did not think there was any immediate danger. Shortly after I left she passed into a comatose state, and died in

a few hours. By the friends her death was attributed largely to the hypodermic injection I had given, and I received considerable discredit. In thinking about her case afterwards, and wondering how I had let her slip out of my hands, I recollected noticing that she had marked tracheal breathing, but did not at the time attribute any particular importance to it. This death occurred about six years ago, and was, I think, the first to impress upon my mind the importance of this sign.

2. A man about seventy years of age, suffering from heart disease, had been under my observation for a couple of years, during which time he had several severe attacks of dyspnea, cyanosis, dropsy and other symptoms due to lack of compensation. An enlarged prostate, necessitating the use of the catheter, which set up cystitis, complicated the case. While I was absent from home on a vacation he became very bad. The physician who was looking after my practice thought he was so bad that he said he could not recover, and that it was no use going to see him any more. When I reached home the friends sent for me, and I felt very much like agreeing with the other doctor. He was in a partial comatose state, pulse very slow, breathing of the Cheyne-Stokes type. However, as I had seen him recover from some very bad attacks before, and as the larynx did not move up and down during respiration, I ventured to hold out some hopes. He recovered from this attack, and was able to go about some. In about three months he had another attack. In a few days tracheal breathing developed, and after this he died in about thirty-six hours.

3. A man about forty-two years of age, who had been troubled with dyspeptic symptoms for years, was suddenly seized with severe pain in the right hypochondrium, and vomiting. I was not able to make a positive diagnosis, but thought it was probably a case of peritonitis, due to perforation of a duodenal ulcer. Although it was recognized by me as a serious case, and consultation was requested, the man himself did not think he was very bad. His mind was perfectly clear, and he refused to believe he would die until an hour or two before his death. Well-marked tracheal breathing was noticed three days before the fatal termination.

4. A man about fifty-seven years of age, who had previously always been healthy, had been suffering from cough and what he thought was the grippe for more than a week. On a Thursday he was taken with a chill, and I saw him on the following Monday. This was his first day in bed. He had considerable

consolidation of the back of the right lung, respirations about 40; pulse 120, weak and irregular. Expectoration, which had been rusty colored, was of a green gage color. Tracheal breathing was well marked. I gave an unfavorable prognosis, and he died on the following Friday.

5. A lady about sixty-eight years of age had been suffering from pernicious anemia for about two years. She gradually became weaker, and it was seen that it was only a matter of time until death would come. I was suddenly sent for one night, as she was thought to be dying. I found her comatose. Her jaw was dropped, and the respirations were very labored. The larynx did not move up and down during respiration. Next morning, however, tracheal breathing had developed, and she died in about twelve hours. In this case the sign was late in declaring itself, and was consequently not of much use in prognosis. Possibly the dropping of the jaw was one reason why the sign was so late to appear.

6. A lady about sixty-eight years of age had for years a bad cough, probably due to chronic tuberculosis. She was very much emaciated. I was called to attend her for a pain in the side. She was feverish, and appeared to be developing pneumonia. Tracheal breathing was well marked. I gave a very unfavorable prognosis. Next day she appeared considerably better. The fever had left her, and the pain in the side was better, but the larynx still moved up and down with each respiration. This type of breathing continued until her death, which did not occur until some months after. This is the only case that I have observed in which the patient was able to go around, or where the symptom was present so long before death. She probably had laryngeal tuberculosis, as she was quite hoarse. Another case of pulmonary tuberculosis had tracheal breathing for a couple of weeks, and possibly longer, before death occurred.

7. A short time ago I had occasion to resuscitate by artificial means a new-born infant. When it first began to breathe of itself there were distinct up-and-down movements of the trachea, but these gradually ceased as respiration became easier.

I have seen recovery occur in a few cases of illness where this sign was present, but in none of them was the movement of the larynx very great.

One case was that of a man sixty-eight years of age, who had rather a severe attack of bronchitis.

An old woman over ninety years of age complained of pain

in the back. This was probably rheumatic. There were slight up-and-down movements of the larynx. It is now some months since I saw her, and I understand she is still living. A friend of mine has told me of a case of severe pneumonia in a young man, where the movements of the larynx were well marked, and where recovery occurred. A case of empyema, occurring in my own practice, and which recovered after operation, had slight tracheal breathing for some days before the operation.

I must confess that I am not prepared at present to enter into a discussion of the physiology of respiration, nor to give an adequate explanation of this sign. In a well-marked case one would almost think the windpipe were dragged upon with each inspiration. This might be due to an irregular dilatation of the chest cavity of such a nature that the ordinary expansion of the lung would not fill the cavity so quickly as in health, and hence the lung as a whole, and consequently the windpipe along with it, would be drawn down. Possibly the contraction of the sterno-hyoid and sterno-thyroid muscles may have something to do with it. At any rate, it is probably due to an effort of nature to obtain more air with each respiration, and is an exaggeration of the same condition which causes the dilatation of the nostrils which we see in ordinary pneumonia.

The object of this paper has been to call your attention to what appears to me to be a valuable clinical sign, and one which, taken in conjunction with other signs and symptoms, may enable us to detect the approach of danger a little earlier than we might otherwise do.

The sign is one that is so easily detected by both sight and touch that it must have been noted by many observers from the time of Hippocrates to the present. My excuse for bringing the subject before the members of this association is that I can find so little concerning it in the literature at my command, and from conversation with a few medical men I have found that none of them had previously had their attention called to it.

CASE REPORTS—(a) INTRALIGAMENTOUS CYST; (b) UTERUS WITH MULTIPLE FIBROIDS; (c) OVARY WITH BLOOD CLOT.*

By W. Gunn, M.D., Clinton, Ont.

Dr. W. Gunn, of Clinton, presented several pathological specimens: Four fibroids and three carcinomata of the uterus; three gangrenous appendices recently removed; a dermoid tumor of the ovary; five prostates, successfully removed; a fibro-adenomatous goitre, and the following specimens, which were considered sufficiently interesting to be reported in more detail:

(1) *Specimen.*—A large intraligamentous cyst. The uterus thinned and elongated to six or seven inches, with the muscular fibres of the broad ligament, are spread over and firmly adherent to the tumor in this location.

History.—Miss McC., age 58. From girlhood menstruation was painful and irregular. In the year 1873 had two attacks of what was called inflammation of the bowels. In 1887 she noticed a swelling on the left side, low down. The growth was slow at first, but more rapid latterly. The spread of the tumor at first was upwards on the left side, but later it extended to the right side. The left leg was swelled and painful. In March of 1896 she was operated on by Dr. Allaway, of Montreal, at the hospital. The diagnosis was an ovarian tumor of fifteen pounds. Recovery was slow, a left-leg phlebitis following the operation. In 1898 she felt the tumor returning on the left side, and it became very large. In 1902 the tumor emptied into the bladder quite suddenly. Filling again, it emptied into the bladder a year later. Six months later there were signs of intestinal obstruction—pain, vomiting and tympanitic distension. Her life was about despaired of, when the tumor broke into the bowel, large quantities of a coffee-ground fluid coming away, and diarrhea following for about a week. In March of 1905 the distension was very great, and the tumor was tapped, and nearly an ordinary pail of fluid taken away, and marked relief followed for a time. Six months later she came to Clinton for operation. The abdomen was the size of a full-term pregnancy, and the usual upward and downward pressure symptoms were present. Dr.

*Reported at regular meeting of Huron Medical Association.

Gunn, of Ailsa Craig, and Dr. Shaw, of Clinton, assisting, the abdomen was opened in the middle line. The sac was noticed behind the posterior peritoneum, the peritoneum having to be twice divided. The large and small intestines and omentum were intimately and extensively attached to the tumor above and in the front. The uterus was thinned and elongated and continuous with the muscular structure of the broad ligament, the latter being spread over and intimately attached to the inner aspect of the sac. To separate the intestines required considerable time and a good many ligatures. The part of the small intestine where the sac emptied was easily recognized, and required a few Lembert sutures. The sac was now emptied, and by the aid of gauze, blunt dissection and a few ligatures, the tumor was separated from the posterior aspect of the bladder, and the ureter for two-thirds of its length. The uterus was now amputated at the cervix, and, with the spread-out muscular fibres of the broad ligament, was removed attached to the sac. To have done this earlier in the operation would probably have rendered the separation to structures behind considerably easier. No opening was left in the bladder after separation, but the communication between the sac and bladder was evidently near the entrance of the ureter into the bladder. After the usual toilet, the peritoneum was as far as possible restored to its normal relations, and a twenty-four-hour drain put down to the base of the bladder behind the peritoneum. Recovery was rapid and without any drawback. The indications for attaching such cysts to the abdominal wall and draining were discussed.

(2) *Specimen.*—A uterus with multiple fibroids, one of which protruded from the cervix. Attached to it a pus tube and a large pus sac in the broad ligament, in which the appendix is embedded.

History.—Miss L., aged 34 years. Suffered from menorrhagia metrorrhagia and anemia for several years. For about six weeks previous to operation, which took place February last, there was a pronounced febrile condition, with the physical signs of an abscess forming on the right side of the uterus. Dr. McCrimmon, of Kincardine, whose patient she was, diagnosed a fibroid of the body of the uterus, a polypus and a pelvic abscess, either due to appendicitis or uterine sepsis. Drs. McCrimmon and McDonald assisting, the belly was opened in the middle line. The abdomen was thoroughly protected with gauze, the appendix separated, and stump inverted. The abscess was aspirated of about twelve ounces of pus, mopped out thoroughly,

packed and closed. The sac was separated with the fingers, gauze and slight dissection, with comparative ease. The uterus and tube was removed in the usual manner. Recovery was complete, but somewhat delayed owing to stitch abscesses.

The discussion following referred to the indications for attacking a pelvic abscess per vaginam.

(3) *Specimen.*—Showing ovary 3½ inches long and 1¾ inches thick, containing ½ oz. of blood clot.; the tube very much thickened and containing about ½ oz. of blood clot. The broad ligament contained a cyst, with well-defined wall, with about 12 ozs. of a sero-santous fluid. The entire mass black and gangrenous. No signs of ectopic gestation. Dr. Campbell, of Zurich, who had charge of the case, gives the following history:

History.—Mrs. P., aged 38 years, mother of five children. Saw her for the first time May 6th, 1906. She complained of a severe, steady pain in the region of the outer border of the left kidney, shooting across the lower part of the abdomen. The pain was more severe at times. There was frequent micturition, a few drops being passed at a time, which burned her. There was an aching feeling in the back. Pulse 110, and weak; temperature, 98°; face pale; expression anxious; cold, clammy sweat. In absence of a better diagnosis, he thought renal colic a fairly probable one; ⅜ gr. morp. and 1-30 gr. strych. gave rest and sleep for four hours. May 7th—Temperature, 98°; pulse, 80. Though tender over same region, was able to resume duties in a few days. May 23rd—Driving to Zurich, felt a pain similar to the one already described. Arriving at a store, she lay down. The pain was very severe, sharp and lancinating. The face pale and bluish. Pulse could not be felt at wrist. Vomiting, anxious expression, cold sweat, no urinary symptoms. The symptoms improved under morph. and strych., and she was sent home, a distance of five miles, on a mattress. May 24—Felt better; pain now referred to the lower abdomen. Temperature, 99°. An enema of soap and water relieved her of some gas. May 25—Severe pain and tenderness in the appendix region. Abdomen tympanitic and much distended above, not so much below. Temperature, 98½°; pulse, 135. Very weak, vomiting persistent, constipation complete, right rectus very tense. Complains of bowels, or gas rolling to appendiceal region, and receding. A swelling the size of a large fist can be felt above Poupart's lig. and below McBurney's point, oval in shape, and dull, but quite tympanitic just below tumor. May 26th—Succeeded in persuading patient and friends that the case was entirely surgical in the

way of treatment. It should have been stated that menstruation was regular every four weeks till six weeks ago, since which time it was every twenty-one days.

Operation.—Assisted by Dr. Caw, of Parkhill, and Dr. Campbell, of Zurich, the abdomen was opened through the right rectus muscle over the most prominent part of the tumor, and a gangrenous mass presented. Examination showed it to be attached to the left side of the uterus, and that the mass was twisted and lying on the cecum. The urinary symptoms were no doubt due to pressure or tension on the bladder or ureter, and the obstruction was caused by pressure. It is hard to say whether the ovary or the cyst in the broad ligament was the primary cause of the torsion. By clamping and ligating near the uterus, the mass was easily removed without breaking. This is the fourth day since the operation, and Dr. Campbell reports the case improving rapidly.

MEDICAL THOUGHTS DURING LEISURE HOURS.

By James S. Sprague, M.D., Stirling, Ont.,
Author of "Medical Ethics," etc.

"Read not to criticize, but to accept, or reject, or to consider."

My last paper to this honored journal had for consideration many interests, but the one most prominent was that referring to the incorporation of nurses—certainly a will-o'-the-wisp infatuation, in fact a butterfly chase, yet in keeping with the temperaments of the promoters and their satellites of the Nurses' Incorporation Bill. Are we so inexperienced and so callous in our observations as to credit such statements as were made by Mr. Crawford, M.P.P., to or in effect that they were a body only second to, if they were second to, the medical profession, and followed the lines of the incorporation of the medical fraternity. If such statement be correct—which, probably, some innocent, without thinking, would endorse, and abundant proof would be thus advanced, that, "although man, a thinking being, was designed, few use the great prerogative of mind"—my opinion is that of every M.D. whose heart is in his profession's best interests, our profession would be made to regret such legal

incorporation, and the attendance of students in medicine at our universities would be lessened, not forgetting the fact that our services would be decreased. Such views need no illustrations or endorsements. If allowed graduation, incorporation and all the academic privileges, of which a degree is in keeping, the legislators will in duty be bound to listen to the appeals of Christian Scientists, faith healers, osteopaths, and all such visionaries, for whom our Governments have most humanely erected homes or refuges in the interests of the dear people—the erratics. Yes, visions are due to disease. I make this statement, if it is in direct contradiction to the saying of Marcotte: "*La nature ne fait rien de rien, et la nature ne se perd point.*" If this assertion, that "Faults in the life breed error in the brain, and these reciprocally those again," should be correct—and such, I believe, is correct—would it not be wise for the legislators to direct these sciolists to put their visions and ambitions in cold storage for a certain and reasonable season?—or better, to go in retirement for close self-study until their brains are freed or purged from delusions and vapors?

Hope, when not well established or placed on reasonable foundation for the anticipation of consummation, or influenced by the bubblings of the yeast of confident enthusiasm, according to well-established laws or rulings; frequently, yes, by its very nature, usually drifts into a relapsing condition, or an apathy decidedly incredulous, and too frequently, yes, ultimately, observable by those who think. Hope, not too well founded, as stated, flattens as a bursted bubble, when deduction, conservative in character—as hard as sea-biscuit—commences its work, and effectually triumphs. And those who, directly or indirectly, should consider these interests, should consider, too, that, although medicine is rapidly reaching higher levels, yet there are many barnacles that grow and fatten to its detriment. To further exemplify our present position, I will state it is necessary to refer to a sketch from a Berlin paper, wherein De Witte, of gigantic proportion, was represented. On his back was the Czar, who was tightly grasping the throat of the peacemaker—the real ruler, the real friend of the Russias. To him the words of De Witte are addressed: "Do not strangle me, for if you do we both will fall." Cannot we bring this simile to bear with force to illustrate how we stand, and with the nurse or her proposed organization on our back, and the unrelenting grip at our innocent throats? To use another simile, wherein the vanity of her ambition is fairly represented. The inane solicitude of the

present Kaiser to do work—meritorious as was that of his illustrious progenitor, Frederick the Great—occasions the remarks of the thrice illustrious one who, some few years since, was cartooned as sitting in a chair, while his relative, our noble Victoria, was placing a cake of ice on his head to keep it cool. The Kaiser remarks, while seeking his progenitor's virtues and bodily proportions: "I've taken every opportunity to hoist myself to your height, but I fear, if so elevated, I shall not be able to hold myself equal." A consideration of those interested is imperative. Christian Scientists and osteopathy, more recently, are struggling, no doubt, for incorporation, and as there are others equally delusive enough to prove the necessity of wider exposure of error which, if preachers would assist us (the doctors) would vanish. However, such is a vain hope when a member of Parliament says the business of the nurse is the equal of the profession of medicine. One fact is this, and if the study of our interests be considered, it will be proven, that "no gentler pirates ever scuttled ships" than those above named, and encouraged are they by the patent medicine concerns, whose products many so-called medical journals nurse, while they so easily recognize the members of our profession as very easy marks—and such they are, and such is attributable to the want of proper and national organization and co-operation.

LONDON, a most prosperous city, a railroad centre rivalling our metropolis, after suffering much injustice in regard to its patriotic and just claims as a centre for examinations for our Medical Council, has been successful, and on May 4th announced its first session. When one considers the position of London, the fine record of its university, and that Detroit and Buffalo have several medical colleges, to which many from this most flourishing district, of which London is the metropolis, have been encouraged, actually been compelled to go, we well can understand the well-conceived and nursed complaints of the medical men of London and its friends; in fact, all loyal men in medicine. One fact is this: the calendars of the medical colleges of Buffalo and Detroit, or Ann Arbor, will not contain among their matriculants and graduates the announcement that one-half the names are Canadians. Is not Dr. W. H. Moorehouse worthy of every praise? Are not those who sustained him, too, equally to be praised?

DR. MATTHEW WALLACE, a name made worthy of adoration, marks well the fact that one man can illustrate the worth, the

dignity and the glory of medicine, for Rev. Dr. Watson wrote me when "The Bonnie Brier Bush" was enjoying immense and well-extended distinction, that not from one, but from the many medical men's lives he drew the picture—to be treasured forever. Yet MacLure was a bachelor; but Wallace was the father of several children. If "he who does not provide for his family is worse than an infidel," how does the world balance this life? Another query is: Had Dr. Wallace claimed *another* alma mater, and was an adherent of *another* church, would his name or his noble works been ever known? *No!* is my answer. Thank God there are other ledgers. Although on earth that of Wallace was poorly kept and worth but little, that in Heaven has more than one page full of his sacrifices, his devotion to the sick; and kind Heaven will not see his wife or his children suffer. Cannot his alma mater give his sons free tuition, thus further to illustrate her faith in the teachings of Hippocrates named in the oath?

To be Continued.

Clinical Department.

Safety Pin Safely Passed by Child of Sixteen Months. By J. A. Postlewait, M.D., Tarkio, Mo., in the *J.A.M.A.*

In *The Journal*, of Nov. 25, 1905, Dr. L. W. Littig reported a case of a child eleven months old who swallowed a safety pin one and one-eighth inches in length and passing it in a few hours less than five days. No inconvenience was suffered and no treatment was given. Some time since I had an experience much the same with a child sixteen months old. In my case the safety pin swallowed was one and one-fourth inches long, open, and three-fourths of an inch wide at the angle of opening. The safety pin was swallowed at noon on Saturday and on the following Thursday at 9 a. m. it was passed. The child did not suffer and no treatment was given.

Rupture of Thoracic Aneurysm into Pleural Cavity, Simulating Pleuritic Effusion. By Joseph B. Greene, M.D., of Fort Stanton, N.M., Passed Assistant Surgeon United States Public Health and Marine-Hospital Service, in the *Am. Med. Jour.*

The following case seems of sufficient interest to report, on account of its rarity and as showing the possibility of confusing blood in thorax with serious or purulent effusion:

Patient, J. D., colored, aged 41, nativity, Kentucky; admitted to the United States Marine Hospital Sanatorium at Fort Stanton, New Mexico, on January 2, 1905; transferred from Louisville, Ky. The records show the family history is good; that the patient had had syphilis several years ago, but that his general condition was good up to one year ago. Since that time he has several times required hospital treatment. He has had occasional hemorrhages from the lungs with slight rise of temperature. For several months after admission to this institution he continued to lose ground, and on July 10 began to complain of considerable pain in the left chest, with all the physical signs of effusion into the same side. His temperature varied from about 37 deg. C. in the mornings to 38.5 deg. C. in the afternoons. We at once used the aspirating needle at five different points at the base of the left lung, and were surprised at finding

nothing. The patient continued to suffer severely, both from pain and dyspnea, and on the evening of July 20 suddenly died.

The autopsy findings showed the entire left pleural cavity filled with dark, clotted blood, which explained our failure to aspirate the pleural cavity. Incision into the left lung showed at the apex a cavity the size of a small orange, completely filled with an aneurysmal sac, which had extended from the arch of the aorta. The aneurysmal sac contained layers of fibrinated blood. The pleural cavity was connected with the aneurysmal sac through a small opening the size of a pencil point. The remainder of the left lung was infiltrated with tubercles. The heart and right lung were apparently normal.

A Case of Bell's Palsy in an Infant of Eight Months.

By JOHN H. W. RHEIN, M.D., Neurologist to the St. Agnes and Howard Hospitals, etc., Philadelphia, in *Am. Ped.*

The patient, an infant of eight months, was brought to the Dispensary for Nervous Diseases, at the Howard Hospital, on October 3rd, 1905, by her mother, who stated that, a week previously, the right side of the child's face became paralyzed the day after a small abscess under the chin on the right side was evacuated by a surgeon.

The family history is entirely negative. Both parents are living and well, as are also two brothers and two sisters. The child was born at term, but was a cross birth, and it was necessary to turn the child and deliver her feet first. The labor was difficult and the child very feeble for nine days after birth, during which time she was unable to nurse at the breast. There was no paralysis noted at this time, and she gradually grew stronger, remaining in perfect health until September 23rd, when she developed an abscess under the chin on the right side, which was incised and evacuated on the third day by Dr. Frank Patterson.

The day after the abscess was opened the mother noticed that the child was unable to close the right eye, that the mouth was drawn to the left, and that the head was slightly tilted to the left. The child was brought to the clinic a week later, when a complete right-sided facial palsy was observed. The paralysis was not apparent when the face of the infant was at rest, but when she cried she did not close the right eye, nor move the right side of the face. There was, as far as could be learned, no involvment of the throat of palate mustles, which was con-

firmed by the fact that the child had no difficulty in nursing. There was no paralysis of the ocular muscles, and no apparent weakness of the arms or legs. The ears and throat were carefully examined, but nothing abnormal was found. The pupils reacted normally. The knee-jerks and the tendon-jerks of the arm were active and equal on both sides. The plantar reflex was normal, and there was no Babinski phenomenon present. No local wasting could be observed anywhere. The bowels were regular, and the digestion good. The child did not present any signs of rachitis. The fontanels were apparently closing satisfactorily. An electrical examination of the muscles showed the presence of the reactions of degeneration. There was a slight increase in the galvanic irritability of the muscles of the right side, and the response to the faradic current was gone to bearable currents. The child presented nothing else abnormal in the history, or physical signs, except that occasionally she suffered from night-terrors.

In many respects this case is not unusual. There is nothing peculiar about the paralysis, or in the cause of the paralysis. The usual causes of unilateral facial paralysis in infants are those which operate in adults. In addition to these, however, we meet with cases of this character immediately following childbirth, when they are due to pressure of the forceps, or pressure exerted by the promontory of the sacrum, or by the ischiatic spines, or, finally, in rare instances, by intrapelvic tumors. Probably the most frequent cause of Bell's palsy in children is disease of the middle ear. It may be the accompaniment of diseases at the base of the brain, such as tumors, meningitis, or fracture of the base of the skull, and may follow surgical operations in the region of the ramus of the jaw. Finally, unilateral facial palsy may be caused by extension of inflammation to the nerve from neighboring inflammatory processes, as in the case exhibited.

It is unusual, however, to see a typical case of facial palsy develop at the early age of eight months. Bell's palsy is rare under ten years of age, and Gowers states that he has seen two cases in the second year of life. It probably occurs most frequently between the ages of twenty and fifty years. In Sachs's opinion (*Nervous Diseases of Children,* 1895, p. 229) the disease is rare under three years of age, although he himself saw one patient nine months of age who suffered from rheumatic facial palsy. Henoch (*Vorlesungen uber Kinderkrank,* 1903, p. 231) reports a case in a child of two, with complete palsy of

the left facial nerve, due to pressure at the stylomastoid foramen by an abscess in the lymph nodes of the neck. He also described two cases in children of five and eleven months, respectively, the cause of which was a granular tumor under and behind the right ear, associated with diffuse swelling of the connective tissue. In a fourth case, a child of four months, there was left-sided facial palsy following gangrenous destruction of the nerve at the stylomastoid foramen, due to noma of the ear.

Grancher and Comby (*Traité des Maladies de l' Enfance*, 1905, p. 621) claim that age has no influence upon the development of facial palsy, making the statement that they had seen cases as young as eleven and thirteen months.

.. Notwithstanding the fact that it is well known that facial palsy develops in young infants, I think it may be concluded that it is comparatively uncommon. This is rather remarkable when we consider that middle ear disease, which is one of the most common causes of Bell's palsy in children, is of very frequent occurrence in young children.

The possibility occurred to me that the anatomic relations of the temporal bone may have something to do with this. It will be remembered that at birth that portion of the temporal bone called the pryamid is spongy and vascular, and that the canal through which the facial nerve passes is often not entirely covered in. Is it not possible that, by reason of these conditions, the nerve is less susceptible to pressure, resulting from caries and suppuration? On the other hand, it must not be forgotten that the anatomic relations may favor the extension of the inflammation to the nerve, because it is so much exposed.

The presence of facial palsy, with abscess of the middle ear, is of considerable prognostic importance. It is claimed by Goodhart and Henoch that this combination of symptoms is almost pathognomonic of tuberculosis, and that the prognosis is always bad.

In the treatment of facial palsy in children it is important, in the first place, not to frighten the patient by a too hasty application of the electric current. Sometimes it is wisest, at the first two or three treatments, to apply the electrodes without any current at all. The preferable method of applying the galvanic current (which is the current to be employed) is to place an indifferent cathode electrode at the nape of the neck, or between the shoulders, and a small interrupting anode electrode in the anterior cervical region, and then to turn on the current until the milliamperemeter registers 2 or 3 milliamperes. The anode

electrode is then brought slowly up over the distribution of the facial nerve, and the skin slowly stroked for three to five minutes. Care must be observed to avoid as much as possible the bony points, in order to reduce to a minimum the amount of pain. It is impossible, in infants, to interrupt the electrode, as it causes a great deal of pain, besides bringing about a condition of fright. The ascending stabile current for the first two or three weeks of the disease, that is, during the acute stages, should precede the application of the labile current.

Massage is also indicated in the treatment of facial palsy, and is of great value not only in stimulating the nutrition of the parts, but in preventing subsequent contractures.

If an incised wound in the soft parts does not heal as readily as it should, examine the urine for sugar.

Repeated attacks of coughing after tracheotomy may mean irritation of the posterior wall of the trachea by the tube; change the length or shape of the canula.

Aluminum instruments should not be boiled in soda solution, like other instruments. They are to be sterilized by boiling in plain water or by passing them through an alcohol or Bunsen flame.

The threading of catgut or kangaroo tendon through a needle-eye not very roomy may be made easy by cutting the suture end obliquely and flattening it between the handles of the scissors. Silk must not be cut obliquely, however, for this makes it apt to unravel while it is being threaded.

The use of an "invalid table," the shelf of which projects over the patient's body, will be found a great convenience during operations as a receptacle for instruments in immediate use. It saves time and temper, and avoids accumulation of instruments on the patient's body.

A LIGHT-BEARING cystoscope is a handy instrument for the non-specialist to use for transillumination of the accessory sinuses of the nose. Place the tip of the instrument in the patient's mouth and let him close his lips firmly.—*American Journal of Surgery.*

Proceedings of Societies.

HURON MEDICAL ASSOCIATION.

The regular meeting of the Huron Medical Association was held in Clinton on May 30th, with the following members present: Dr. N. W. Woods, President, Bayfield; J. W. Shaw, Secretary, Clinton; W. Gunn, Clinton; J. P. Kennedy, Wingham; Lorne Robertson, Stratford; Alex. McKenzie, Monkton; Hamilton, Belgrave; J. Lindsay, Blyth; Weir, Auburn; J. N. Gunn, Clinton; McCallum, Londesboro; Turnbull, Goderich; McFadden, Hensal, and Thomas Gray, St. Thomas. The president gave an address on "Medical Ethics and Lodge Practice." For transportation of bodies on railways and filling the papers, he suggested, a fee should be made. In notification of contagious cases the Government should allow a fee in each case, similar to births and deaths, and suggested that the secretary of the Provincial Board of Health be notified of our suggestions. Papers were read by Drs. Kennedy, W. Gunn, McKenzie and J. N. Gunn, which appear in full in this Journal. Dr. Gray, of St. Thomas, exhibited skiagraphs, illustrating fractures before and after diagnosis and treatment. His remarks showed how the best physicians and surgeons often err in their diagnoses of fractures. Each of the papers came in for a full discussion.

FREQUENTLY referred to the surgeon because of the constant pain and marked tenderness, is to be noted a group of cases of what might be termed *occupation wrist pain*. They differ from the ordinary case of "writer's cramp," "piano-player's cramp," etc., in that, while these latter frequently have pain in, or about, the wrist, the cases here referred to have no spasm, the pain is constant, and it is not of a neuralgic character. Sometimes it radiates along the thumb (as in mail-openers); sometimes it is localized to the inner border of the lower end of the ulna, which is very sensitive to pressure (as in shirt-ironers). The fingers are free. There may be pain in the forearm muscles (flexors). —*American Journal of Surgery*.

Physician's Library.

International Clinics. Vol. I. Sixteenth series, 1906. Philadelphia and London: J. B. Lippincott Co.

This is one of the best volumes of the International Clinics which has been issued. In treatment, the subjects dealt with are: "The Medical Treatment of Exophthalmic Goitre," "The Treatment of Gastroptosis," "Coughing, and Its Relation to Treatment," "The Dechloridation Treatment in Diseases of the Heart," "Indications for and the Methods of Performing Venesection." Casey A. Wood has a good article on "Death and Blindness as a Result of Poisoning by Methyl, or Wood Alcohol and Its Various Preparations." There is another good article on "The Causation and Treatment of Eclampsia." Over one hundred pages are given up to a review of the progress of medicine during 1905.

Case Teaching in Medicine. A series of graduated exercises in the Differential Diagnosis, Prognosis and Treatment of Actual Cases of Disease. By RICHARD C. CABOT, A.B., M.D. (Harvard), Instructor in Medicine in the Harvard Medical School, and Physician to Out-Patients at the Massachusetts General Hospital. Boston: D. C. Heath and Co.

There is something unusual in this book. It represents the histories of a series of cases set out clearly and then analyzed. It illustrates Dr. Cabot's method of instructing students, and will be found valuable by all students of medicine.

The Theory and Practice of Medicine. By FREDERICK T. ROBERTS, M.D., B.Sc., F.R.C.P., Fellow of University College, Emeritus Professor of Medicine and Clinical Medicine at University College, Consulting Physician to University College Hospital, etc. In two volumes. Price, 26s. net. Tenth edition. London: H. K. Lewis.

Roberts was formerly a leading text-book in the medical schools of Canada until it was largely displaced by Osler. It, however, was a work of the highest authority and order. It is

still a text-book in medicine on the curricula of our colleges, but the fact that it has been so long since the ninth edition appeared rendered it behind the times, especially in pathology, bacteriology and much of the modern methods of treatment. The two volumes before us are satisfactory. They are royal 8vo., and embrace together 1,382 pages. The work largely embraces the personal experiences and observations and opinions of the distinguished author, and hence for that reason alone all the more valuable. It has been brought up to present-day medicine, and is in every way a work of the first magnitude.

Taber's Pocket Encyclopedic Medical Dictionary. Edited by CLARENCE W. TABER, and published by him at Chicago, will prove a handy volume for medical students during their course of studies. At lectures or clinics the word whose meaning is not known can readily be looked up.

We desire to call the attention of our readers to the advertisement of A. C. Butters & Co., New York, in this issue. These standard sets are gotten up in nice, tidy style, and anyone procuring any of them will be satisfied with their general make-up and typography.

The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enrol themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $2.50 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

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// Dominion Medical Monthly

And Ontario Medical Journal

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COMMENT FROM MONTH TO MONTH.

The Canadian Journal of Medicine and Surgery has issued a handsome special number, a British Medical Association meeting number. Altogether it embraces reading matter and illustrations 112 pages, advertisements 147 pages. Such commendable journalistic enterprise as this should receive nice encouragement from the general profession.

Startling are the shocks which periodically emanate from the United States. We say United States, as, if we said America, one would think we were away on a holiday abroad. Fast following on the insurance scandals comes the "Great American Fraud," the San Francisco disaster and the slaughterhouse atrocities of Chicago and one or two other western cities. The United States of America is a great nation; so one must consequently look for something on a large scale and altogether out of the common now and again. The invitation to the British Medical Association, when convening in Toronto, to send a special committee to Chicago to investigate the conditions pre-

vailing in the slaughter houses and packing houses, would no doubt prove a very nice and enjoyable trip to the special committee, a sort of medical High Jointers' jamboree.

The Boston meeting of the American Medical Association of 1906 seems to have been a record-breaker, there having been nearly 5,000 physicians registered. It appears to have been an emphatic endorsement of the plan of campaign as set forth in the organization, in progress, in the establishment of county societies and closer affiliation of State societies with the national organization. It proves beyond the shadow of a doubt that organization counts for a great deal, and that the time and the day has come when the profession of medicine, not alone in the United States, but in Canada as well, and in other countries, must stand united, and not continue to work alone, as in former days. It is said to have been the largest medical meeting ever held.

When the national medical association of our neighbors to the south of us is showing such splendid evidences of growth and development, it seems appropriate for Canadians to be up and doing. Indeed, for too long have we lagged; but a start has been made. It is most important that a very representative meeting should gather in Toronto this year, on the afternoon of the 20th and the forenoon of the 21st of August. The Special Committee on Reorganization appointed at Halifax last year will have a report to bring in; and every province should have a large delegation present to discuss the various phases of that report. The welfare of our national medical organization should excite the keenest interest in the breasts of all its members, of whom there are now nearly 1,500. No doubt when reorganization is accomplished there will be a large influx of new members.

It will not be long before some enterprising chemist has upon the market as a toilet preparation of great value and unique handiness, the box of calomel ointment, as, according to Pro-

fessors Metchnikoff and Roux, syphilis may be arrested by rubbing the site of inoculation soon after infection, with calomel ointment. These scientists have recently made thirteen experiments upon monkeys, and with such striking results that a medical student of Paris submitted his body for experiment, and was inoculated with the virus from two separate and distinct hard chancres. One hour thereafter the site of inoculation was rubbed with the calomel ointment, and at the end of three months not a single sign of the disease had manifested itself. This is all the more striking as several monkeys inoculated at the same time with virus from the same sores either died or contracted the disease. Thus there is hope that a disease which has spread its ravages for many centuries may at last become subservient to the calomel gallipot.

An item appears in a recent number of the *British Medical Journal* anent the approaching meeting, which, if it were not written in a serious mood, might be considered a trifle humorous. Altogether, it is ridiculous. Delegates coming out are advised to carry along a bottle of shoe shine, as "it is a very difficult matter to get a shoe shine in Canada." Evidently these delegates are expected to take to the woods once they arrive on Canadian, which is also British, soil. The silk hat as affected in European capitals is altogether out of place in Canada. That was another very bright bit of wisdom. The temperature in August in Toronto is said to be 66 F. Probably it is; but sometimes it is 100 F. Good, heavy woollen clothes for ocean travel are just the thing, too, when the thermometer is at 100 F. Really, it is too bad we are so very far behind the times. It is to be hoped that it doesn't snow. Probably the Dawson rainmaker might be engaged to keep the snow away during the week of the meeting.

Science Notes.

Respiratory Power and Its Limits.

Nowadays, when questions of steerable balloons, airships and aeroplanes are the *piece de resistance* of many scientific and other journals, the side issue suggests itself with renewed vigor in the form of a vital problem, to wit, to what height can an aeronaut ascend without losing his life? Some twenty years ago experts stated that it was impossible to exceed an altitude of from 26,244 to 29,523 feet. Accidents were likely to occur at 19,683 feet and, after this altitude, the aeronaut becomes insensible. Mr. Paul Bert, however, demonstrated that it was possible to avoid the risk of suffocation at great altitudes by repeated inhalations of oxygen, and it was due to the use of oxygen that some three years ago Messrs. Besson and Suring succeeded at Strasburg in reaching the highest altitude ever attained, viz., 34,770 feet; even then, despite a liberal use of oxygen, one of the intrepid aeronauts fainted.

A few years ago Prof. Musso, of Turin, made some researches in connection with the question of asphyxiation at great altitudes, and he came to the conclusion that to enable the influence of highly rarefied air to be successfully combated, it was necessary to inhale oxygen mixed with a strong proportion of carbonic acid.

Mr. Agazzotti, one of Prof. Musso's pupils, has now just taken up again the experiments commenced by his old master. Instead of making an ascent in a balloon, he had himself inclosed in a large bell, in which the air, by means of a pump, was gradually rendered more and more rarefied. The bell was provided with a tap, communicating with the outer air, by means of which and a small pump the foul air was expelled. The experimenter then covered his face with a specially constructed mask provided with two valves; one of these enabled the air expired to escape, while the other permitted the inspiration of a mixture of 67 per cent. oxygen, 13 per cent. carbonic acid, and 20 per cent. nitrogen.

When thus equipped Mr. Agazzotti entered the bell, and, in half an hour's time, the air was rarefied up to a pressure of 440 millimetres, almost equal to the atmospheric pressure prevailing on Mont Blanc. Mr. Agazzotti seemed to be suffering no inconvenience at this time, but, a few minutes afterward (when the

rarefaction of the air had reached 360 millimetres) symptoms of asphyxiation were observed. The mixture of oxygen and carbonic acid was now brought into play, and an immediate improvement was noted in the condition of the subject in the glass bell. The pressure was now brought down to 140 millimetres, and, more marvellous still, even to 122 millimetres of mercury. On leaving the bell Mr. Agazzotti said to the attendants: "I could have stood a still greater rarefaction, as my memory was quite clear, and my power of movement normal."

As a matter of fact, upon the occasion of a third experiment made quite recently, the rarefaction of the air produced in the bell corresponded to that prevailing at an altitude of 14½ km. (9 miles), thus exceeding by 4 km. (2½ miles) the greatest altitude ever reached by man—even in a practically semi-conscious condition. The experiments made by Mr. Agazzotti, therefore, show that with the use of the mixture prescribed it will be possible for the aeronaut of the near future to render great services to science at large.—*Scientific American.*

Prevention and Mastery of Disease.

It is probable that most of us have heard more or less about the remarkable success which attended the efforts of the Japanese to prevent and control disease among their armies in Manchuria; but it has remained for Major Louis L. Seaman to place the full facts before the world in a work to which he has given the appropriate title, "Real Triumph of Japan." The high reputation of Major Seaman as an army surgeon, and the fact that his assertions are based upon personal observation during his presence with the armies in Manchuria, place the statements contained in his work, extraordinary though they be, beyond all question as to their veracity and accuracy.

It is shown by Longman's Tables that for nearly two centuries past, in wars that extended over any great period of time, on an average at least four men have perished from disease to every one who has died of wounds. In the late Boer War 8,221 officers and men were sent home on account of wounds, while 63,644 were invalided home by disease. Major Seaman quotes from Vital Statistics for 1898, in which the Surgeon-General of our army shows that while deaths from battle casualties were 293, those from disease amounted to 3,681, or 14 from disease to 1 from casualty. These surprising figures are compared with

the record made by the Japanese. The Japanese statistics show that from February, 1904, to May, 1905, although 52,946 were killed or died from wounds, only 11,992 died from various diseases. That is to say, only one died from sickness to every four and one-half men who died in battle or from wounds.

This complete reversal of the statistics of the two leading nations of western civilization constitutes, according to Major Seaman, the real triumph of Japan; for it is a fact that in their war with China only ten years before, the Japanese lost about the same average as that which prevailed during our own Civil War, namely, three from disease to one from bullets. In that war they realized that disease was even more fatal than the enemy's weapons, and in the intervening years they set out to master the invisible foe, with a success to which the statistics, as above given, bear eloquent testimony. These results were obtained by careful study of military sanitation and hygiene, and by a most thorough bacteriological examination of the water along the line of march and in the vicinity of the camps. The water-testing outfit formed part of every sanitary detachment, and every foraging and scouting department was accompanied by a medical officer, who made an examination of the water to be used by the troops. In view of the extraordinary facts developed as the result of Major Seaman's investigation, it is not putting the case too strongly to say that, as matters now stand, the medical corps has as much, if not more, to do with the winning of campaigns and the mitigation of the horrors of war as any other department of the army.—*Scientific American.*

Recent Experiments in the Preservation of Meat.

In a report by the Italian Minister of Agriculture on the subject of refrigerating in Italy, Mancini gives some interesting results obtained by the Craveri process for preserving meat, a process which was much discussed some months ago, but of which a more definite idea can now be formed, since a series of experiments has been conducted under the direction of a number of university professors.

The Craveri method would seem to have solved the problem hitherto unsolved—of preserving meat in a form fit to be eaten, by means of chemical treatment. Excluding for hygienic reasons ordinary antiseptics, and recognizing as insufficient for practical purposes the usual method of salting, Craveri resorts to injec-

tions into the veins of slaughtered animals, from which the blood has been drained, of a solution of 100 parts of water, 25 of kitchen salt, and 4 of acetic acid; in other words, of a solution of a mixture of substances such as are found normally in our bodies, and which form part of our nourishment. The solution is injected to the amount of one-tenth of the weight of the living animal. Prof. Brusaferro, of Turin, experimented upon two animals, a sheep and a calf; the two carcasses were hung in a subterranean room for 75 days, at a temperature of 16° C. (about 61° F.). After this time they were skinned, dressed, and cut up. The heart, brains, liver and intestines seemed somewhat macerated, but were normal in appearance. The fat beneath the skin was perfectly preserved, the flesh appearing bright red in color, moist, and giving out an agreeable, slightly acid odor. In no part was there any trace of putrefaction, even incipient. This meat broiled produced an excellent broth, resembling in every particular that obtained from fresh meat. Roasted, it was tender, and even tasted better than ordinary meat, was digestible and nutritious. As a result of these and other experiments, Prof. Brusaferro declares it as his opinion that the Craveri method promises great advantages over others. The other professors engaged in the experiments came to exactly the same conclusions. Submitted to a bacteriological examination, the meat proved to be free from bacteria; in the long period of preservation given, the beginning of dissolution was noticed in the visceral and muscular tissues, but without the production of any toxic principle whatever.—*Scientific American.*

HEMORRHAGE from the bladder may yield to irrigations with ice-cold water and with 1-10,000 adrenalin solution, successively. —*American Journal of Surgery.*

DURING the conduct of a narcosis, more important than the activity of the conjunctival reflex or the actual size of the pupil in determining the depth of the anesthesia, are the *changes* in the reactibility of the lid and the alterations in the size of the pupil. They are reliable indices to fluctuations in the depth of the narcosis. Sometimes a patient is quite relaxed and anesthetic although a fair conjunctival reflex is present; and, again, it may occasionally happen that a patient reacts even when that reflex is abolished.—*American Journal of Surgery.*

News Items.

THERE is a small epidemic of typhoid fever at St. John, N.B.

DR. ROYAL WHITMAN, New York, has been visiting in Montreal.

DR. SOFTLEY, of Claude, has been appointed a coroner for the County of Peel.

DR. COOPER, of the Winnipeg General Hospital house staff, has located at Sperling, Man.

IT is stated the Ontario Medical College for Women, at Toronto, will be discontinued.

SENATOR DR. L. GEO. DEVEBER, Lethbridge, Alta., has been visiting in Toronto over Victoria Day.

A CLASS of 22 nurses was graduated from the Winnipeg General Hospital on the 22nd of May.

THE death is announced of Dr. Reuben Curry, Guelph, Ont. He was one of the oldest practitioners in that district.

DR. A. EDMOND BURROWS has been appointed jail surgeon at Parry Sound Jail, in the place of Dr. Hugh C. McLean.

JOHN GRAHAME, M.D., has started to practice at Mono Road. Dr. Grahame is a former principal of Bolton Public School.

DR. HONSBERGER, a well-known Stayner physician, dropped dead in his office a few days ago. Heart failure was the cause.

DR. SPROULE, of Markdale, has been re-elected Sovereign Grand Master of the Orange Order of British North America.

DR. E. P. LACHAPELLE has resigned as Superintendent of Notre Dame Hospital, Montreal.

DR. P. H. BRYCE, Chief Medical Officer of the Department of the Interior, has been inspecting in the Maritime Provinces.

House surgeons for Toronto General Hospital are now chosen by competitive examination.

The funeral of Dr. J. C. Stinson, who was killed in the San Francisco disaster, took place at Brantford, Ont., on May 7th.

Dr. J. H. Emory, Gravenhurst, Ont., has been invited to advise in the preparation of plans for a State sanatorium in Wisconsin.

Dr. C. Dickie Murray, Halifax, we are pleased to announce, is convalescing rapidly from an eight weeks' illness from pleurisy.

Dr. G. E. Long has been elected President of the Blyth Public Library Board, to fill the vacancy caused by the removal of Dr. Lindsay.

Dr. N. J. Tait, of Ingersoll, was presented with a gold-headed umbrella and address by his friends prior to his departure for Europe to study.

Dr. L. de Lotbinier Harwood has been appointed General Superintendent of Notre Dame Hospital, Montreal. He is a graduate of Laval of 1890.

Dr. Andrew Macphail, editor of the Montreal Medical Journal, is the author of a book highly spoken of and which has just appeared.—"The Vine of Simbah."

The District Labor Council of Toronto will seek to induce the Trustees of Toronto General Hospital to allow public ward patients choice of their own physician.

Winnipeg General Hospital during the week ending May 19th treated 326 patients, 172 being men, 111 women, and 43 children; 107 out-patients were also treated.

The Anti-Tuberculosis Association of British Columbia is making a personal appeal to all residents of British Columbia for subscriptions towards a consumption sanatorium.

The local committee of the Dermatological Section of the British Medical Association desires any doctor who has any interesting case of skin disease, to communicate with the secretary, Dr. D. King Smith, 311 Jarvis Street, as arrangements for presentation of cases at the clinic will be made by the committee.

DRS. ROGERS and Tait, of Ingersoll, have dissolved by mutual consent the partnership which has existed for the past few years, and the practice will be conducted by Dr. Rogers.

DR. FRANCIS J. SHEPHERD, Montreal, Professor of Anatomy in McGill, has been elected president of the Montreal Art Association, in succession to Sir Geo. A. Drummond.

BY the will of the late Miss Elizabeth Orkney, of Montreal, the Montreal General Hospital will get $50,000, and the Protestant Hospital for the Insane at Verdun a like amount.

DR. ROBERT CRAIK, LL.D., Montreal, died on the 28th of June, at the age of 77 years. Deceased was Dean of the Medical Faculty of McGill for eleven years prior to Dr. Roddick.

QUEEN'S Medical Convocation took place on the 12th of April. Dr. C. K. Clarke, Superintendent of the Toronto Provincial Hospital, received the honorary degree of Doctor of Laws.

DR. R. H. RICHARDS, formerly a practitioner at Winnipeg, but latterly ship surgeon on the "Miowera," sailing from Vancouver to Australia, committed suicide at Vancouver on June 15th.

DR. S. J. BOYD, an old Listowel boy, who at one time taught in the Carthage section, has spent a year in the London hospitals, and obtained the degrees of M.R.C.S., and L.R.C.P., London, England.

THE thirteenth annual Sanitary Report of Nova Scotia states that there have been serious outbreaks of cerebro-spinal miningitis in Lunenburg and Victoria Counties, with a mortality of about ten per cent.

THE Corporation of McGill University have approved of a resolution submitted to them by the Medical Faculty, advising the extension of the present medical course to five years. It is likely the change will go into effect in the session of 1907-8.

THREE cases of typhus fever are said to have developed in Winnipeg. The statement is made in the public press that there has been no typhus fever in Canada for fifty years. Five thousand are said to have died of it in Montreal at that time.

Dr. E. D. Carder, son of M. D. Carder, Grand Recorder of the A.O.U.W., Toronto, after spending a year in the hospi als in London, England, has decided to locate in Vancouver, B.C., and is now temporarily acting as superintendent of the General Hospital there.

Notice.—The Executive Session of the Ontario Medical Association will be held in Toronto on Monday, the 20th of August, at 8 p.m. All members are respectfully requested to attend, in order that the business of the year may be finished, including election of officers for ensuing term.

The seventh annual meeting of the British Columbia Medical Association will be held in New Westminster on August 1st and 2nd. Discussions will be had on the subjects of "Patent Medicines" and "Life Insurance Examination Fees." A number of medical men from the State of Washington will take part.

Canadian members of the British Medical Association who intend to avail themselves of the special rate, single-fare $67.25, excursion to the Pacific Coast at the close of the meeting in August, should communicate their intention at once to the General Secretaries, Medical Laboratories, University of Toronto, in order that information may be given to the railways of the probable number for which provision must be made.

At the instance of the College of Physicians and Surgeons, the Ontario Government is asking the Court of Appeal to construe Clause 49 of the Ontario Medical Act, with a view to determining whether those practising medicine without the use of drugs are entitled to charge for their services. Osteopathists and persons who give electrical treatment not registered under the Act, and the idea is to find out whether they do not under Clause 49 come within the Act.

Following is the list of successful candidates in the competitive examination for the positions on the intern staff of the Toronto General Hospital, held on Tuesday and Wednesday of this week: W. F. Lemon, Aylmer; J. A. Kinnear, Toronto; C. S. Strathy, Toronto; F. J. Munn, Toronto; C. E. Spence, Toronto, and A. G. Wallace, Humber. The names appear in order of merit. These will receive their positions, provided they

are successful in passing their examinations in the College of Physicians and Surgeons of Ontario. A further examination will be held for the position of first assistant in the clinical and pathological laboratories.

FISHING AND SHOOTING.—A new region, known as the "Temagami" (pronounced Tem-mog-a-me) District, is being brought to the notice of the public as one of the finest fishing and hunting confines in Canada. Excellent sport is assured all who take advantage of a trip to this magnificent territory which is 300 miles north of the city of Toronto at an altitude of 1,000 feet above the sea. Black bass, speckled trout, lake trout, wall-eyed pike and other species of fish are found here in abundance, and large game such us moose, caribou and deer abound in the forests. A handsome booklet, profusely illustrated, giving all information, including comprehensive maps, can be had free on application to J. D. McDonald, D.P.A., Union Station, Toronto.

AMONG the recent graduates of Manitoba Medical College most have gone out to take up the practice of their profession here and there in Manitoba and the North-West. Dr. J. T. Cooper is at Sperling, Man.; Dr. C. R. Dudderidge at Snowflake; Dr. G. N. Giles at Miniota, and Dr. A. Moir at Lenore. Dr. A. W. Montague has opened an office in Winnipeg, while Dr. J. J. Mugan has gone to practice at Langdon, N.D. Dr. Riddell will likely go to Crystal City. Dr. F. A. Smith is at Medicine Hat, and Dr. J. D. Stewart at Darlingford, Man. Dr. G. M. Stuart is at Creelman, Sask., Dr. J. E. Tisdale at Baldur, and Dr. A. E. Walkey at Selkirk. Drs. R. B. Mitchell, G. P. Bawden, W. W. Musgrove, D. A. Stewart, C. Kerr, H. O. McDiarmid and E. Hudson will be house surgeons for the ensuing year at the Winnipeg General Hospital. Others have not yet definitely located.

THAT London is to have a Hygienic Institute is confirmed by a statement made by Premier Whitney and communicated to the medical men there. When the supplementary estimates were brought down $50,000 was apportioned Kingston to go to the Medical Department of Queen's University for educational purposes in that line. "A similar amount will go to London next year," said the Premier. The estimate that was named by the medical fraternity of London for the Hygienic Institute was

$75,000, but the Provincial Legislature evidently follow the tactics of the Dominion House,, and do not grant the full amount the first year. The amount London asked for, $75,000, is a liberal estimate as to the cost of the institution, but should the required amount run over the $50,000, there is no doubt it will be forthcoming.

THE Trustees of the Hospital for Sick Children, Toronto, have appointed the following staff for the year commencing July 1, 1906: Consulting Staff: Surgical—Dr. R. B. Nevitt, Dr. G. A. Peters, Dr. N. A. Powell. Medical—Dr. A. McPhedran, Dr. H. C. Scadding, Dr. R. J. Wilson. Surgical Services: No. 1—Mr. Irving H. Cameron, senior; Dr. A. Primrose, associate; Dr. B. Milner, junior. No. 2—Dr. G. A. Bingham, senior; Dr. F. N. G. Starr, associate; Dr. Charles Shuttleworth, junior. The surgical services are co-equal in status. They are numbered separately for convenience. Orthopedic Service: Dr. Clarence Starr, senior; Dr. W. Gallie, Toronto, associate. Medical Services: No. 1—Dr. H. T. Machell, senior; Dr. W. B. Thistle, associate; Dr. R. D. Rudolf, junior. No. 2—Dr. Allan Baines, senior; Dr. J. T. Fotheringham, associate; Dr. H. C. Parsons, junior. The medical services are co-equal in status. They are numbered separately for convenience. Isolation Wards: Medical—Dr. William Goldie, Dr. C. J. Copp, associate. Surgical—Dr. S. Westman, Toronto. Specialists: Eye—Dr. R. A. Reeve, senior; Dr. James MacCallum, associate; Dr. W. Lowry, junior. Ear, Nose and Throat—Dr. G. Wishart, senior; Dr. G. Boyd, associate; Dr. D. N. MacLennan, junior. Pathologist: Dr. T. D. Archibald. Anesthetist: Dr. Alan Canfield. Registrars: Surgical—Dr. E. Stanley Ryerson. Medical—Dr. H. S. Hutchison. Director of the Roentgen Rays Department: Dr. Samuel Cummings. Residents: Dr. A. C. Bennett, from January 1, 1906, to December 31st, 1906; Drs. A. H. Rolph, James C. Masson and Robert E. Woodhouse for one year each, from July 1, 1906, and R. A. Jones and Fred. W. Manning for one year each, from January 1, 1907.

THE special committee to which was referred the question of deleterious or fraudulent medicines organized on May 14th, and elected Hon. Mr. Templeman chairman. It was decided to gather information respecting legislation enacted or proposed on the subject in the provinces of Canada and in the United States.

Mr. H. H. Dewart, K.C., Toronto, submitted a draft bill on behalf of the Proprietary Medicines Association, based on the resolutions passed at the annual meeting in December last. This bill makes provision that each person, firm or corporation manufacturing or importing for sale in Canada any medical preparation or preparations shall submit to the Department of Inland Revenue yearly a statement showing whether such preparation contains alcohol or any of the poisons mentioned in the schedule to the bill. The Minister may then make further inquiry as to whether the preparation is a legitimate medicinal preparation or whether alcohol is used in excess, or poisons in quantity dangerous to health. Then the Minister has power, where alcohol or such poisons are used, to compel the production of the formula of the preparation for his confidential use, and where an analysis does not agree with the statement submitted or the preparation is found to be dangerous or unfit for use, there may be a hearing, and in case of adverse decision the Minister may order the printing on the wrapper of the percentage of alcohol or poison and the manufacture and further sale of such medicine in Canada shall be prohibited. Penalties from $50 to $500 are provided.

TUBERCULOSIS EXHIBITION.—An exhibition that will surely be unique and distinctive in a city noted for its expositions and conventions, is to be given in Toronto for two weeks, commencing Monday, August 21st. This exhibition had its inception in New York rather more than six months since, conducted by the National Association for the Study and Prevention of Tuberculosis, with leaders in the movement like Dr. Herman H. Biggs, Dr. S. A. Knopf, Dr. Lawrence F. Flick, Dr. Vincent Y. Bowditch, taking a prominent part in the management. So great was the interest stirred up in New York that since then, by invitation, the exhibition has been shown in Boston, Chicago, Philadelphia, Milwaukee, Indianapolis, Cleveland and other leading cities. In the early spring successful efforts were made by the National Sanitarium Association of Canada to have this exhibition brought to Toronto in the month of August. The date has been fixed so that the exhibition will open during the week of the meetings of the British Medical Association, and will continue the following week, which will be the first week of Canada's National Exposition. The exhibition is of a size that requires a building sufficient to allow of 5,000 feet of wall space, besides large floor space and accommodation for the holding of

meetings. One hundred and two different exhibits will be made, including large exhibits from Paris, Switzerland, Massachusetts State Sanitarium, Phipps Dispensary, Johns Hopkins Hospital, Henry Phipps Institute, of Philadelphia; White Haven Free Hospital for Poor Consumptives, Agnes Memorial Sanitarium, Denver, Col.; Adirondack Cottage Sanatorium, Health Department, of New York City; in fact, from almost every association interested in fighting the white plague by whatever means. Prominent in the New York exhibition, and in other cities where given, was the exhibition made by the Muskoka Cottage Sanitarium, the Muskoka Free Hospital for Consumptives, and the Toronto Free Hospital for Consumptives. These will be repeated in the exhibition in Toronto. The exhibition will be one of peculiar interest to medical men, social reformers, sanitary scientists, to governments, in fact, to the great mass of the people interested in social and economic questions. Mr. J. S. Robertson, Secretary of the National Sanitarium Association, who has the work of the exhibition in hand, is not prepared at this writing to give in detail the names of those who will take part in the educational progress prepared for each evening, but the first draft of the programme prepared includes names of leading professional and laymen of Great Britain, United States and Canada, further particulars of which will be given a little later.

THE following resolution was adopted on board the steamer *Brockville*, en route to Montreal, June 3, 1906:

Whereas, the members of the American Medical Association, en route to Boston, via the Grand Trunk Railway System, including the Missouri Valley Special, Iowa and Chicago delegation, were cordially entertained during their visit to Toronto, on June 2nd, by the Canadian and Ontario Medical Associations, Ontario Medical Library Association, Toronto Clinical, Medical and Pathological Societies;

Whereas, we, as a body, including our wives and families, enjoyed to the fullest extent our entertainment at luncheon at the Toronto Medical Library; and,

Whereas, we were accorded the hospitality of the Queen City, its provincial and municipal institutions, and were furnished auto transportation over their beautiful city; therefore,

Be it resolved, that a copy of these resolutions be transmitted to Dr. G. A. Bingham, President Ontario Medical Association; Dr. R. A. Reeve, Dean Medical Faculty, University of Toronto; to the officers and members of the Ontario Medical Library

Association, to the Reception Committee, to the daily press of Toronto, and the editor of the *Journal* of the American Medical Association, for publication. (Signed) Committee: A. E. Prince, J. A. Downs, T. J. Schweer, Edwin B. Shaw. Representing the Chicago, Iowa and Missouri Valley delegation: H. Liston, Montgomery, E. E. Dorr, Chas. Wood Fassett.

BRITISH MEDICAL ASSOCIATION, TORONTO, ONT., AUGUST 21ST TO 25TH, 1906.—1. *Fares, Going Dates and Limits.*—(*a*) Domestic business, certificate plan arrangements; free return regardless of number in attendance; passengers going rail, returning R. & O. Nav. Co., or *vice versa,* rate to be one and one-half fare. (*b*) European business.—On presentation of certificate, to be prepared and signed by the Secretary of E.C.P. Association, and countersigned by the Secretary of the Canadian Committee, or Secertary of the British Medical Association, one-way tickets to be issued at one-half lowest one-way first-class rail fare; round trip tickets at lowest one-way first-class rail fare between all points in Canada. Rates to Pacific Coast subject to concurrence of T.C.P. Association. Steamship lines to advise Secretary what, if any, additional arbitraries are required. Dates of sale, July 1st to September 30th, 1906, inclusive. Final return limit, September 30th, 1906. 2. *Extension of Time Limit.*—On deposit with joint agent of standard convention certificates issued from points in the Maritime Provinces, from points west of Port Arthur and from points in the United States, on or before August 28th, 1906, and on payment of fee of $1.00 at time of deposit, an extension of time until September 30th to be granted. Joint agency to be conducted in the name of G. H. Webster, Secretary E.C.P. Association, will be kept open from August 21st to September 15th, 1906. 3. *Side Trips.*—Side trip tickets to be sold from Toronto to delegates from the Maritime Provinces, from all points west of Port Arthur and from the United States, on presentation of validated certificate, or deposit receipt, at lowest one-way first-class fare for the round trip, to all points in Canada. Dates of sale, August 23rd to September 1st, 1906, inclusive. Return limit, September 30th, 1906. Usual additional arbitraries *via* Upper Lake steamships to apply, viz., going lake

returning same, $8.50 additional to be collected; going lake, returning rail, or going rail returning lake, $4.25 additional to be collected. Also usual arbitraries *via* St. Lawrence route, for delegates desiring to return by steamer, on presentation of tickets to purser, viz., $6.50 Toronto to Montreal; $3.50 Kingston to Montreal. *Via* Northern Navigation Company, on lines where meals and berth are not included, the rail rate will apply; on lines where meals and berth are included, rate to be single fare, plus meal and berth arbitrary.

Publishers' Department

OBSERVATIONS IN THE TREATMENT OF IRREGULAR MENSTRUATION.

By A. W. Shields, M.D., Eaton, Colo.

In prescribing a new and comparatively unknown remedy, the conscientious physician must work slowly and carefully along lines which are necessarily of a more or less experimental nature! In my own experience, I have always found it hard to desert an old, well-tried preparation and transfer my faith to one which, though highly recommended and endorsed by reputable physicians, is known to me only through such recommendations and endorsements! But in the case of Ergoapiol I feel differently; for, when I first encountered it, the mere name in some way appealed to me as descriptive of a preparation or combination which I thought ought to prove efficient in the treatment of that class of cases for which it is recommended. I have in the latter part of my sixteen years' experience been a great believer in apiol as an emmenagogue, and especially in those painful cases which occur in young girls, who have just reached the menstrual period, and in whom functional inactivity is the chief cause which retards the normal process of nature.

But, after many successes and a still larger number of failures, due, I believe, to the unreliability or instability of the drug, I resorted to Viburnum and the various compounds con-

taining it. My clinical experience with it was fairly satisfactory, but I was still on the lookout for "something better," when it was my good forunte to run across Ergoapiol (Smith). This was only about six months ago, when it was recommended to me, while in consultation with a physician in my locality, and the results were more than satisfactory.

Still, as often happens, through force of habit, I believe, I forgot it for the time being, and wandered back to my old routine, and it was not until my attention had once more been drawn to Ergoapiol by the receipt of a sample package that I once more prescribed it. I was just then wrestling with a case of obstinate amenorrhea, and it was on this case that I expended ten of the capsules, giving one every three or four hours. These proved sufficient to give relief at that particular time, though, of course, I have followed up the same line of treatment ever since with excellent results.

It was then that I began to consider the matter seriously, for I had tried every one of the so-called Standard preparations without feeling any certainty as to results; but, now, as a result of many trials, and but few failures, Ergoapiol is one of the trusted remedies in my armamentarium, and is likely to remain in that class as long as it is obtainable.

I have now had sufficient experience with it in the treatment of cases of uterine and menstrual disorders so common in the every-day practice of the general practitioner, that I have no hesitation in recommending its use.

In this introductory note, I can only say further that the cases quoted below, as having been successfully treated with this remedy, are only such as are met with in every-day practice, and as I regard this class of most practical importance to the general practitioner, I shall give but little attention to those that are only rarely encountered.

Case 1. Mrs. J. N.—I first saw this case in April of this year, and, on inquiry, discovered a history of two abortions, both in the third month of pregnancy. A slight leucorrhea has resulted from the first mishap, but after the second one this became aggravated, and was accompanied by severe pain in the region of the ovaries and an almost continuous backache, both of which were very markedly increased just previous to and during menstruation. Currettment had been performed twice, but without much improvement, and the menstrual periods began to be irregular, both as to time and quantity of flow. At first I applied the usual forms of medication, internally and by douche, but while a slight improvement occurred, it was not until I put

her on Ergoapiol (Smith), as her exclusive internal treatment, that I obtained any marked results. The May period was a week late and somewhat scanty; but those of June and July have come on time, and the amount of flow almost normal; the pain in back and sides is present in a slight degree, and then only during the first two days of menstruation. The color of the discharge is improved (due, perhaps, to the later addition of an iron tonic to the treatment), and in a general way, she is gaining rapidly. In this case I have never used more than four capsules daily, and that number only for a few days previous to the establishment of the flow and for two days thereafter.

Case 2. Mrs. A. N.S., about 30 years of age, consulted me in regard to her condition about three months ago. She gave a history of a rather severe laceration of the cervix, the result of her first confinement, five years ago, but her previous record disclosed the fact also that her menstruation had always been difficult and very painful. After the laceration occurred, the periods became irregular, the flow sometimes being profuse and sometimes very scanty in amount. Pain in the back and iliac regions was severe, and finally it was decided that an operation for the repair of the lacerated cervix must be performed in order to obtain relief. This was done about nine weeks ago, but the condition was but little improved, although a currettment had been done simultaneously with "Trachelorrhaphy." The case having been previously in the hands of another physician, I requested and obtained a consultation with him, during which I suggested the use of Ergoapiol (Smith). To this he agreed, and we prescribed one capsule three times daily for a period of two weeks prior to her next menstruation, with results that surprised not only the patient, but even ourselves. There was still some pain in the regions mentioned above, and the quantity of the flow was still below normal; but, looking at the case from every point of view, and considering the very short time during which the patient had been under treatment, I regard the results as remarkable. Her present condition is good, though a slight leucorrhea remains, and I anticipate an easy menstruation, when next it occurs, which is only a few days hence. She is, of course, still taking the capsules as before, and, indeed, has been doing so right along.

Case 3. Mrs. W. A. J., a widow of three years, had always been irregular in her periods, and had been late (almost eighteen years of age) in commencing. She had never borne any children, and after hearing the usual history of pain and cramping for two or three days previous to the beginning of the flow, and

more or less during its continuance, I made an examination, by which I discovered that the uterus was small, poorly developed and flabby. She was very anemic, and the quantity of discharge had always been small in amount and light in color. I did not hesitate a moment as to treatment in this case, but put her at once on Ergoapiol (Smith), together with Blaud's Pill, and recommended a nourishing diet. There wasn't much change at the next period; but the one following, and still more so, the one after that, showed most markedly the excellent results of the Ergoapiol treatment. The uterus had gained much in tone and the cervix in firmness, while the patient herself is now in very good health generally, and has gained almost sixteen pounds since the treatment began.

Case 4. This case is interesting, in so far as it shows the versatility, so to speak, of Ergoapiol, or, to express it more correctly, the varied and unusual forms of uterine and menstrual troubles, in which that valuable preparation may be used advantageously.

Here I shall quote the case of a young lady, Miss M. F. N., 21 years of age, who came under my care four months ago. All kinds of treatment had been tried on her without avail, for although she had passed the age of full womanhood, she had never menstruated. When I first saw her she gave me a history, such as follows: When she was fourteen years of age she, on the 16th day of that particular month, got up in the morning feeling languid and disinclined for exertion of any kind; she had a slight headache, and complained later on in the day of a dragging pain in the back in the lumbar region. The family physician was called, and, naturally enough, diagnosed the approach of her first menstruation, requesting the mother to warn the girl of what she might expect, and leaving some appropriate (?) prescription; Ergoapiol (Smith) being then unknown to him. However, that day passed, and another, and another, without any appearance of a flow, and by the end of the fifth day all the symptoms had subsided. The girl remained comfortable, until about the middle of next month, when the same course of symptoms was passed through again, with similarly barren results.

Thus she had lived, undergoing all sorts of treatment, until I saw her five months ago. I at once, though with difficulty, obtained permission to make an examination, in the course of which I found the uterus flabby and ill-developed, the os small and contracted, while the ovaries, with their appendages, were quite indistinguishable by palpation. I advised dilatation of the os and cervix, and prescribed both special and general tonics;

but although everything was done and the treatment maintained for some time, no improvement seemed to result.

At last I determined to try Ergoiapiol, which had been brought prominently before me just about that time, and I at once began giving it in addition to one or two of my former tonics, which had failed to do the work alone. The results, when the next time for menstruation came around, were easily perceptible, although the patient had only been under the new treatment for twelve days. The uterus had gained some tone, and usual signs of approaching menstruation were more decided, but it was not until the second month that any actual flow appeared. About an ounce was then passed, but at the third month (i.e., the last one I have observed), the discharge was fairly free and of good color, and although the development of the uterus has not yet shown any marked gain, still it has enlarged somewhat in size, and is much firmer in consistency throughout. I do not have a doubt as to the ultimate results, and believe that within a few months the uterus will possess all the features of a comparatively normal organ.—From the *Medical Examiner and Practitioner.*

PHYSICIANS desiring to sell their practices must take every precaution against publicity or inviting opposition. These difficulties are fully overcome when the practice is placed with Dr. Hamill, of the Canadian Medical Exchange, as he binds all prospective buyers legally and morally against piracy, publicity or opposition, before giving the name or address of vendors to anyone. Full particulars can be obtained by writing him for his circulars, which he would advise those thinking of selling to do.

BATTLE & Co., St. Louis, have just issued the tenth of the series of twelve illustrations of the Intestinal Parasites, and they will send them free to physicians on application.

ENTERO-COLITIS.—I was called last August to see an eight months' old boy, who was said to be dying of cholera infantum. He had been treated by two capable men, both of whom agreed that the child could not possibly outlive the day. Every conventional remedy had been tried, and the favorite methods of both men had been exhausted. They frankly admitted that all had been done that could be done. I found the patient almost moribund, and displaying all the symptoms of a child dying of what I diagnosed as entero-colitis. The symptoms, to my mind, were classic, despite the previous diagnosis. The case was turned over to me at 9 a.m., August 7th. A trained nurse was

already on this case. She is an unusually competent woman, in whom I have the most implicit confidence. Then began one of the hardest battles of some years in my experience. I ordered high enemas of glyco-thymoline in 25 per cent. solution, and warm. Used four ounces at a time, with a soft rubber catheter once every three hours. The child could retain nothing, was in frightful pain, and passing constantly thin, foul-smelling discharges tinged with blood. The child was emaciated to the last degree, and for several days before I was called had been in a semi-conscious state. The poor little baby was a pitiful sight. For nourishment I ordered several combinations to be administered, an ounce at a time, as a rectal clyster following the enemas of glyco-thymoline. I know it is not good practice to give hypodermics to an infant, but this was a grave case. My predecessor had ordered gr. 1/64 morphine, gr. 1/960 atropin, sub. q. every four hours, if needed, with strychnine 1/240 gr., if necessary. I continued this, as the baby was often in intense pain, and there seemed to be no other way. This was my plan of campaign, and I am both thankful and pleased that it was successful. The baby improved from the first, but so slowly that it was scarcely discernible to the parents, but the nurse and myself saw it. After three days the child could take some nourishment per oram. I then gave 2 m. of glyco-thymoline in one ounce of water every two hours before feeding. It began to have short periods of natural rest, and the discharges were in every way improved. At the end of a week (August. 14th) the improvement was quite marked, but we did not relax our vigilance. The hypodermics, except of strychnine, were discontinued. The enemas were continued fifteen days, once every three hours, then at less frequent intervals for a month, then once a day for six weeks. The recovery of the little patient was long and slow, but uneventful. The mother and nurse were devoted, and ably seconded my efforts. At this time the baby is a strong, rosy youngster. It gives me great pleasure to tell you of this case. The experience may be of value, and it certainly proved to my satisfaction at least, the potential possibilities of glyco-thymoline in gastro-intestinal work. May you be speeded in your good work.—By W. O. Corb, M.D., Easthampton, Mass.

The Role of Iron in the Nutritive Process.—It is an established custom of physicians to administer iron whenever a patient with pale, waxy, or sallow complexion complains of extreme exhaustion, muscular feebleness, easily accelerated pulse, aplaxia, anorexia and the several symptoms which constitute the characteristic issues of a qualitative or quantitative