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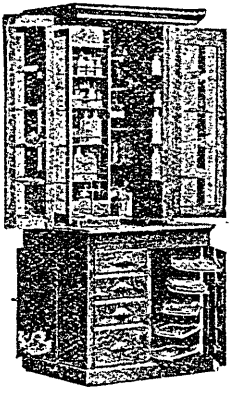

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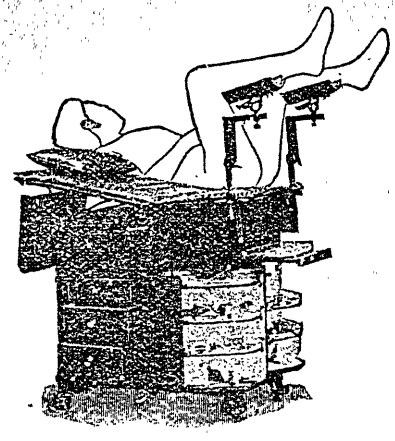

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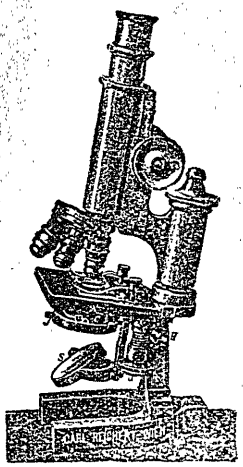

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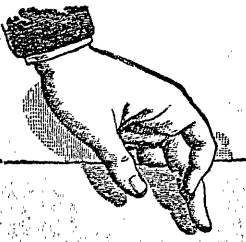

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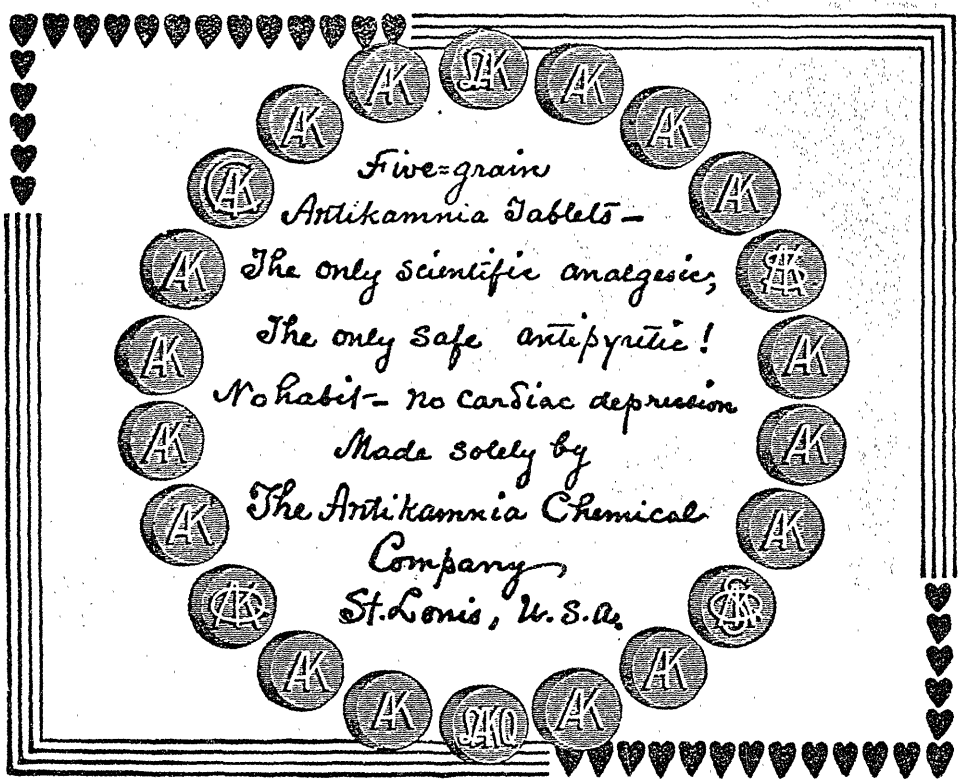

THE

MARITIME MEDICAL NEWS,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XII. HALIFAX, N. S., DECEMBER, 1900. No. 12.

Original Communications.

PHYSICIANS, SURGEONS AND SPECIALISTS.*

By F. W. GOODWIN, M. D., C. M., M. R. C. S., L. R. C. P., Professor of Materia Medica, Halifax Medical College.

Every one who graduates is in some sense a surgeon but only a few become operators. Many medical men say they do not like surgery, and so they are perhaps liable to neglect the study of anything that savours of it. But it is the duty of every general practitioner to keep up in the principles and practice of surgery, on account of what is due to his patients, even though he prefers not to operate himself. He should be tolerably good in the diagnosis of surgical cases so that he may know what cases should be sent to the operator and what cases are urgent—admitting of no delay. Not in a state of ignorant helplessness, but having an intelligent idea of what may be done he can send proper patients to surgeons at the right time.

I do not see any reason why syphilis should be regarded as surgical for the treatment of it is mainly medical. Skin diseases of all kinds are dealt with in works on medicine. Simple fractures and some minor operations might be dealt with by the general practitioner.

*Read at meeting of Medical Society of Nova Scotia, Amherst, July 5th, 1900.

The operating surgeon should, I think, be considered a specialist; and it would be, in my opinion, to the advantage of all concerned, if he would, as far as circumstances will allow, confine himself to his specialty. In England there is a pretty sharp distinction between physicians and surgeons, and both are equally honorable, though the surgeon is called plain Mr. (By the way I would prefer that we all dispensed with titles.)

Specialties seem to be developing of late years on both sides of the Atlantic, but more especially perhaps in America. To me they seem to tend towards advance. Most of the improvements and discoveries have been made by specialists in their particular line. It was a German who, having spent his life on one of the Greek letters, wished that he had confined himself to the Digamma, thinking that thus he might have learnt more. Yet, though specialties be multiplied until the navel is considered a sufficient field for one man's energies, I do not see how we could get along without the G. P. He need not humble himself before the specialists. In many respects he is the greatest. If the philosopher could say "*humani nihil a me alienum puto*," he can say "no part of the human body or indeed of human nature is foreign or without interest to me."

The general practitioner interrogates all the organs and gets a broader view. While the oculist treats the eye and the gynecologist the uterus, he treats the individual, and the individual is greater than any organ.

In an ideal state of things it seems to me that all cases should go first to the general practitioner, and he should send to the specialist when in his judgment it was required, and he should not altogether lose his charge or surveillance of the patient. Under present conditions a man gets something wrong with his eyes; he goes direct to the specialist and thus kidney disease is first discovered. Or a woman goes to a gynecologist complaining of pruritus and polyuria while she may be suffering from diabetes.

The G. P. should be conversant with all recent advances in surgery and the specialties in order to do his duty. A livelier interest in surgery and the specialties is required.

We often see medical men treating patients who should be encouraged to go to the surgeon or specialist. Lives are often lost for lack

of prompt advice by the physician in getting surgical aid. Many a man is wearing a truss that ought to have the radical cure. Many are blind and deaf because they were not sent to the specialist at the proper time. Many cripples testify to the ignorance or carelessness of the general practitioner.

We see the G. P. often trying to be an operator. Sometimes he succeeds and his brethren send cases to him. The surgeon gets all the *kudos* and, because he does a laparotomy successfully, the public think he can treat anything, as for instance pneumonia, better than the physician who does not operate. This fact induces the general practitioner either to try to learn operating or retain cases too long that ought to be sent to the surgeon.

As indicated before, when a man finds that he is suited by nature and taste for an operator, he should restrict himself to his specialty as far as circumstances will allow. By so doing he would be better supported by the profession and public, thus getting more cases to operate on. In this case he would become an adept.

We want men who operate every day. A great musician said: "If I miss one day from practice, I notice it myself, two days my friends notice it, three days everyone notices it."

In such a state of things we would find the public soon become less afraid of surgical operations, and not so many going from Nova Scotia to Boston and New York, or even Montreal.

It struck me that in England patients were much less afraid of the knife than they are here. They have been educated to the good results of surgery. There, physicians advise patients promptly where surgery is required. On the other hand the surgeons often send patients to physicians for treatment or get them to examine their general condition with reference to an operation to be done. Thus there is reciprocity between physician and surgeon. Here with the surgeon it seems to be "heads I win and tails you lose." The pure surgeon everywhere is perhaps inclined to despise medicine. Lawson Tait, when a physician wanted to give antipyrin and other drugs called them "*rubbishine.*"

One word more about specialists. We should before sending patients to them, require them to show good evidence of special training in their line. Some regard a specialist as a man that knows about

as much as the G. P. about one thing. But a specialist should have had as much training as the G. P. to begin with, and much more training in his particular branch.

After this long preface or introduction, I would like to touch on some particular points that the G. P. ought to be familiar with, in order to fulfil his obligations to his patients.

Beginning with the *bones*. Take the disease called "acute necrosis" which occurs in debilitated children following some slight injury of the part, but fortunately rare in this country. Immediately the nature of the disease is discovered only surgery is available to save limb and perhaps life. In chronic periostitis the physician must discover whether it is due to syphilis, rheumatism, tubercle or traumatism. Whether surgery is required or not depends on the diagnosis of the cause.

Rickets is fortunately rare with us, but in case the medical man meets this disease he should be well acquainted with all the surgical means for relief. Life cripples may thus be prevented. I have seen legs as crooked as a ram's horn made tolerably straight by surgery.

Joints. In tubercular diseases of the joints often the G. P. is first applied to, and by recommending rest, and surgical appliances to gain rest, he may be the means of saving further trouble. If he calls it rheumatism and continues treating it medically he may make himself responsible for very serious results. He should also have a good idea when excision would be required. I need only instance hip disease, sacro-iliac disease and Pott's disease of the spine.

Aneurisms often fall into the hands of the physician who should know when to advise surgical measures.

That common disease, varicose veins, can be radically cured by surgery, and the G. P. should know what cases are eligible. Every day in London one may see cases operated on with happy results in almost all.

Nervous System. In neuralgia of severe and protracted character surgery may be required. If cause can be ascertained, such as pressure of new growth, it can be removed; or in atrocious cases, even though the cause cannot be clearly ascertained, relief may be so imperiously demanded that neurotomy, neurectomy, neurexaresis or

removal of ganglion has to be done. Such cases as severe supra-orbital neuralgia or that of other branch of fifth nerve are often transferred from the medical to the surgical side in the great hospitals.

Epilepsy, especially when of Jacksonian character, often indicates surgery. The physician should be up-to-date in cerebral localization for this as well as other conditions.

That old chestnut concerning the distinction between (1) intoxication, (2) opium poisoning, (3) apoplexy, which are medical, and the effects of injury of the head, has to be cracked in reality by the physician very often.

Tumours of the brain and their localization should be diagnosed by the physician, who should be in a position to estimate the surgical possibilities. Hydrocephalus also has some surgical points worth while knowing.

Diseases of the Organs of Special Sense. General practitioners ought to know more about the eye, ear and throat than they do. It is not every case that needs to be sent to the specialist. But it is a great thing to know when the specialist should be called in.

Take ear diseases. How many ordinary practitioners know how to examine the membrana tympani and in an ordinary case of acute catarrh, when to incise the membrane? Or how many are there that could diagnose cerumen as a cause of deafness and remove it by properly syringing?

Note the complications of chronic purulent catarrh of the ear:—(1) Polypi, (2) mastoid disease, (3) caries and necrosis, (4) meningitis and intracranial suppuration, (5) phlebitis and septicæmia. The G. P. meets many of these cases and needs to be keenly alert for complications. Often lives can be saved by timely surgical interference. And yet one would not expect every case of middle ear disease to be handed over to the surgeon or specialist.

In the eye many superficial inflammations could be treated by the family physician. Optic neuritis is one of the symptoms of cerebral tumour, abscess of the brain, tubercular meningitis and nephritis as well as of acute myelitis, syphilis, chlorosis and lead poisoning. There is no good reason why the physician could not be able to detect this condition by a practical acquaintance with the use of the ophthalmoscope. Chronic glaucoma may be arrested or cured by special treatment, but otherwise goes on to total blindness. The physician should be able to recognize the condition in time.

Again it has been pretty well drummed into our ears that persistent headaches are often due to errors of refraction. Therefore in continuous headaches the eyes should always be examined by an oculist, unless some other cause is evident. Errors of refraction also are generally the cause of squint in the young, and when the condition is seen by the family physician the oculist should immediately be called in.

Epithelioma of the lip may be seen first by the general practitioner and he should see to it that operation is not delayed too long. Procrastination in cancer of the tongue may also be prevented by the family physician. Epulis is another condition usually requiring the attention of the surgeon.

We have heard lately from the specialist a good deal about adenoids of the naso-pharynx, and they should be recognized and sent for proper treatment by the physician. Cases of ordinary naso-pharyngeal catarrh could, I think, be treated by the G. P. Of course cauterizing and sawing off projecting spurs should be left to the specialist.

In diseases of the œsophagus producing stricture the physician should estimate the condition and know what surgery can do. He should be familiar with the use of Symond's tube and know when gastrotomy should be resorted to. Tracheotomy in emergency cases might be done by the physician. Certainly O'Dwyer's tubes do not need a surgeon, for they are just as easily passed as a catheter. In diphtheria, scarlet fever and œdema of the larynx, life may often be saved by them.

In thyroid affections surgery can sometimes do something, and we should be familiar with its limitations in diseases of the gland.

Pott's disease of the spine often finds its way into the hands of the G. P. It may be mistaken for neuralgia, rheumatism or lumbago, and in the later kyphotic stage for rickets, aneurism, tumour or hysteria. I saw one case that had been in the hands of a number of physicians, and it was being treated for dropsy. Ascites was simulated by a double abscess projecting on each side of the abdomen. To make it more puzzling there was albuminuria, œdema of the lower extremities and the spinal displacement was almost *nil*. Early recognition and treatment is necessary.

Abdomen. It is not so very long since an eminent surgeon said "abdominal surgery is abominable surgery."

Now that we see surgeons with little fear of the abdomen before their eyes it behoves us to be up to the times in knowledge of advances made and in the diagnosis of diseases of this region.

The physician ought to be able to estimate the condition of the abdomen as well as the surgeon, because most cases come originally to the general practitioner. Take intestinal obstruction. Cases of this trouble present themselves to the G. P., and we know how difficult it sometimes is to determine the cause, and yet how important it is. I was pleased to notice in a recent issue of the *British Medical Journal* a case of intussusception in a child reported by Farmer, of Oxford, who successfully operated. He says, "The credit of the happy result in this case is primarily due to the promptitude of Dr. P., who first saw the child, in diagnosing the trouble and sending the patient for operation without delay."

Appendicitis has been a subject upon which a good deal of attention and discussion have been expended. The physician should be up-to-date on this disease and have clearly in his mind the indications for operation, if indeed they are yet generally agreed upon. For my own part, I have not reached the stage of believing or agreeing with some American surgeons, who have a simple rule that *all* cases should be operated on.

In certain diseases of the liver aspiration or incision may be necessary, as in abscess or hydatid cyst. The dangers of these procedures should be known. Tapping the abdomen might be considered a minor operation and could be done by the physician himself. Various operations of recent introduction for gall stones should be thoroughly understood. Cases requiring them usually fall into the hands of the physician. The lingering and recurrent misery of some of these cases calls loudly for something to be done. Fortunately in many cases surgery is available though operation in that neighborhood always seemed to me tedious and difficult.

The diagnosis of dilatation of the stomach falls in the province of the physician. The next point is to determine the cause. The various diseases of the pylorus are to be considered in this connection and the surgery of that region understood. He should know the indications for Loreta's operation (dilating pylorus), pyloroplasty, pylorectomy and gastro-enterostomy.

Suture of the stomach for perforating ulcer requires promptness of ll things. Here the responsibility of the physician in charge is

paramount. Early operation is the only salvation. Sub-diaphragmatic abscess sometimes occurs in these cases and should not be overlooked.

Hernia. The question of operation for strangulated hernia has been thoroughly impressed on all our minds, and we are keenly alive to the necessity of promptness when taxis fails. But the question of the radical cure of hernia may not have received much attention from some of us. Many physicians probably feel they have done their duty when they have recommended a truss. But if they were more familiar with the small dangers of an operation and the good results of an operation on the one hand, to be put against the inconvenience of wearing a truss and constant danger of strangulation on the other, they would recommend operation in suitable cases. Scarcely a day passes without such operations in all the large London hospitals, nor are they confined to adults. In femoral hernia of course the results of radical operation are not promising.

Fistula in ano as you know generally requires surgery. Piles are frequently cured by medical treatment, but failing this, the physician should have an intelligent opinion to give regarding operation.

Cancer of the rectum may fall under the physician's care, and upon him depends the responsibility of recommending the knife. He should be familiar with the points necessary to come to a conclusion whether interference is justified or not.

Kidneys. The frequent successful operations of late on these organs make it incumbent on the physician to bear in mind what surgery can do in chronic kidney troubles. The diagnosis of stone in the kidney, pyelitis, abscess, hydronephrosis and floating kidney is quite within the province of the physician, and such cases generally fall to him first. Hence all their surgical aspects should be quite familiar to him. I saw a case of distended gall-bladder mistaken for floating kidney by a number of practitioners, and finally an operation commenced, to be abandoned, when the true state of affairs was discovered. I saw another supposed for some time to be pregnant, but really suffering from pyonephrosis and abscess of kidney. Hydronephrosis may be mistaken for ovarian cyst hydatid of liver or omentum, distended gall-bladder, solid tumor or pyonephrosis.

Bladder. Stone or tumour of the bladder of course usually requires surgery. In prostatic enlargement of old men the physician should be able to estimate the condition, know when catheter life should be

commenced, and what surgery can probably do. He should clearly understand the indications for supra-pubic lithotomy, perineal incision, tunnelling prostate, castration and vasectomy.

In stricture the attendant should be well versed in the knowledge and indications for surgical procedures, such as aspiration or cystotomy in retention, or Syme's, Wheelhouse's or Cock's operation in various conditions.

Phimosis needs circumcision in contracted, long or adherent prepuce, when inflammatory changes are going on underneath, or when any of the usual sequelæ such as hernia, prolapse of rectum occur. This little operation might be allowed to the physician.

Testicle. Even this organ does not belong exclusively to the surgeon. The family physician should be quite familiar with its diseases, and tapping for hydrocele need not be forbidden him.

Female Organs. This subject opens up a wide field for the surgeon or gynecologist. The diagnosis of some conditions requires keen perception and long practice. The intelligent physician will know what cases require surgery, and recommend accordingly. Possibly his influence may sometimes be required in restraining some too enterprising surgeon in this field.

On the one hand we have seen vesico-vaginal fistula treated by diuretic medicines—emmenagogues for imperforate hymen—"pus tubes" causing untold suffering left for years, pessaries used *ad nauseam* where ventral suspension might have ended the trouble—astringents continued where fibroids easily removable by operation were the cause and tumours treated as pregnancy.

On the other hand some surgeons may have been too ready to use the knife and sacrifice important organs, when judicious medication might have cured them.

Diseases of the breast require grave consideration. Abscess of breast needs to be opened and drained.

In cases of tumours the question of malignancy is most important, and every attention should be given to this point by the physician who first sees the case. When in doubt the knife should decide, and that right early.

I have only had time to touch on a few points, but hope I have made some impression as to the desirability of the physician taking an interest in surgery, and even watching operations. The technique may not so much interest him, but the conditions found at the operation and the general methods are very requisite for him to know.

THE RADICAL TREATMENT OF CHRONIC OTORRHŒA AND AURAL POLYPUS*

By J. H. Morrison, M. D., St. John, N. B.

The successful treatment of chronic otorrhœa is operative; it is not therapeutic. The injection of antiseptic solutions and the insufflation of antiseptic powders are merely methods of producing uncertain conditions of cleanliness in the ear. But cleanliness is not enough, the origin of the discharge must be sought for. The pathological condition producing it must be removed.

Aural polypi and chronic otorrhœa are so often associated, and the causes producing them are so closely allied, that we are justified in considering both these affections together.

It might be superfluous to say that the treatment of aural polypi is operative, seeing that the removal of the polypus is always indicated. But unfortunately, removal of the polypus too often constitutes the whole treatment. The condition producing the polypus is usually entirely ignored, and is left as a soil well prepared to produce another crop. Chronic otorrhœa is not necessarily complicated with polypi; but polypi are always accompanied by chronic otorrhœa.

In general it may be said that the cause of both these affections is the same. An attack of acute otitis media has resulted in destruction of a portion of the membrana tympani and of the mucous membrane which lines the cavity of the middle ear, or in destruction of the periosteum of the ossicles. This results in caries of the bony wall, or of the ossicles, granulations appear over the seat of the caries, a chronic discharge is set up by the granulation tissue, and polypi spring up from various portions of the diseased area. Nearly all aural polypi have other origin within the cavity of the middle ear and push their way out through any opening that may exist in the membrana tympani. In some few cases they spring from the wall of the auditory canal. Obviously then chronic otorrhœa and aural polypi are caused by the presence of diseased bone. The only rational treatment of diseased bone is its removal when the operation can be safely done.

*Read at meeting of Maritime Medical Association, St. John, July 18th, 1900.

Some few cases of chronic otorrhœa are due to hypertrophy of the mucous membrane lining the middle ear. They are the exception —not the rule. In these cases the application of nitrate of silver, protargol, and similar drugs may induce the absorption of the hypertrophied tissue and cure the discharge. The mere injection of lotions or the insufflation of powders will not cure the disease.

In every case of chronic otorrhœa search must be made for dead bone. It is best to administer an anæsthetic and to make a thorough exploration of the middle ear cavity. In every case of aural polypus it is necessary to first remove the polypus and then make diligent search for the diseased bone from which it sprang. It may not be found in every case of chronic otorrhœa, but it will be found in nearly every case of polypus.

To remove a polypus by means of a snare, and to stop there, is but to coax the disease along. It is like removing a section of a tapeworm and leaving the head and the undisturbed portion to produce another body.

When the presence of diseased bone is demonstrated in either of these affections, the indications are clear and distinct. The patient must be anæsthetized and every vestige of diseased tissue must be removed. For this operation the ear curette is the instrument *par excellence*. I have entirely discarded the snare for the removal of aural polypi unless the polypus is very large and protrudes from the meatus. The curette is in every way the superior instrument.

In cases of chronic otorrhœa due to caries of the ossicles, removal of the ossicles is all that is necessary. If granulation tissue be present it must be thoroughly scraped away with the curette, the flexible shank of which may be bent so as to enable the operator to reach with the cutting ring, any remote portion of the middle ear. If caries be encountered the curettement must be prolonged until all diseased bone is removed and the surface left clean and smooth.

Diseased bone is most often found in the region of the attic of the tympanic cavity. Polypi may spring from anywhere. Granulation tissue will be most often found upon the inner bony wall of the cavity. In cases of chronic otorrhœa of long standing, the extent of the diseased cavity is sometimes surprising. Exfoliation of bone in small, brick-dust-like masses has gone for so long a time that the avity becomes twice or three times its normal size. Its greatest

extension is generally posteriorly towards the mastoid region. If a portion of the membrana tympani be present, care must be taken not to remove it unless small and peripheral.

The operation calls for much *tactus eruditus* on the part of the operator, as, after the first stroke of the curette, the sense of touch is his only guide: hemorrhage prevents any possibility of a view of the field of operation. Healthy tissue must not be disturbed, and when the canal is full of blood, healthy tissue can only be distinguished from diseased tissue by tactile sensation. The hemorrhage cannot be controlled, nor can the blood be wiped away with a cotton pledget sufficiently to give even a momentary view of the cavity. The roof of the tympanum is a very thin bony wall and this may be said to be the danger region. It must be curetted very gently, yet with sufficient force to remove the diseased tissue, unless it is evident there is sufficient necrosis to make perforation of the bony plate possible.

In cases where there is only a small polypus it is necessary only to remove the polypus and curette the place from which it sprang.

After the curetting operation, the cavity should be thoroughly washed out first with boiled water and then with a 1-2000 bichloride lotion or a 1-20 solution of carbolic acid, the latter of which I much prefer.

In cases where there is no trace remaining of the malleus and incus, it is my custom to dry the cavity thoroughly after irrigation with boiled water, and then apply to its walls pure carbolic acid with a small cotton pledget, immediately neutralizing it with absolute alcohol. After thorough cleansing, the cavity should be packed with iodoform gauze, cut in strips one-quarter inch in width, the packing being continued until the entire auditory canal is filled. A more satisfactory procedure, perhaps, is to pack the cavity of the middle ear with iodoform gauze and to fill the auditory canal with dry boracic acid, tamping it down solidly with the handle of the curette. This enables us to leave the packed cavity undisturbed for several days while we may remove the powdered boracic acid on the second day for purposes of inspection. If there be no evidence of pus formation, the dry powder packing should be replaced. A patient will often tolerate the packing in the tympanic cavity for several days, if there be no pus formation, when packing in the canal would give rise to considerable pain or irritation. The cavity should be kept packed with gauze, iodoform, or boracic acid, for at least ten days, renewing the packing as may be

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Each fluid ounce of this Elixir contains forty grains Viburnum Opulus (Cramp Bark), thirty grains Hydrastis Canadensis (Golden Seal), twenty grains Piscidia Erythrina (Jamaica Dogwood), ten grains Anemone Pulsatilla (Pulsatilla).

DIRECTIONS.—The Elixir being free from irritant qualities may be given before or after meals. It has, indeed, the properties of a stomachic tonic, and will promote, rather than impair, appetite and digestion. The dose for ordinary purposes is a dessertspoonful three times a day. When the symptoms are acute, or pain is present, it may be taken every three or four hours. In cases of dysmenorrhœa, neuralgic or congestive, the administration should begin a few days before the onset of the expected period. In irritable states of the uterus, in threatened abortion, in menorrhagia, etc., it should be given frequently conjoined with rest and other suitable measures. For the various reflex nervous affections, due to uterine irritation, in which it is indicated, it should be persistently administered three times a day. When the pains are severe or symptoms acute the above dose, a dessertspoonful, may be increased to a tablespoonful at the discretion of the patient, or advice of the attending physicians.

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The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

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deemed necessary, after which it should be thoroughly irrigated several times daily. Powders and antiseptic solutions though *useless as cures*, are *necessary as cleansers*, and it is after such an operation that their value is demonstrated.

In cases where the malleus and incus have been previously destroyed, general curettement of the middle ear does not reduce the hearing. Close examination of an ear from which there comes a constant or recurrent discharge often reveals the fact that the portion of the middle ear cavity below the attic is intact, and that the discharge comes from a small bony cavity anterior, posterior or superior to the drum membrane. The only rational treatment for these cases is exploration and curettement of the discovered cavity. Little danger of any kind attends the operation of curetting the middle ear when done by one familiar with the anatomical relations of the parts. Where there has been extensive necrosis, it often happens that facial paralysis may follow the operation and persist for some days; but it gradually disappears. It may be due to a wound of the facial nerve, either by the curette or the rough edges of a sequestrum of removed bone—more often the latter—or to pressure exerted upon the nerve by the gauze packing or to congestion of the aquæductus Fallopii. In one remarkable case which occurred in my practice two years ago, complete unilateral facial paralysis had existed for seven years, during which time there had been a continuous, foul smelling discharge from the ear. The auditory canal was full of polypi, with extensive necrosis of the tympanic cavity. Curettement of the cavity was followed by prompt and permanent relief of the facial paralysis.

Chronic otorrhœa with and without the complication of aural polypi, is a most dangerous legacy from an acute otitis media. It has been not inaptly said that a patient with a chronic discharge from the ear might as well be going around with a charge of dynamite in his ear. It is liable at any time to set up more serious troubles which may result in mastoid abscess, septic thrombosis of the lateral sinus, cerebral, cerebellar, or epidural abscess or meningitis—each an exceedingly grave affection. We do not seem to be justified in allowing such patients to go on from year to year in the constant shadow of such grave eventualities.

Does the operation of curetting the middle ear always cure otorrhœa? We cannot say that it does. In the great majority of cases it does; and when it fails to altogether arrest the discharge, the

improvement as to quantity and odor is most marked. In such cases the operation should be repeated, care being taken to most thoroughly explore the remote recesses of the cavity and to remove every trace of granulation tissue or diseased bone.

When there is evidence that the disease has worked its way backward to the honeycomb structure of the mastoid, the radical mastoid operation is indicated, and this should be done in the most thorough manner, establishing with the curette a good passage from the mastoid antrum to the middle ear, providing for the freest irrigation, which, after the packing has been removed, should be faithfully kept up until the opening in the mastoid has completely healed.

Should we advise the radical treatment in every case of chronic discharge from the middle ear? I hardly think we would be justified in going so far as that. In cases where there is nothing more than a thin watery discharge, the lesions may not be such as would demand the curetting operation. But where the discharge is purulent and foul smelling and of long standing, nothing short of the radical operation will be of any avail. It has long been a reproach of the profession that patients should be permitted to go through many years of their lives with "running ears." These running ears can be cured—not always—but in the great majority of cases. It may require several curetting operations, it may even be necessary to open and curette the mastoid cells, but as long as diseased tissue can be reached it can be removed, and to remove diseased tissue is to improve the condition of the patient and his chances of an ultimate cure.

It is extreme folly to tell a patient that he will "outgrow" his running ear. It is but a humiliating confession that we are powerless to do anything more for him. Such advice is decidedly unprofessional. There is always something more to be done when the cavity of the middle ear is filled with granulation or polypoid tissue. This tissue *must be removed* and the underlying diseased bone treated upon correct surgical principles.

In closing this paper, I desire to urge upon my friends in general practice, the more general use of the head mirror and ear speculum in the class of cases under consideration. We are not justified in attempting to treat these cases while we are unfamiliar with the pathological conditions present; and these conditions can only be observed and determined by the aid of these two very necessary and inexpensive instruments. By their use the middle ear is brought

plainly into view; without them no specialist will venture a diagnosis. An ordinary lamp will provide the necessary illumination, and if artificial light is not convenient, sunlight is always at hand.

[Two interesting cases were presented who had markedly improved under treatment after many years of deafness. One patient had been deaf for forty years in one ear and twenty-two in the other, both ears having discharged much pus. Before treatment he could not hear the clock strike, except when very close to it. Treatment as advocated in the paper was carried out, which resulted in a cure and excellent hearing.]

Clinical Report.

NOTES ON A CASE OF MYXŒDEMA.*

By H. H. McKay, M. D., New Glasgow, N. S.

On Feb. 20th, 1900, I was called to see Mrs. N——, aged 40; she had been married 2 or 3 years, but had no children. Her husband told me she had been failing in health for more than a year, and had been getting worse lately. Owing to the changed appearance of her figure and the stopping of the menstrual function they expected she would have been confined four or five months ago. Lately she suffered from difficult breathing and a feeling of suffocation, which they attributed to her having taken cold. My first glimpse of the patient gave me the impression that I had a case of anæmia with general dropsy, but that idea was dispelled by trying to pit the swelling on the forehead and eye-lids. There was no pitting on pressure, but the tissues had a tense feel and would vibrate on making rapid lateral motion, giving a sensation somewhat similar to that got from shaking sandy clay soil when the frost is coming out.

There appeared to be a layer of this dense easily vibrating tissue, more or less over the whole body, with great accumulations on the back of the neck and shoulders, and a tremendous thickening on the abdomen and buttocks, giving the appearance of pregnancy. The face had a stolid or stupid expression. The skin was rough, dry and scaly. The tongue was large and there appeared to be œdema of the throat, and lately there had been fits of laboured breathing with a sensation of suffocation.

She was very deaf and could not comprehend a question quickly, and her memory was defective. Her speech was slow, labored and hesitating. Her gait was waddling or clumsy. Her hair was falling out, dry and brittle. She complained of a feeling of numbness and loss of sensation, and her hand was broad, thick and coarse looking, with rough, dry, scaly skin. Her pulse was slow—48, and temperature was subnormal—97. She was admitted to the Aberdeen hospital, eb. 27th, 1900, and was put on dessicated thyroid, one grain three

* Read at meeting of Medical Society of Nova Scotia, Amherst, July 5th, 1900.

times daily for two days. The first day she was in the hospital she was greatly distressed with a sensation of suffocation and pain in region of heart, which was worse during the night; on the second day this was greatly relieved, when she was given two grains of thyroid three times daily for two days more, which completely relieved the feeling of suffocation and discomfort. The amount of urine was increased from 25 to 52 ounces.

The dessicated thyroid was increased one grain every second day until five grains three times daily was given, when the increase had to be stopped on account of rise of pulse and temperature. Her hearing rapidly improved and was almost completely restored within ten days. Her features were also completely changed and her mental processes were quickened. Her speech also lost its slow hesitating character and became quick and continuous. The skin on her hand began to peel off and the skin generally began to desquamate and get soft. The change had been so great in three weeks that her husband said he would hardly recognize her.

Whenever any untoward symptoms, such as rise of pulse or temperature manifested itself, the thyroid was decreased and then gradually increased as at first. The largest dose reached was five grains three times daily. I noticed frequently during the first few weeks of administration that some of her fingers would get cold and feel as if they were dead, though not always the same fingers; it would last for an hour or more and then pass off and would return the next day about the same time. I think it was due to some vaso-motor disturbance.

She was discharged on April 29th, 1900, a completely transformed woman, with all her former faculties and activity regained. I ordered her to take four grains of thyroid once a day for three days and then stop two days and repeat as before.

On last accounts, about a month ago, she was still keeping well.

How did the thyroid work?

Selected Article.

A MISTAKE IN THERAPEUTICS.*

BY EDWARD P. BUFFET, M. D., JERSEY CITY, N. J.

This mistake is the over-estimate of the efficiency of drugs in the cure of disease. It is a mistake made by both physician and patient, but more frequently and decidedly by the patient than by the physician.

It is a popular belief that disease is inevitable. There is a superstitious or a fatalistic sentiment widespread that through some unfortunate event the human race became heir to ills innumerable imposed by some malignant power, which should be expected and waited for with as good grace as possible. As a remedy for these unavoidable ailments it is thought, on the other hand, that some benevolent being has hidden away, in various obscure localities, the specific drug which has been specially devised for each particular ill that flesh is heir to. If only this remedy can be found, the demon of disease can be exorcised; if it cannot, bad luck to the patient. The idea that the mischievous germ can be met and destroyed before it has entered the human organism has not yet become a popular one. Neither is it a general belief that the human animal was ever intended, like the wonderful one-hoss shay, to run his allotted course without medical repair until he is actually worn out and the time arrives for him, as the hospital interne says, to "go to pieces" all at once.

It is in consequence of the mistaken impression as to the value and necessity of drugs that they have been and are now accumulating in marvellous proportions. Eighteen thousand preparations of medicines are registered in the National Dispensatory, with the nature and uses of which the patient kindly assumes that the doctor is familiar, and the number is increasing daily with distressing rapidity.

With drugs so numerous, the habit is easily acquired of using them to excess, and ascribing to them undue importance. The patient divides his ailments into two classes, those which are fatal and those

*Read before the District Medical Society for the County of Hudson, N. J., October 16, 1900.

which are not. In the treatment of each class he thinks only of the drugs used. They are the visible and tangible weapons upon which he relies. If he recovers, the drugs and the skill of the doctor in their use are supposed to be the efficient cause. If he dies, the drugs and the doctor are held responsible. Undeserved praise is given to both drugs and the doctor when the issue is favorable, undue blame when it is unfavorable. The doctor often allows one to counterbalance the other, and makes no comment. But there is a fact which experience teaches him and which he does not always disclose to the patient. This fact is that some other cause than the drugs used has effected the recovery, when recovery has taken place. This cause he may not himself fairly understand. He knows only that some inherent tendency to recovery helps him along very unexpectedly at times, and very satisfactorily. He finds it convenient, as well as proper, to cover his ignorance as to the precise nature of that which gives him aid, by the Latin phrase, "vis medicatrix naturæ."

It seems hardly necessary to bring arguments to prove to an audience of intelligent and experienced physicians that an overestimate of the value of drugs in the cure of disease and, as a consequence, of the skill of the physician in using them is made by the patient It is the experience and observation of the doctor which will convince him of the fact, and if he is not already so convinced, words will be useless. It is the evil effect of the popular mistake and its remedy which is the important subject for consideration.

Noah Webster defines a quack as a boastful pretender to medical skill, one who boastfully pretends to knowledge not possessed. Not many regular practitioners are quacks as thus defined. Most are inclined to lament their want of medical knowledge, rather than to boast of their proficiency. But it does sometimes happen that the patient who believes that his recovery has taken place in consequence of the dose selected by his doctor, when recovery was inevitable under any condition, will boast on his doctor's behalf of a knowledge not actually possessed by him. Should the doctor wink at such undue praise by the patient he becomes a quack by proxy or substitution, and here results one of the first evils of the mistake made by the patient. But in addition to the unfortunate position of the practitioner who receives undue credit the mistake opens the door to outside quackery, and gives a start and an imaginary success to every new so-called system of practice which can be concocted in the brains of

any medical enthusiast, and to every patent-pill-maker who can combine two or more drugs so as to act as a cathartic without immediate death to the patient. If in nine cases out of ten the patient would recover without the use of a drug in which now the drug gets the credit, of course any quack or nurse when he attempts the cure will get the same credit in the popular estimation as does the educated physician. Also, if the physician allows the mistaken belief as to the importance of the remedy to go uncorrected, he simply places himself in the nine cases out of ten on the level of the quack and the nurse who can and do practise as successfully as himself when the patient is sure of recovery. It is true that in the tenth case, in which knowledge and skill in the careful selection of the drug may save the patient, he outshines his rival the quack, but this is only one case in which he appears to advantage, whereas in all he should be shown to be a superior in knowledge by his superior success in practice.

The next important question is, What is the remedy for the evil? What shall the physician do to outrival his neighbor the quack, who practises so successfully when nature effects the cure? The answer is plain—correct the popular mistake. Let the doctor make known to his patient how often recovery would take place under the same careful hygienic treatment, even if drugs were not used at all. Let him acknowledge the fact, if he believes it to be a fact, that drugs—and doctors, in so far as they rely upon drugs—are getting credit for cures, which does not belong to them. Teach the patient to rely less upon medicine and more upon an adherence to the rules of hygiene. Inform him that an ounce of prevention is worth several pounds of cure, especially when the ounce is the bactericide which destroys the germ before it has invaded the body, and the pounds are the useless drugs deposited in the stomach after the disease has made its onset. Let the doctor ennoble his calling by acting as a teacher rather than a nurse, a professor of medicine rather than a druggist. Let the doctor of the future give more attention to the rules of sanitation, to the dietetic and hygienic treatment of his patient rather than so exclusively to the medicinal, to the diagnosis and prognosis of disease. If he can do no more than inform his patient of the nature of his ailment, and its probable duration and issue, his services will be in great demand. In the performance of these duties he need not fear the competition of the charlatan. If truth if better than error, and it certainly is in the long run, the doctor will finally be reimbursed for any temporary loss he may sustain of either property or prestige.—*Medical Record.*

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Editorial.

THE TREATMENT OF INFLUENZA.

The way which influenza has of being always with us has the effect of maintaining an active interest in that disease at all times. While there are "off seasons," when its comparative infrequency tends to lessen the attention we devote to it, at other times the unusual prevalence of the malady awakens a very lively interest in it. Such a season is the present, when we find cases coming in steadily growing numbers, so that we look eagerly for any new developments in the study of the disease, and for any new knowledge which will better our methods of treatment.

Very seasonable indeed is a series of half a dozen articles appearing in the *Medical Journal* (New York) of December 15th, and although their perusal does not bring much solace to the inquiring mind, it is yet worthy of a brief review. Three of these articles deal particularly with treatment. Dr. A. Jacobi discusses the treatment of influenza in children. He urges the importance of prophylaxis, at which an honest attempt should be made. There is no specific form of treatment. Calomel at the outset, scanty and fluid diet, and the treatment of the symptoms; this is a brief sum of the matter. Cold baths or packs should be avoided, but warm baths may be of use. Hot baths should be used only in case of collapse. The symptom "fever" may need treatment. Any indication of injury to tissue by a high temperature calls for interference. "In their injurious influ-

ence on nutrition protracted infectious fevers act, first like direct losses or like starvation, and, secondly, as immediate poisons. The younger the patient the greater is the danger from that source. That is why a high temperature without any or with a trifling remission should not be allowed to last, though its immediate effect may not appear very ominous." Of the more commonly used antipyretics, acetanilid is objected to as being poisonous. Phenacetin, salipyrin and salophen are preferable, but with all the tendency to heart failure in influenza should be remembered, and if there be any suspicion of such, these drugs should be guarded with caffein, or strychnine, or other suitable agent. Reference is made to the reported prophylactic influence of vaccination (against small-pox) in influenza.

Dr. R. W. Wilcox takes up the treatment of influenza in adults. He advocates, in uncomplicated "respiratory" cases, the use of ammonium carbonate, in five to ten grain doses, in milk, to relieve cough and chest oppression and fortify the heart. If this be not well borne, strychnine or nux vomica are suggested. Diet should be fluid and nutritious. Skin, kidneys and bowels must be kept active. If pneumonia complicate, "the bleeding of the lesser into the greater circulation by the nitrites, preferably nitroglycerine, and increasing and frequently repeated doses of strychnine, must be carried out until the patient is convalescent." Gelsemium is recommended for the relief of headache and backache.

The treatment of influenza by the employment of hydropathy is dealt with by Dr. E. L. Shurly. His paper is frequently in disagreement with the teaching of Dr. Jacobi's article. To aid in the elimination of the infection, he advocates "the persistent use of the hot water bath, steam bath or hot pack, in conjunction with quinine and mild anodynes." Of course there may be contra-indications, such as feeble heart action. "The employment of the cold pack should take precedence over hot baths, etc., whenever the temperature is very high, for in such cases the leading therapeutic indication is to reduce the temperature from a dangerous to a safe degree, and then follow with hypodermic injections of normal saline solution, one ounce every hour until diuresis or diaphoresis has become established." These hydropathic measures are most likely to prove effective if adopted early in the course of the infection.

Society Meetings.

ST. JOHN MEDICAL SOCIETY.

Dr. J. R. McIntosh, President, in the Chair.

Nov. 14th—The meetings of the society were resumed after a recess of three weeks.

Dr. Clara Olding read a paper entitled "Water as a Therapeutic Agent." Water is one of the most valuable remedies in the treatment of disease, its use is by no means as universal as it should be. People, in general, do not drink water enough. Patients with high temperature drink of it freely; life itself is a slowly burning fever which a free supply of water would do much to keep in check. Each adult should consume five pints of water daily to enable the system to duly perform its functions. One should drink a glass or two, two hours after meals, and a large tumberful of hot water each morning on rising. This washes and stimulates the stomach and promotes digestion and assimilation. It is really an internal bath—headaches, rheumatism, indigestion, etc., is the cry of the system for water. Assimilation and excretion are retarded by lack of its use and the body is poisoned by retained waste products, hence a long list of grave diseases. Externally, the use of water is constantly increasing. Hot water is almost a specific for sprains and headaches, applied from twenty to sixty minutes at a time. In the prodromal stages of influenza and fevers, it frequently lessens frontal congestions and induces sleep. Hot water also is a hæmostatic for capillary hæmorhage and efficacious for removal of sloughs and cleansing of dirty wounds. Opinions vary as regards baths; all agree, however, that cold baths will reduce high temperature, stimulate the heat, allay restlessness and promote sleep. Baths arouse the heat by stimulating the peripheral resistance in the skin, which, in itself is capable of retaining thirty-five per cent. of the blood in the body, and according to Woods, of really acting as a secondary heart by its rhythmic contractions. Cold morning baths will often do much to cure chlorosis and fortifies the system against cold. Such baths to be effective should be followed by a good reaction and so in some cases, hot water may be substituted with good

effect. Very hot baths are recommended by Doch as an aid to diagnosis in abdominal cases, in ten minutes a pronounced relaxation of all tissues is produced.

A discussion of the subject then followed.

The President considered that the benefit obtained from medicinal springs was largely due to the large amount of water consumed, rather than to the medicinal ingredients contained in them. Rheumatism and gout were instances of diseases benefitted by drinking such waters.

Dr. Ellis considered that people obtained a fair supply of water in the daily consumption of tea and coffee. There was now a decided reaction against the indiscriminate use of cold baths in fevers.

Dr. G. A. B. Addy prescribes water for dyspeptics, when large draughts are taken; the temperature of the water should be at blood heat. The stomach, in this way, becomes cleansed of undigested food and mucus.

Dr. McLean said, that in nervous cases with scanty secretion of urine, the best method to increase it is by the ingestion of water. When cold water is taken in small particles, it is warmed before reaching the stomach.

Dr. Crawford found water at all temperatures useful in many eye diseases, especially in corneal troubles and iritis. Hot fomentations have a useful anodyne effect in these cases.

Dr. Inches thought more water could be used profitably. Five pints however, was too much for many people. At water resorts, change of air and surroundings had often much to do with the benefits received; massage and electricity also had good effect. He doubted the reliability of the favourable statistics of the use of cold baths in fevers and quoted the death rate of typhoid patients in St. John during the past few months as pointing to the inefficacy of cold baths.

Dr. Melvin spoke of the use of hot water in skin diseases, more especially in facial troubles as acne, seborrhœa and eczema. In some forms of eczema, more particularly of the acute form, it is pernicious. Tepid water is always relaxing and should be avoided generally in skin diseases.

Dr. James Christie did not think the taking of copious draughts of warm water in the morning judicious. The taking of water largely is a habit. The results of hydrotherapy at the Hot Springs, Arkansas, were mentioned. Syphilitic patients were enabled to take enormous

doses of potassium iodide along with the waters with almost magical effect. Rheumatic cases were benefitted by these waters. There is excellent authority for taking food with but a limited quantity of water.

Dr. Olding in closing the discussion explained that the five pints of fluid to be taken daily meant the total average amount contained in all kinds of ingesta. The time for taking water was not at meals but after the food had left the stomach.

Nov. 21st—Case of injury to eye. The President exhibited a patient suffering from loss of sight, due to a penetration of the cornea and lens by a particle of steel. The foreign body was probably not now present. There was some hope for future vision after absorption of the lens.

The resolution relative to the late Dr. John Berryman was adopted, and has already appeared in the NEWS.

The paper of the evening, a review of one hundred and fifty skin cases was read by Dr. Melvin, and will appear in full in the NEWS.

In the discussion of this paper, the President referred to the popular and erroneous belief in syphilis as a causative factor in alopecia.

Dr. Thos. Walker referred to itchiness as being an occasional symptom of syphilitic eruptions and also spoke of erythema nodosum and purpura hæmorrhagica.

Dr. T. D. Walker thought it would be interesting to consider the prevalence of the various skin diseases in New Brunswick.

Dr. Murray MacLaren referred to a number of cases of tinea versicolor in debilitated subjects; and also to blasto-mycetic dermatitis.

Dr. Inches had seen many cases of urticaria and erythema nodosum.

Dr. G. A. B. Addy expected to hear of a large number of cases of eczema in Dr. Melvin's list, as the climate of this country was generally considered to predispose towards this disease.

Dr. Melvin, in closing the discussion, said that pruritus when present in syphilis was generally due to an accompanying seborrhœa. If any skin disease was peculiarly absent from St. John, it was tinea tonsurans. Lupus was more prevalent here than in the United States, less so than in England.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Nov. 21st, 1900.—Dr. G. C. Jones, President, in the chair. Meeting was held at the Victoria General Hospital.

Dr. Kirkpatrick presented a case of a woman with a growth in the left nostril, attached to the lower part of the middle turbinated bone. Eighteen months ago a small growth, the size of a pin-head, had been removed by Dr. Dixon of Amherst, which recurred and was removed several times till last June, when it began to block the nares. In October she came to the Victoria General Hospital, where Dr. Kirkpatrick removed it with the electro-cautery. Within three weeks it recurred as large as ever. Report of the microscopic examination had not yet been had.

Dr. Murphy presented a case from which a very large tumor, which had grown slowly for many years, had been removed from the neck of an elderly woman. The tumor was easily enucleated and showed no sign of recurrence.

Dr. Murray said he had seen the case at the consultation, and he then thought tumor was due to long standing obstruction of the salivary duct.

Dr. Murphy then showed a case of empyema from whom 112 ounces of pus were removed, and three ribs resected with a good result.

In reply to Dr. Walsh, concerning irrigation, Dr. Murphy said he had used a week iodine solution, 15 drops to the quart. The tube had on one occasion slipped into the cavity, but had been removed.

Dr. Walsh related a case in which he irrigated with peroxide of hydrogen and aphasia resulted, which was of short duration.

Dr. Murphy presented for Dr. Farrell, a case of amputation at the hip-joint for sarcoma of the femur—Wyeth's operation. This was done three weeks ago, and the patient was now setting up. He mentioned at the same time a Furneaux Jordan operation, done by him for necrosis of femur, with good result.

Dr. Murray showed two cases of locomotor ataxia, and one of partial paralysis, and asked for opinions as to the diagnosis and treatment of the last case.

Dr. G. M. Campbell suggested infantile paralysis.

Dr. Silver opposed this opinion.

Dr. Murray suggested transverse myelitis, high up.

Dr. Ross presented a case of acute eczema, and mentioned some points in the treatment. The discussion which followed was taken part in by Major Peeke, Drs. Goodwin and Ross. (This case has since developed into exfoliative dermatitis.)

Meeting then adjourned, and at the invitation of Mr. Kenney, Superintendent of the Hospital, the members sat down to a bountiful supper, which was much enjoyed and which was followed by a few bright speeches from several present.

December 5th, 1900.—Meeting held at 8.30 p.m., at the Halifax Hotel

Major Peeke being called upon to open the discussion on "Treat- of Fractures," read a carefully prepared and exhaustive paper upon the more recent work in this direction. (This paper will appear in next issue of the NEWS.)

Dr. Mader, who was asked to continue the discussion, exhibited a portion of a rib fractured by a 22 calibre bullet. The bullet was removed on the tenth day, but septicæmia developed and the boy was laid up for two months, after which he coughed up a piece of bone from the rib. Dr. Mader referred to the ambulating treatment of fractures so much used in Germany, with good results; the leg being put in plaster of Paris. He also spoke of treatment of fractures in children by vertical suspension of the limb, and exhibited VanArndale's splint for treatment of fractures of the thigh in children.

Dr. W. S. Muir of Truro, being then called upon, expressed his agreement with Major Peeke on the importance of attending to other points besides fixation, such as circulation. The discussion at the recent British Medical Association meeting on this subject was referred to. He said the most frequent fracture he had to deal with was Colles' fracture. The great difficulty was to prevent deformity. The result in these cases should not be criticized unless the fracture had been seen at the first. He used two straight splints and early massage and passive movement. Next most frequent fracture was Pott's, where he also used two splints, but only for a short time. In fracture of the patella he believed it was usually necessary to wire. He referred to the practice of Lister and MacEwan. In intracapsular fracture he used sand-bags with extension. He condemned patent splints. X-ray work which he had seen at the Montreal General Hospital was also referred to.

Dr. Murphy being asked to continue, said he had listened with much pleasure to the discussion. He mentioned the practice of Arbuthnot Lane and Golding Bird, who almost always cut down and wired the fragments. He referred to the difficulty he had experienced in getting good apposition and union in the upper half of the tibia. He mentioned a case at the Victoria General Hospital where the bone had been crushed and fissured into the knee-joint with great effusion into the joint. He had cut down and wired the fragments, but gangrene set in and rendered amputation through the thigh necessary. A case of a woman, 79 years of age, with compound fracture of the olecranon and intracapsular fracture of the neck of the femur was also mentioned. He used Buck's extension for the latter and early movement, a very good result following.

Dr. Walsh referred to several exceedingly rare and interesting cases.

Dr. Goodwin said he had treated many fractures with never a bad result. He used both Liston's splint and Buck's extension in fracture of the thigh. He would always wire patella, and referred to wiring around the jaw for oblique fracture.

Dr. M. A. B. Smith mentioned a case of fracture of the femur above condyles and into the knee-joint with ankylosis following, and also a case of fracture of the tibia with a loose piece of bone, which was placed in position and united. Such fractures should be put up in a straight position. He did not believe there was any danger of ankylosis from keeping joints fixed for any length of time and quoted Dr. Phelps to that effect.

Dr. Hogan, speaking of Dr. Smith's case, said it was unwise to draw general conclusions from one case.

The President referred to a case of fracture of femur in a child five years ago to which Dr. Mader referred, which is recorded in the minutes of November 15th, 1895.

Major Peeke, in closing, referred to the interesting discussion which had taken place. He said X-rays were not an unmixed blessing to the surgeon, as the patient may make an X-ray examination for himself and not be pleased with the result. It is very easy to get a wrong impression from the X-rays or fleuroscope. Several points of view should be taken, at least three or four, to get an accurate picture. It does not matter what form of splint is used in Colles' fracture so long as you attend to passive movement and after treatment. A case of fracture of the humerus was referred to in which the man had D. T's., and frequently took off the splints as early as the first and third days, and still a good result followed.

Matters Personal and Impersonal.

Dr. E. F. Moore, formerly on the staff of the Nova Scotia Hospital for the Insane, is now settled at Cheverie, Hants County.

Dr. M. Chisholm, who had been confined to his house with a serious attack of la grippe, is now convalescent and is recuperating in the western part of the province.

Dr. E. Farrell, after showing signs of improvement in health, lately developed pleuro-pneumonia, and the latest report is that his condition is very serious. It is earnestly hoped that his numerous friends in the profession will yet see him restored to his former vigor.

Two "faith healers" have been arrested in Victoria, B. C., for murder, on account of a death from diphtheria. The only treatment adopted was incantations by the healer, who was one of Dowie's "Zionites."

The annual calendar for 1901, issued by the Antikamnia Chemical Company has just come to hand and shows four new "Skeleton Sketches" from the drawings of the late Dr. Cruzius, which will terminate this well-known series.

Dr. Nicholas Senn's gift of $50,000 to Rush Medical College will be used towards the cost of a clinical building for the college. It will be six stories high, and will contain two amphitheatres, a dispensary, laboratory and several small clinic rooms.

Obituary.

DR. JAMES MACLEOD.—The sad intelligence of the death of Dr. James MacLeod, of Charlottetown, has reached us as the NEWS goes to press. An extended obituary will be given in next issue.

DR. W. E. TYLER.—The death of Dr. Walter E. Tyler took place at Blandford, Halifax Co., the last week in November, aged 42 years. Dr. Tyler was a graduate of the University of New York and practised first at St. Margaret's Bay, then at Shad Bay, subsequently coming to this city. About fifteen month ago, owing to a liking for country practice, he left the city and took up his residence at Blandford, where he was much liked and respected. Dr. Tyler leaves a widow and two children.

DR. E. R. SQUIBB.—The death of the former head of the well-known firm of E. R. Squibb & Sons took place on October 25th, at Brooklyn. His ability and character were the principal agents in giving to this widely known firm in pharmaceutical products its present standing.

Matters Medical.

THE USE OF TOBACCO ON ACTIVE SERVICE.—The *Lancet* of November 10th says that "the war in South Africa has taught many things of greater and of less importance. Perhaps nothing that it has demonstrated has been more marked than the important part which tobacco plays in the soldier's existence. Whether this is to be reckoned as a great fact or a small one, there can be no doubt about the truth of it. Yet the Duke of Wellington's armies had no tobacco worth speaking of. If they did not forbid its use, at any rate the Iron Duke's officers were directed to advise their men strongly against it. What a curious contrast with the campaigning in South Africa, where marches and privations as long and as stern as any suffered by our great-grandfathers were borne by the volunteers and soldiers of to-day with a grumble only when their 'smokes' failed them. We have it from many who took part in the forced marches leading to Paardeberg, to Bloemfontein, to Pretoria, and beyond that, when rations were but two or three biscuits a day, the only real physical content of each twenty-four hours came with the pipe smoked by the smouldering embers of a camp fire. This pipe eased the way to sleep that might otherwise have lingered, delayed by the sheer bodily fatigue and mental restlessness caused by prolonged and monotonous exertion. It is difficult then to believe that tobacco is anything but a real help to men who are suffering long labors and receiving little food, and probably the way in which it helps is by quieting cerebration—for no one doubts its sedative qualities—and thus allowing more easily sleep which is so all-important when semi-starvation has to be endured. The cases of acute mental derangement in the course of campaigns such as the present are many. There have, indeed, been many in South Africa. It would be most profitable and interesting could medical officers have taken special note of the capacity for sleep previously evidenced by those who broke down and also of their indulgence or non-indulgence in tobacco. We are inclined to believe that used with due moderation tobacco is of value second only to food itself when long privations and exertions are to be endured. Two features are to be noted with regard

to the smoking practised on active service. It is almost entirely in the open air and is largely on an empty stomach. The former is always an advantage, the latter we generally reckon a most unfavorable condition. Shall we see in the near future patients with tobacco amblyopia or smoker's heart acquired while the trusting friend of tobacco thought that he was enjoying the well-earned solace of a hard day's march? We believe not—and that the open air will have saved what might have been the untoward results of smoking when unfed.' The most suggestive part of this instructive article is that which refers to the cases of mental derangement in the course of campaigns and their connection, if any, with smoking. Insanity has been considerable among our soldiers in the Philippines, and the surgeons there might with advantage investigate the question raised by *The Lancet* writer as to the capacity for sleep previously evidenced by those who broke down and also of their indulgence or non-indulgence in tobacco. —*Medical Record.*

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SANTONIN IN THE TREATMENT OF EPILEPSY.—Dr. G. F. Lydston, as the result of his experience with the remedy, prefers santonin to the bromides in the treatment of epilepsy. He claims that the results are better, that santonin will act in cases where bromides entirely fail or are not tolerated, and that its use is not followed by drowsiness, mental depression or melancholia, conditions not infrequently attributed to the bromide treatment. He gives the drug in doses gradually increased to 15 grains three or four times daily. At times it may advantageously be given in conjunction with the bromides, the latter being administered at bedtime.—*Therapeutic Gazette.*

ASEPSIS OF THE SICK ROOM.—Sevestre advises the use of the following solution, which may be spread or evaporated by boiling: ℞.—Thymic acid, grm. 5; carbolic acid, grm. 10; alcohol, grm. 100; aq., grm. 885,—*Liebreich, Exchange.*

HYDROCHLORIC ACID IN THE LOCAL TREATMENT OF SCIATICA.—Von Eljasz-Radzikowski (*Therapeutische Monatshefte*) reports upon twelve cases of rheumatic sciatica treated with strong hydrochloric acid applied to areas several centimetres in diameter over the tender points in the course of the nerve and at the side of the vertebral column. In general, the acid may be applied every second or third day, but it should not be reapplied before the irritant effects of the preceding application have passed off. The pain caused by it is moderate, and sometimes there is none at all. Occasionally the first cauterization gives relief, but generally several pencillings are required, from four to eleven.—*N. Y. Medical Journal.*

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Degenerate Results of Defective Heredity.—By Chas. Denison, A. M., M. D., Denver, Colorado.—*Transactions of the Colorado State Medical Society.*

Methods in the Diagnosis of Diseases of the Stomach.—By Charles D. Aaron, M. D., Detroit.—*The Medical Standard.*

Notes.

SANMETTO IN CHRONIC ORCHITIS.—J. A. Strothart, M. D., Savannah, Ga., reports the following case: "During November, 1898, a Greek fruit vender called at my office, suffering with chronic orchitis. The patient stated that the first attack occurred four years prior to this time. During the four years there had never been more than two and a half months between the attacks. He had been under treatment most of this time, and several times in the hospitals, and had been discharged as cured by several physicians. The testicle had almost arrived at the condition of ossification, but at no time had there been any pus formation. I prescribed sanmetto, and directed that the treatment be continued for two or three months. My treatment was carried out to the letter, and there has never been any return of the trouble since beginning the use of sanmetto. I have used sanmetto in other urethral troubles with very satisfactory results."

BLOOD CURE OF TUBERCULAR LARYNGEAL PHTHISIS, by T. J. Biggs, M. D., Stamford, Conn. Peter L———, aged thirty-three; Irish; admitted October 29th; diagnosis, laryngeal phthisis. The case was sent to me by Dr. S———. Examination showed it to be a well developed case of tubercular laryngitis, presenting the following symptoms: almost entire loss of voice, patient anæmic, generally debilitated, cough of an irritating and painful character, associated with slight expectoration, painful and difficult deglutition. There was a remitting fever with slight night sweats, loss of appetite, loss of flesh, insomnia; laryngoscopic examination revealed the characteristic broad, shallow, irregular, grayish ulcers, with the thickened surrounding mucous membrane. The vocal chords showed infiltration, thickening and some ulceration. There was also redness generally of the mucous membrane showing here and there scattered tubercles. The ulcers were covered with a grayish exudate. The mucous tissue around about the ulcers was thickened. So advanced was his condition, that I gave the patient but little assurance of anything like a favorable result. The patient was put to bed in an isolated room, a tablespoonful of bovinine given every two hours, in milk, and a light general diet. Every three hours the larynx was thoroughly cleaned out with bovinine and hydrozone; following that, iodoform bovinine was sprayed in.

November 5th, bovinine was ordered, a wineglassful every three hours; and the ulcers now beginning to heal, it was decided to substitute bovinine pure for iodoform-bovinine, as a spray, but the cleansing process was continued as before.

November 12th, the patient began to feel stronger, and slept better, had no night sweats or abnormal temperature, appetite was good, and the voice, some clearer, swallowing and talking did not produce as much pain as at first.

November 21st, the ulcers with the exception of one, had entirely healed, and that one was doing nicely. Treatment continued.

November 28th, the remaining ulcer had healed, the inflammatory condition of the membrane had disappeared, no tubercles were visible, patient's voice had been almost restored to normal. General condition splendid. It was deemed wise to continue the treatment a short time longer. December 3rd, the patient was discharged, cured, with the voice absolutely restored.

As the prognosis in the condition is unvariably unfavorable, and as this case was one of the worst I had ever seen, I think that the result obtained here was a most remarkable one, and presents much food for deep thought. Never, in my experience before had I seen a similar case to this do anything like as well under other treatment.

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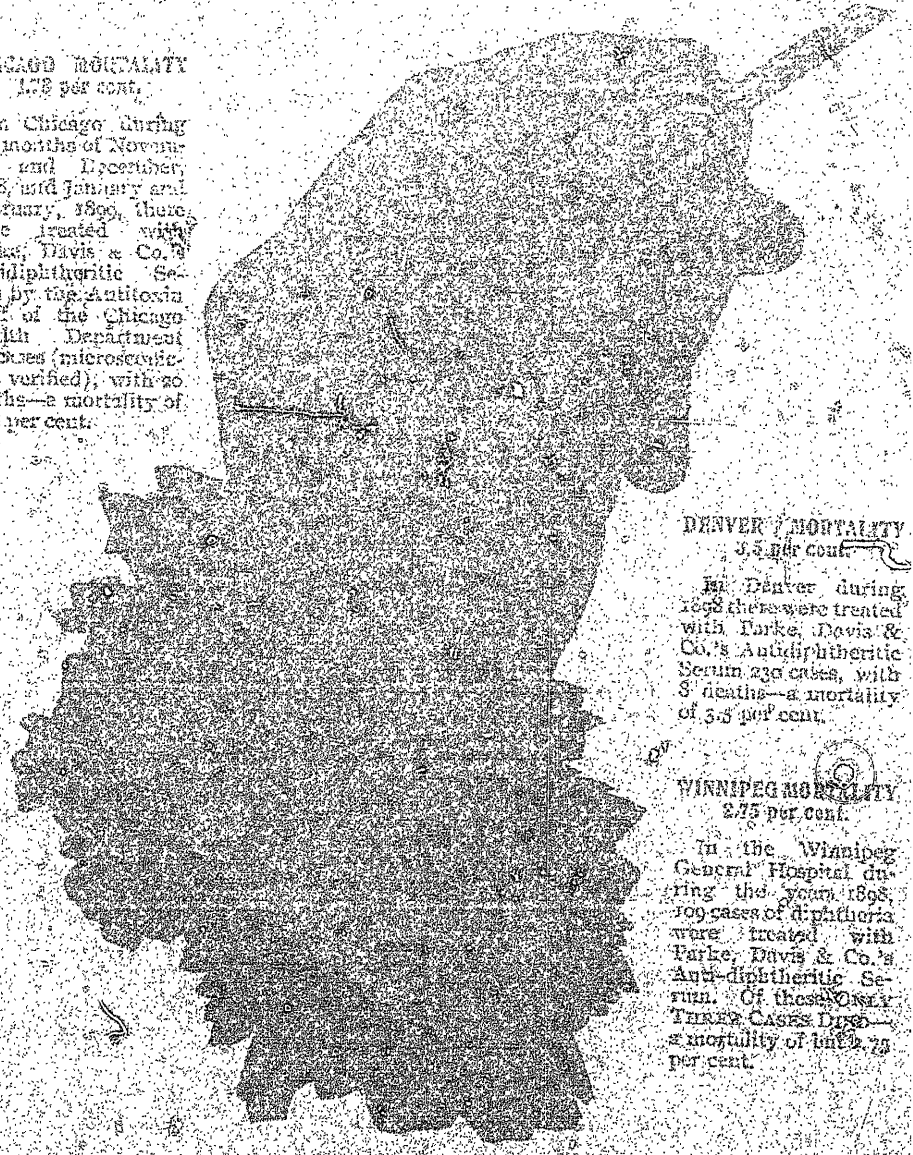

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