DOMINION

MEDICAL MONTHLY

AND ONTARIO MEDICAL JOURNAL

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VOLUMES XXXVIII., XXXIX.

TORONTO:

GEORGE ELLIOTT, PUBLISHER

219 SPADINA ROAD

1912

Contents of Volumes XXXVIII. and XXXIX.

CONTENTS OF VOLUME XXXVIII.

CONTENTS OF VOLUME XXXIX.

VOL. XXXVIII. TORONTO, JANUARY, 1912. NO. 1

Original Articles

A REPORT OF SIX CASES OF INTESTINAL OBSTRUCTION IN THE REGION OF THE CECUM.*

BY W. GUNN, M.D., CLINTON, ONT.

CASE I.

Intestinal obstruction caused by adhesions between the caput cecum and an abscess sac in the broad ligament, complicated by uterine fibroids, a pyosalpinx and a cystic ovary.

SPECIMEN REMOVED.—Uterus with multiple fibroids, one of which protruded from the os as a polypus, a cystic ovary, a Fallopian tube much thickened and full of pus, a pus sac containing about eight ounces of pus, removed from between the layers of broad ligament, appendix being still attached, the walls of the sac from one-fourth to one-third inch in thickness in places.

Operation, June, 1906.—Result, recovery. Under care of Dr. McCrimmon, Kincardine.

HISTORY.—Miss M. (aged 34).—For several years had symptoms of uterine tumor. For about six weeks previous to operation, there were added to the above the physical and local signs and symptoms of pelvic inflammation of the right side. Dr. McCrimmon made an almost exact diagnosis of the trouble early in the disease and advised immediate operation. This was refused till obstruction of the bowels became complete.

OPERATION.—A long incision through the right rectus muscle, appendix amputated and stump inverted. The caput cecum which was thickened was carefully separated from the broad ligament and the wall of an abscess which it contained. It was also separated

* Read at the County of Elgin Medical Association, Nov. 3rd, 1911.

was separated with fingers and gauze. As the sac wall was thin at the part to which the appendix was still attached, with the most careful dissection a slight leak of pus was unavoidable.

The adjustment of pelvic peritoneum, toilet of the pelvis, an abdomino-vaginal drain, and through and through sutures of silk worm gut to close the wound completed the operation.

REMARKS.—Appendicitis is not an uncommon cause of intestinal obstruction, but this case, by reason of complications, probably merits a place in our list. The pus tube and cystic ovary might well be caused from an infected uterus, but the abscess in the broad ligament was evidently secondary to a diseased appendix.

As a rule, when practicable, it is safer to drain a pelvic abscess per vaginam and to postpone further operation that may be necessary. The virulency of an abdominal or pelvic abscess diminishes in proportion to its age or as the peritoneum becomes immune to the infection. As a rule a pelvic or abdominal abscess is virulent in proportion to the effort the omentum has made by means of adhesions to guard the general peritoneal cavity from the infection. Suspect an abscess, however small or sweet smelling, if the omentum regards it as dangerous. A bad odor does not indicate a virulent abscess. The reverse is often the case.

In removing inflammatory tumors of the pelvis, it is well to guard against cutting or ligating the broad ligament transversely far out. To do so is seldom necessary. It is often associated with troublesome bleeding, and may endanger bowel, mesentery or ureter that may have happened to be in the mass.

The abdominal vaginal drain and through and through sutures are often indicated in pelvic pus cases.

To have separated the appendix early from the abscess wall would have added very much to the danger of infection in this case.

CASE II.

Intestinal obstruction associated with displaced right kidney, nephritis, septic pyelitis and paranephritis, a large inflammatory mass involving the ascending colon.

Separation of kidney, decapsulation, nephrotomy, nephropexy drainage.

RESULT.—Recovery. Operation October, 1905. Patient under care of Dr. McDiarmid of Hensall.

HISTORY.—Mrs S. (about 35 years of age).—Family history somewhat tubercular. For several years suffered from severe headaches and bladder symptoms. For some time before operation the headaches were intense and there were symptoms bordering on convulsions. Temp. 100 to 104. There was vomiting and obstinate constipation. Before operation the obstruction was almost complete. A tumor could be felt just above the cecum. It was painful and tender to pressure, fixed and somewhat tympanitic on percussion. The urine contained albumin, pus, blood, bladder and kidney epithelium, casts of different kinds, uric acid and oxalate of lime. Urination was frequent and painful. At times there were symptoms of nephritic colic. The findings justified the provisional diagnosis of displaced kidney nephritis, a septic pyelitis and cystitis.

OPERATION.—A retroperitoneal incision revealed a displaced kidney, enlarged and firmly fixed. The kidney was separated from its surroundings with considerable difficulty. A dense inflammatory mass was now observed in front of the kidney, apparently involving the ascending colon. No attempt was made to interfere with it and the peritoneal cavity was not opened. The kidney was decapsulated and split, exposing the pelvis, which contained pus, a bloody grumous substance and some small calculi. The kidney was fixed by its capsule in the normal position, a drain inserted, and a drain and some packing put below it. The wound healed in about four weeks and the patient has had excellent health ever since.

REMARKS.—In this case, the findings in the urine confirmed the diagnosis. Apart from such, the mistake of opening the abdomen through the peritoneum might have been made.

The cystitis was probably kept up by a septic pyelitis and a debilitated system, for the condition improved soon after operation.

The bowels became regular, either from relief of kidney pressure or absorption of the inflammatory product, or both combined.

Jas. McKenzie of London, England, says that all the symptoms of acute abdominal obstruction may be caused by a stone in the ureter, owing to reflex spasm of the anal sphincters, causing retention of gas, abdominal distension, etc.

CASE III.

Intestinal obstruction from an extensive inflammatory product about the lower end of the ascending colon, which looked like a malignant growth, causing complete obstruction of the bowels, five weeks after an operation for a small cystic ovary, and the removal of catarrhal appendix.

Lateral anastomosis between cecum and colon.

RESULT.—Recovery. Operation October, 1908. Patient under care of Dr. McNaughton, Brussels.

HISTORY.—Miss F. (age 32).—Good family history. Had left ovary removed by a Toronto surgeon several years ago. An ovarian cyst as large as a navel orange and a catarrhal appendix were removed July 10th, 1908, at the Clinton Hospital. The operations were of a simple nature and at the time nothing abnormal was observed in the ascending colon. Everything seemed to go well for two or three weeks, when obstinate constipation developed. At the end of the fifth week, there was complete obstruction. The pains were very severe.

OPERATION.—The abdomen was opened, at midnight, Dr. Clark, now of Pontypool, and Dr. Shaw of Clinton, assisting. Everything seemed to be normal at the sites of former operations, but there was an enormous mass resembling a cancer involving the first six or eight inches of the ascending colon. After a difficult dissection, the colon was liberated and found to be very much thickened and indurated, and its calibre entirely obliterated. As the colon was already mobilized, it was not very difficult to approximate and unite the cecum laterally to the colon, beyond the seat of disease. This was done with Connell suture. The patient made a good recovery, and has had very fair health since then, over three years ago.

REMARKS.—I am aware that it is contrary to the best teaching to make a short circuit of the bowel, such as was done in this instance, but as the parts came together without much difficulty, I did not see the need for a longer circuit. Besides owing to the weakened state of the patient, the operation was intended as a temporary expedient, a resection later on being anticipated.

This inflammatory growth with almost certainty developed within five weeks. The etiology I make no attempt to explain. I recall several instances where chronic inflammatory growths were confusing at the time of operation. One of these, a case, under the care of Dr. Elliott of Lucknow, where an appendectomy was done on a man 68 years of age. The appendix contained a calculus, but no pus. A very large mass resembling a carcinoma involved the region of the cecum, which at the time was considered inoperable, but the patient is well six years after. A patient of Dr. Burrows of Seaforth, had a gastro-enterostomy for pyloric obstruction. There was a tumor in the first part of the duodenum, as large as a small hen's egg, and some involvement of adjacent glands. At the time of operation we considered the tumor to be cancerous. It is over six years since the operation, and the patient is quite well, having gained fifty

pounds in flesh. The growth was evidently inflammatory, the result of an ulcer of the duodenum.

CASE IV.

Intestinal obstruction caused by twist of pedicle, left ovary (fibro-cystic) pressing on the cecum.

SPECIMEN REMOVED.—A fibro-cystic ovary larger than a normal kidney, containing blood, left Fallopian tube containing a half ounce of blood clot—a cyst in the broad ligament containing about twelve ounces of a sero-saneous fluid. The mass gangrenous.

RESULT.—Recovery. Operation, May, 1907. Patient under care of Dr. Campbell, Zurich.

HISTORY.—Mrs. P. (age 40).—Mother of five children. Had fairly good health till present illness.

On May 2nd, 1907, felt a very sudden, severe pain on the left side of the lower abdomen. The pain was colicky in character. micturition became frequent, and with it a scalding sensation.

When Dr. Campbell saw the patient shortly after, she was in a state of collapse. For the present, the symptoms were relieved by a hypodermic of morphia and strychnine. About two weeks later, when driving to Zurich, there was a second attack. The symptoms were of the same nature as the previous ones, but more severe—the shock more pronounced. Partial relief was again obtained by morphine and strychnine. On May 25th, two days later, there were severe pains in the region of the appendix. The abdomen was much distended and tympanitic, vomiting frequent, no gas or feces passed the lower bowel. Soon after the second attack Dr. Campbell detected a tumor, tender and dull to percussion, over the cecum, and advised an immediate operation, which was refused.

On May 26th, the fourth day from the onset, when consent to operation was granted, the pulse was 130, temperature about normal, vomiting persistent, and intestinal obstruction was complete, the bowels were much distended, and the gas could be seen to accumulate and recede at the point of obstruction.

OPERATION.—The abdomen was opened through the right rectus. A gangrenous mass presented, which, at first sight, gave the impression of a gangrenous bowel. On lifting the tumor, its pedicle could be traced to the left side of the uterus. The diagnosis being made, the mass was separated from the uterus, the pelvis cleansed, wound closed and a drain inserted which was left for 24 hours. A speedy and permanent recovery followed.

REMARKS.—This form of intestinal obstruction is sufficiently rare

to be included in this list. It will be observed that the mass that pressed on the cecum came from the left side of the uterus.

The frequent and painful micturitions, which were marked symptoms, especially in the first attack, were no doubt due to traction on the ureter or pressure on the bladder, or to both combined.

As the pain radiated to the left kidney, the symptoms altogether simulated renal colic, which Dr. Campbell at first thought it might be.

The suddenness of the onset, and the absence of fever were strongly suggestive of a twisted pedicle, but the cyst in the broad ligament, which could be felt behind the uterus, helped to obscure the diagnosis, which in this case, as in some others, was postponed till the abdomen was opened.

CASE V.

Intestinal obstruction from pressure of a distended gall bladder on the cecum and ascending colon. Gall bladder descended to the brim of the pelvis and contained pus, mucus, bile and about one hundred small gall stones. Cholecystotomy.

RESULT.—Recovery. Operation December 20th, 1908. Patient under care of Dr. Campbell of Zurich.

HISTORY.—Mrs. W. (aged 30 years).—The mother of two children, and with a good family history.

For some years had been treated by different physicians for indigestion. On Dec. 17th, or three days prior to operation, patient complained of an intense pain just below the sternum, which came on suddenly. Dr. Campbell, who saw her shortly after, found her in a state of collapse. The pain was very severe and vomiting persistent. There was a slight jaundice and the urine contained some bile.

Dr. Campbell detected a tumor on the right upper quadrant on the second day, but the rigidity and distension were so great on the third day (the day I first saw her) that nothing of the nature of a tumor could be outlined. There was marked dullness over the whole of the right abdomen, however. The temperature never rose above 100, the pulse was fast, and the respiration quick and "catching."

OPERATION.—The abdomen was opened by a long vertical incision through the rectus muscle. A grayish mass that looked at first glance like a greatly distended colon presented which descended to Poupart's ligament. The diagnosis of distended gall bladder having been made, the tumor was carefully raised out of the wound and the abdominal cavity protected with pads. The gall bladder was

emptied of its contents, fastened in the upper part of the wound, and drained in the usual manner. Several stones were removed from the cystic duct, but none were found in the common duct.

The patient gained rapidly in health and strength soon after the operation, but for some reason the wound at times discharged bile for three months. The patient became pregnant about this time and the fistula healed completely.

REMARKS.—Pressure from distended gall bladder is not a common cause of intestinal obstruction.

Early operation was imperative in this case, for, apart from the obstructive symptoms, rupture of the gall bladder apparently could not have been long delayed.

It was nigh impossible from physical signs to make anything like a positive diagnosis on the third day on account of the rigidity and abdominal distension. Dr. Campbell had made a tentative diagnosis of gall bladder distension from the early marked pain and tenderness in the region of the gall bladder, the finding of a tumor on the second day, the jaundice, and the history of indigestion with gastrodynia. The enormous distension in so short a time would seem to be a feature of the case.

CASE VI.

Intestinal obstruction from cancer of the cecum, which was mistaken for a movable kidney. Resection—lateral anastomosis. Specimen, six inches of the ascending colon, six inches of the ilium, the cecum, appendix and adjacent glands. The cecum almost a solid mass, with a calibre that would hardly admit a lead pencil.

RESULT.—Recovery. Operation August, 1910. Patient under the care of Dr. Redmond, of Wingham.

HISTORY.—Miss G. (age 27). Mother died from cancer of the uterus at about the age of 45—otherwise, family history unimportant.

PERSONAL HISTORY.—For about a year before operation the patient was anemic, lost flesh, and suffered from constipation. Two weeks before operation, Dr. Redmond was asked to see Miss G. on account of pains in the right abdomen. These pains were colicky in character, and there was an elevation of temperature of 1 to 3 degrees, lasting several days. The bowels were moved with difficulty and vomiting was a pronounced symptom. There was frequent micturition and bladder irritability, although the urine showed nothing specially pathological.

Dr. Redmond detected a tumor in the region of the cecum. From the feel of the tumor, and the fact that it could be moved to

the normal position of the kidney, and other symptoms, Dr. Redmond and Dr. McDonald were disposed to regard the condition as one of displaced kidney, and thought nephropexy advisable.

OPERATION.—A short incision having been made, retroperitoneal examination showed the kidney to be normal in size and position. The wound was now extended to the inner side of the spine of the ilium to near Poupart's ligament. The peritoneum was opened and the diagnosis of tumor of the ilium made. This opening, resembling the lumbo-ilio-inguinal incision for exposing the ureter, gave an admirable working space. The outer leaf of the mesentery was divided, the mass raised out of the wound, and turned on its inner leaf, the vessels were ligated and cut, and pads placed for protection. The colon and ilium were doubly clamped six inches from the cecum. The parts so isolated, with the adjacent glands, were removed. The ends of the colon and ilium were inverted and the parts united laterally. The openings were two and a half inches in length, and as near the ends as possible. The union was made antiperistalticly, and with the Connell suture. A cigarette drain was inserted in the lower part and the wound was united in layers. Union was somewhat tedious on account of stitch abscesses; otherwise recovery was uneventful.

The patient reports that she feels as well as she ever did.

REMARKS.—This case is interesting from a diagnostic standpoint. The size, shape and mobility of the tumor certainly resembled a displaced kidney. The colic pains simulated the pains caused by an obstructed ureter. The age of the patient was somewhat misleading.

While constipation was very obstinate, there was not total obstruction, although the calibre of the gut was so reduced.

The findings in the urine were against a displaced and affected kidney, for a kidney giving a rise of temperature should show something pathological in the urine.

The incision employed was unusual for such operation, but it gave a good working space.

The last six inches of the ilium has the same blood and lymph supply as the cecum and ascending colon, and should always be removed with them for cancer. W. Mayo removes all of the ascending colon with a cancerous cecum and also the last six inches of the ilium.

In uniting the ends of the bowel laterally, it makes little difference in result whether these are joined in an isoperistaltic or an antiperistaltic manner. Ease of coaptation is the main thing to be considered.

It is almost a surprise how easily the cecum and ascending colon are mobilized by first cutting the outer leaf, and hemorrhage is comparatively trifling when the mesenteric vessels are ligated at the beginning of the operation. The glands follow the course of the iliocolic vessels which supply this part of the bowel. The ureter must be carefully guarded. A Murphy button should not be used in this part of the bowel.

In conclusion, I would offer the following propositions or suggestions:—

It would seem as if inflammatory products in some subjects have a tendency to become excessive as compared with others, or else the infection is of such a character that it tends to such result. This apparent freak that an inflammatory process takes at times is not at all rare, and the condition has caused confusion many times in diagnosis, treatment and prognosis for to the naked eye these tumors are not distinguishable from cancer.

I consulted Dr. Primrose of Toronto regarding Case No. 3, where the ascending colon became totally occluded, and he informed me that he was preparing a paper on the very subject for the Ontario Medical Association, held at Niagara. Dr. Primrose, in his instructive paper, entitled "Inflammatory Tumors Producing Intestinal Obstruction," cites four cases which had recently come under his care. In concluding the paper, he remarks as follows:— "My object in recording these cases is to emphasize the fact that when such inflammatory tumors exist, the operative interference should be of the simplest variety, such as the creation of a fecal fistula or the resection of a damaged portion of the bowel." In case (1) of our list, it is probable that the large abscess in the broad ligament, if left for some time longer, would have emptied into the cecum and the remaining cavity would become filled with granulation tissue, which, with the thickened sac wall, would result in a large inflammatory tumor. It would seem that a pus sac becoming filled with granulation tissue is the history of some, at least, of those tumors, but others have their origin in an ulceration of the bowel, acting as a septic focus in producing inflammatory growths. When the septic focus is removed, absorption of these growths follows, as a rule.

Purgatives and delay are constantly bringing surgery into disrepute.

Purgatives should never be given in acute abdominal troubles till organic obstruction can be excluded with certainty.

A case in which there is sudden severe abdominal pains with vomiting, and neither gas nor feces passing from the bowel, is

surgical from the start. It is especially so if attended with shock. Fecal impaction alone rarely if ever produces all the symptoms of acute organic obstruction, neither does the administration of opiates. They will not cause stercoraceous vomiting.

The long rectal tube hardly ever passes above the rectum. An examining finger will find the tube coiled back upon itself in the bowel.

The question is often asked by the friends of the patient, "Would the patient have lived if operation had been done early?" The surgeon has either to sidetrack the truth, which he often does, to save his confrère, or he assumes the responsibility of performing a needless operation.

It follows that in cases of intestinal obstruction the best interests of all concerned are served by an early operation before local inflammation, or general infection begins.

Too many people imagine that a surgeon's motives are not wholly disinterested, hence for obvious reasons it is the physician's duty and privilege to advise and insist upon early operation when such is indicated.

In deaths associated with acute intestinal obstruction, the exploratory incision or operation in competent hands can seldom be regarded as a factor bearing on the result.

PNEUMONIA.

James R. Mitchell (*Medical Record*) says that the logical treatment of pneumonia is rest, support and calcium. He favors calcium chloride as the ideal heart tonic in pneumonia. Every aspect of pneumonia bears testimony to the value of calcium. The pneumococcus extracts calcium from the medium in which it grows, that it extracts calcium from the human culture medium, that convulsions are caused by this calcium poverty, that gray hepatization is impossible without the presence of calcium, and that edema of the lungs and collapse of the heart occur only when the coagulation time of the blood is delayed. He considers that cold air treatment and cold sponge baths are harmful and brutal, and that warm air is just as fresh as cold air.

AGNODICE.*

By J. S. Sprague, M.D., Perth, Ont.

Long ages since when plunged in thickest night of ignorance and error lay the world, save where, in one small part called Greece, there blazed the noonday sun of learning and of art, destined to shed its beams unto all time, in the Athenian tribunal hall, summoned for judgment, stood Agnodice.

A form of noble majesty and strength, such as the genius of that ancient's clime has left in priceless legacy of stone, outrivalling in stately, calm repose the sculptured column at whose side it stood; serene those features, cast in mould superb, yet fine cut as a carven cameo.

A mouth whose generous curves bespoke a soul large, brave, yet tender; prone to sympathy. Eyes like a crystal pool, yet in their depths lurked, baffling idle gaze, dark mysteries, all fathomless as in the deep green sea.

Then spake the justice: "You are summoned here, a charge most grave to meet; for it is claimed the noble art of medicine you've used to cover other base, designing arts against the peace of the domestic hearth, corrupting Athens' maids and matrons pure; that feigning ailments of the flesh to heal, that which tenfold more precious is, the health of the immortal soul, you undermined. Here in the court do your accusers stand, Athenian citizens of high repute, prepared to prove conclusively their charge. A stranger, Athens gave you learning, fame. How ill do you requite her if this crime be fastened on you, which by Grecian law must be atoned by death! Now, prisoner, the court of Athens will permit your plea."

The form beside the column raised its head, down bent the while the judge's speech was made, and in a voice whose full, rich, swelling tones were like unto an organ's, came these words: "O righteous judge, and all assembled court, I face you with the truth upon my lips. As to the grievous crime upon me charged, a strange dilemma I'm compelled to meet. I do avow the practice of deceit on my Athenian fellow-citizens. But that I have seduced their wives and maids is fully false, a piece of calumny which in three simple words I can refute; yet these of fell import, for Athens counts as infamy th' offence I thus avow, no less than that where-

* These are a few selections from Chapter XXIX. of Dr. James S. Sprague's proposed blication, *Ideals in Medicine and Religio Medicorum.*

with I am wrongfully charged: in either case my life the forfeit pays. Should I keep silence I might win release, for of my guilt there can be brought no proof; yet foul, unmerited dishonor's stain on Athen's blameless matrons there would rest. I cannot purchase life at such a price. Know then, O citizens, that I who stand before you, charged with this vile crime, am but a woman, and my name Agnodice."

Throughout the court at this confession strange arose a tumult that not soon was quelled, while motionless and calm its subject stood, as though the matter nothing her concerned.

"I marvel not that ye should stand amazed to hear the revelation of my sex. Well have I kept my secret, since not one of the wise men of Athens did suspect that underneath the learned doctor's garb there beat a mere weak, craven, woman's heart. And now that I am doomed, I pray the court for leniency, while I do relate the story of my life, to warn rash youth of Athens, lest they follow in my course."

Consent was granted, and Agnodice continued her recital: "As a child I saw my brothers at their games and books, wherein they told me I could have no part, because forsooth, I was a woman-child! That to my sex forever was denied the boon of knowledge, for the gods ordained that woman by her nature was but fit for household tasks and bearing of the young. I answered naught, but in my heart was born faint stirring of rebellion 'gainst my fate. I mused—'How strange that these same mighty gods have placed such aspirations in my breast that do of right belong to men alone!'

"And so apace this knowledge hunger grew until it gnawed into my very soul.

"And when at length I could no longer brook the torment, did I make a last resolve to brave the wrath alike of gods and men, attain the wisdom I so coveted at any cost. I left my native heath, and well disguised in masculine array, journeyed to Athens, where I boldly knocked upon her doors of learning; the result you know full well. For I bore off the palm from all my masculine competitors, although I was a woman. Strange, indeed, if a woman's brain is by the gods decreed of poorer quality than is your own, that I should outstrip all the noble youth of Athens! Mark you then, if this my act has been displeasing to the eternal gods, as in the eyes of men, would they have shown such favor to the maid Agnodice? Would they have placed these laurels on my brow?

"Such wrongs the mighty gods could never do—endow a woman

with the attributes that to the sex superior belong, and then deny her opportunity to exercise these faculties divine. And so I reasoned, 'twas a blunder made, for which the gods were not responsible. Dame Nature 'twas who in erratic mood had linked a man's mind to a woman's form. And none suspected, none in all these years, the secret of my sex. Oh, strange indeed, the ways of gods are—not like those of men—that by mere change of garb a woman is transformed into the semblance of a man, and that great inner difference concealed!

"The gods were good; they granted me success. My fame spread far and wide, and from all parts came the afflicted, seeking for relief. But of all patients did my heart the most incline unto my suffering womankind. For I too was a woman, and my heart went out to these, my sisters, in their woe. For they have trials that ye reck not of, oh, men of Athens, following the path of glory, wealth and honor in the world, unmindful of the dull and thankless lot that falls to them, your mothers and your wives, makers and moulders of the race, that bear the burdens of yourselves and of your sins before birth, and until your dying hour.

"So to the mothers and wives of Athens I gave my services and sympathy. I sorrowed in their sorrow, and rejoiced when they were glad. In pity for their pain, I wrought appliances for their relief; devices crude which science may some day perfect, forgetting that the hand and brain that first did fashion them were those but of a simple woman, called Agnodice.

"Yea, I confess I loved them, and from them won love and gratitude. And such as these are the base arts ye charge that I have used, O men of Athens, whom your vices make prone to suspicion, these the dealings foul that I have had with your chaste wives and maids. Such are the soundless depths of infamy to which have slunk these slandered Grecian dames. Ah, now, accusers, does the flush of shame not tinge your brows to hear the simple truth?

O men of Athens, if you could but know what finer forces dwell within the frames of your submissive, gentle womankind! These are your warriors, doing battle brave with armed hosts of sin and suffering! With smiles that hide the heartbreak giving up the sons they've borne to fight their country's foes. Mightier in battles fought in blood to win a kingdom, and more glorious victories, these conflicts of the soul from which there come patience, obedience and self-sacrifice! These are your statesmen, teaching to your sons—the little lads that cluster round their knees—the love of Greece and reverence for her law. These are your sages who in

silence learn a truer wisdom of the heart and soul, the flower of their life's experience! What do ye with them? Shut them up to spin?

"O men of Athens, hearken to my plea! Do as you will with me, but give to them a larger freedom, standing at your side, as equals, and no longer slaves and toys! Give all their faculties development; no longer bind their souls in iron bands of custom, forged from superstition's flame. Then from a fairer Greece shall spring a race greater and nobler than ye yet have seen.

"I would not be so impious as to say the gods have erred. Ye have not read aright, O men of Greece, their mystical decrees. Lo, here I make to you a prophecy: if in your blindness ye shall still ignore, and your descendants, this mysterious force, this potent energy—the feminine—in the affairs of life, 'twill not be lost. Naught in the universe is ever lost! but, beaten back upon itself, pent up, mute, motionless, and stifled in the breasts of womanhood, a hundred thousand fold it will multiply until long ages hence, bursting asunder its fast prison bars, in one tremendous, irresistible outflow of power, 'twill o'erwhelm the world, triumphs achieve that man has never dreamed!

"Thus then will the eternal righteous law be vindicated; so the mighty gods avenge the fatal ignorance of man!

"My tale is done. Do with me as ye will!"

She ceased, and for an instant silence fell upon the multitude. Then through the court was heard a murmurous undertone that swelled in volume, rising ever like the tide, until a very ocean it became of sound tempestuous, upon whose wave, above the mighty roar, these words came borne:

"Well hath she done and spoken. Set her free! Let all revere the brave Agnodice!"—Selina Seixas Solomons, in *Arena*.

ANNOTATIONS, SCHOLIA, AND CONSIDERATIONS.

Agnodice.—The name of the earliest midwife mentioned among the Greeks. She was a native of Athens, where it was forbidden by law for a woman or a slave to study medicine. According to Hyginus, however, it would appear that Agnodice disguised herself in men's clothes, and so contrived to attend the lectures of Hierophilus, devoting herself chiefly to the study of midwifery and the diseases of women. Afterwards, when she began practice, being very successful in these branches of the profession, she excited the jealousy of several of the other practitioners, by whom she was summoned before the Areopagus and accused of corrupting the morals of her patients. Upon her refuting the charge by making

known her sex, she was immediately accused of having violated the existing law, which second danger she escaped through the intervention of the wives of the chief persons of Athens, whom she had attended, who came forward in her behalf and succeeded at last in getting the obnoxious law abolished.—Smith's "Dictionary of Greek and Roman Biography and Mythology."

They accused her before the Areopagus of corrupt practices and conduct, "quod diceren eum glabrum esse, et corruptorum earum, et illas simulare imbecilliatem."—Hyg., Fab. XXIV.

The Greeks of this historic and heroic period (400—300 B.C.) had their wives to watch their children and the household gods, and for their lighter hours the blond-haired hetaerae, attractive and beautiful. A query naturally arises, and it is this: Were the fountains of her youth—(of Agnodice)—dried up, was the nimble spirit of her arteries and of her nerves unstrung? Was this fair maid of Athens "blue eyed, and fair of face, but waning fast into the sere of virginal decay?" as Henley would ask. Was she—this Doctress Agnodice—(who gave draught, counsel, diagnosis, exhortation) as Henley also says:

> "Frank-faced frank-eyed, frank-hearted; always bright
> And always punctual—morning, noon and night;
> Bland as a Jesuit, sober as a hymn;
> Humorous and yet without a touch of whim;
> Gentle and amiable, and full of fight?"—

Were the golden gleams of her early dreams—the dreams of wealth and husband—were they the things of the long ago?

Did Dr. Herophilus—the dean, (whom Cicero, Plutarch and Pliny praise), the most learned in anatomy in Greece, yes, did this learned dean say, as William would have said or thought, "Lady, you are the cruellest she alive, if you will lead such graces to the grave and leave the world no copy."

Did the learned Dean say:

> "Her soft white hair adorns
> Her withered brows in quaint straight curls like horns,
> And all about her clings an old sweet smell,
> Prim in her gown and quaker-like her shawl."
>
> . . . . . .

Was she

> . . . "a wee old maid that sweeps the Bridegroom's way,
> Strong in a cheerful trust that never fails"?

While recalling to memory "The Wedding of Schon McClean," by Buchanan, the following few lines came to my ink-horn Was her voice "like the whistlings of birds, the humming of bees, like the sough of the south winds in the trees; or the singing of angels, the playing of shawns; like ocean itself with its calms and its storms; like a thousand laverocks singing in tune; or like countless corncraiks under the moon; or a mermaid's harp, or kelpie singing? for whom no epithalamic song was sung? Was this Agnodice—Doctress Agnodice—whose eyes were filled with "dark mysteries," yet with "eyes like a crystal pool" and "baffling idle gaze"?—yes, was she a bone-punching and rib-adjusting osteopath or a spinal column wrencher—chiropractic—an olympic god scientist, or a regular of the Aesclepiadae? Did the Areopagus allow bone-punchers, spinal column adjusters, defamers of the gods—called scientists, full authority to practice the noble art of medicine—and yet arrest the licentiate Agnodice? Do we not in this civilized age allow pernicious and soul and body-destroying cults existence, and yet, when one of our own licentiates errs, the whole medical Areopagus silences him by fines or imprisonment?

. . . . . .

"Women who study side by side with men," says Dr. Montravale Greene, a professor of obstetrics and clinical gynecology, Harvard University, "are injuring themselves in the present and weakening their powers for the future, and the whole theory of co-education is doomed to fall of its own weight."

Men in medicine often wonder why the opposite sex should wish to become "women in medicine." It is true it is an attractive study, but the life-work is by no means ideal. Woman, with her high and finer sentiments, her spontaneous goodness and affinity, could find a far better calling or profession and a much better life even in the church. One fact is, there never was, is not now, or ever will be, a demand for "women in medicine," and one fact also is that "the pursuit of 'careers' by women is fatal to domestic happiness," and consequently ruinous to the commonwealth.

If the late distinguished poet-laureate of England could but behold the glimpses of the moon and the blood-red spots on the sun, he would recall his words:

> "That light its rays shall cast
> From portals of the past,
> A lady with the lamp shall stand
> In the great history of the land,"

for, instead of "the lady with the lamp," he would in London see *the* lady of his dreams with beer bottles and clubs belaboring the

custodians of the peace—even policemen—and in civilized and Christianized America—women as jurors, even as barristers, mountain climbers, jungle huntresses, doctors and police mistresses or rather police madams. "As soon as a man or a people or a literature or a period becomes feminine in type it declines in prestige and in power," says Amiel, "and as soon as a woman leaves that state of subordination in which her natural merits have full play we see a speedy increase in her natural faults. Complete equality with man makes her contentious. A position of supremacy makes her tyrannical. For a long time the best solution will be found in honoring her and at the same time in controlling her."

My apology for this presentation of *Agnodice* is this, that but few, a very few of the most scholarly, however well perfected their studies in the humanities, are able and gifted to "wrestle, wrangle, wriggle and writhe" with words and metre and produce such sentences of flawless and inimitable periods of pleasingly and unerringly controlled rhythm and music in its appeals, and its hortatory apophthegms—and not least, to ascribe to Agnedice the beginning of many evils with which the world is now contending and with which and against which the gods or man have no control.

To the writer of *Agnodice* the following classical words do not refer:

"Nam neque chorda sonum reddit quem vult, manus, et mens,
Poscentique gravem persaepe remittit acutum;
Nec semper feriet quodcunque minabitur arcus."

"Alas, but few can touch the magic string, and noisy fame is proud to win them; Alas for those who never sing, and die with all the music in them," said Dr. Oliver Wendell Holmes.

"A wife is half the man, his truest friend;
Source of his virtue, wealth, the root;
Whence springs the line of his posterity.
A wife of gentle speech, a docile dove,
Sufficient wealth, unbroken health—a friend,
And learning that subserves some useful end—
These are a living man's six greatest blessings."
—Mahabharota, B.C. 200.

As Milton has it: "He for God only, and she for God in him," would save a dying age and bring again those halcyon days "when knighthood was in flower," when men were men and the gods reverenced. *Nec tecum vivere possum, nec sine te.*

NEPHRECTOMY FOR CHRONIC PYELO-NEPHRITIS PROBABLY OF HEMATOGENOUS ORIGIN.

By J. P. Kennedy, M.D.
Surgeon to the Wingham General Hospital.

Infection of the kidney and its pelvis comes about through the blood stream or by direct extension from below from the bladder and genitals up through the ureter. We were formerly taught that all renal suppuration came from below, but it is now apparent that this is not the case; and when one considers the excretory function of the kidney, one perceives how inevitably it is subject to damage in connection with all sorts of diseases. Pathogenic bacteria lodge in the kidney in the course of measles, smallpox, scarlet fever, typhoid fever and tuberculosis; the colon bacillus and pus-producing cocci all may pass through it.

Acute unilateral hematogenous infection of the kidney may be mechanical by actual infected tissue carried to the kidney or emboli of bacteria themselves may be lodged in the kidney parenchyma. Women are more commonly affected than men. The infection may be rapid and fatal, or, after a rapid onset the symptoms may subside and the course become chronic. When it becomes chronic it was formerly described under the old fashioned caption "surgical kidney."

In the case of "surgical kidney" which I am about to report, the infection in all probability was carried to the kidney substance by the blood stream and was not of the ascending type which is most common, and for this reason I thought the case worth reporting.

Mrs. McG., widow, presented herself for examination on May 13, 1909.

Family History.—Father died at 68 from pneumonia. Mother died at 68 from heart trouble. Brothers, three living and well. Sisters, none. Husband died at 44 years of age from cancer of the stomach. No history of tuberculosis in the family. Mother's sister died with cancer of the uterus at 70 years. No history of kidney or mental disease in the family.

Previous Illnesses.—Measles when a child.

Menstrual History.—Normal in every way.

Marital History.—No children, no miscarriages.

Present Illness.—Sixteen years ago last August and September the patient had typhoid fever, was six weeks in bed. Never properly regained her strength after the attack. Thirteen years ago she began to have frequency of urination. She had no pain, but simply the desire to urinate frequently night and day. About seven years ago she took a sudden severe pain in the right side, she vomited and the pain was so severe that she had to go to bed. This attack lasted about two hours. For a time these attacks of pain came on about every four to six weeks. About three years ago the attacks got further apart, coming on about every eight or ten weeks and with them she had chills and fever. These attacks continued up to the time she came to consult me. A year before coming to me she consulted a surgeon in Detroit who said that her urinary trouble was due to a retro-displaced uterus and advised an operation. This she consented to and the surgeon performed an internal shortening of the round ligaments. This he followed by local treatments of the bladder from December to the following April. The operation and treatments were followed by practically no improvement. When she consulted me I made a cystoscopic examination of the bladder, but could find no local condition to account for her symptoms.

Urinalysis at this time was as follows:

Color.—Pale amber, cloudy.

Reaction.—Slightly acid.

Sp. gr.—1020.

Alb.—Slight trace.

Sug.—Negative.

Microscopical.—Many pus cells, much squamous epithelium and a few amorphous urates. Repeated examination of the urine showed practically the same condition. It was always found loaded with pus. In the meantime I put her on urotropine diuretics and washed out the bladder twice a week, although from the first I was convinced that the primary trouble was higher up, probably in the right kidney.

This treatment producing no amelioration in her symptoms, I referred her to Dr. B. R. Schenck of Detroit for ureteral catheterization. Dr. Schenck's report was as follows:—

" Mrs. McG. came in the last of last week, and I have seen her on four different days. Cultures from the bladder urine show what is apparently the colon bacillus in pure culture. I have not yet traced it through all of the media, but feel sure that it will prove to be B. coli communis. The urine coming from the right kidney is heavily loaded with pus, and I think that the source of the trouble is in the pelvis of the kidney on that side. One day I thought that

I could make out an enlarged kidney on the right, but later I was not sure whether it is enlarged or simply moveable and prolapsed. Whether it is a case of pyelitis or one of pyelonephrosis, I am inclined to the view that it is simply pyelitis."

Later Dr. Schenck wrote me that the organism obtained from the bladder urine turned out to be, as expected, the colon bacillus.

I accordingly advised nephrotomy and drainage. It was not, however, until April, 1910, that the patient would consent to operation. At the Wingham General Hospital, on April 16th, I opened into the loin and brought up the kidney. As far as I could judge from the macroscopic appearance, the kidney, although small, appeared healthy on the surface. I split it along Brodel's line down to the pelvis. The hemorrhage was quite free, but was controlled with hot sponges; I then inserted drainage and sewed up. The wound healed in about four weeks, and for several months my patient enjoyed comparative freedom from her distressing urinary symptoms. During the winter of 1910 and 1911, however, the frequency became as bad as ever, so bad indeed that her rest at night was seriously disturbed by frequent urination. The patient began to fail in flesh and general health. She occasionally had attacks of pain in the right side over the region of the kidney, chills, followed by some elevation of temperature. In the spring of 1911 I advised her to have the kidney removed. To this she consented, and, on April 29th last, in the Wingham General Hospital, I again opened in the loin, brought up the kidney and removed it.

The macroscopic appearance of the kidney was as follows:—The kidney was small and contracted, and showed evidence of traumatic injury, the whole being surrounded by a thick, fibrous capsule. On palpation it was hard and firm to the touch. Along the external and posterior surface could be felt a hard cord running from the inferior to superior pole of the organ. On section there was increased resistance of the cutting instrument. The cut surface shows inferiorly that the kidney substance proper is almost wholly displaced by connective tissues, while superiorly a small amount of secreting substance about the size of a walnut but paler than normal could be found, which could be detached from its capsule. The microscopic examination of the specimen was made by Professor McKenzie of Chicago, and is as follows:—

"Each section examined presented a thick, connective tissue capsule, to the outer side of which was attached remnants of kidney tissue, in which could be recognized a few atrophic Malpighian bodies, as well as a number of tubules which showed marked degeneration of their epithelial lining. The contents of the connective tissue

capsule, was simply a network of connective tissue strands, holding in their meshes, masses of pus in which no bacteria were demonstrable. Owing to the complete disappearance of all normal kidney tissue, it is safe to assume that the organ did not functionate for some time before removal."

Diagnosis—Pyelonephritis.

The operation was followed by practically no shock, and Mrs. McG. made an uninterrupted recovery. I have been surprised in a number of instances at the small amount of shock following nephrectomies. Dr. W. J. Mayo says there is very little risk about nephrectomy, even when the other kidney is somewhat diseased. The remaining kidney soon hypertrophies and takes on the function of both kidneys. Mrs. McG. is now in perfect health, the urine is normal, her distressing symptoms have entirely disappeared, and, in fact, she says she never felt so well in her life.

*SUCCESS IN CATARACT OPERATIONS

By W. M. Brown, M.D., L.R.C.P. London, Eng., Neustadt, Ont.

Mr. President and Gentlemen,—The object in offering this paper is to induce discussion, elicit opinions, voice mistakes, because it is upon these latter circumstances that we can learn and from bitter experience, dearly bought, know how, in future, failure may be averted.

I would suggest that at the next meeting of this section, a symposium upon the errors, accidents and complications of cataract extraction be given. It could not fail to be instructive.

Genius is said to be "ability to take infinite pains." If this be so every good operator must be a genius, for there are a multiplicity of minute details, the observance of which means success to the operator.

The operation for cataract requires more nerve, skill, judgment, delicate manipulation, painstaking care before and painstaking care after, than any other done upon the human body. A cut a $\frac{1}{4}$ of an inch too little, or too much, here means failure or disaster, while in other regions of the body has little bearing upon the result. The chief aim of the operator is good vision, let the cosmetic results be what they may. When your hair becomes grey and you are a past master in the art of section making, then strive for optical appearances. Technique and manipulation may be faultless and

* Read at Ontario Medical Association, 1911.

results poor—on the other hand a badly done operation is often followed by excellent vision.

We have all been on the "anxious seat" in our first extractions. The hopes and fears that filled our hearts. The anxious friends who crowded around and who looked on sceptically and gave but doubtful countenance to the proceeding. It tries your heart and soul, and when you have successfully passed through it you know you have been through the "fire" and that you have sounded every depth of surgical terror. It means so much to you, as well as to the patient.

There are a few conditions which contra-indicate operation. Dacryocystitis is one of them. The surgeon certainly takes great risk in extracting in its presence even with the canaliculus tied off. Cough should be cured—a bark cough, after section, tends to reopen the wound. Oezena is another contra-indication. Our procedure is as follows: Eyebrows and eyelashes having been clipped off, sterile towels applied to the head and chest and in a good light

1. Wash with soap and water.
2. Wash with sulphuric ether
3. Wash with bichloride (1-4,000).
4. Evert the lids, and by undine wash thoroughly with hot bichloride (1-4,000).
5. Add 1 drop eserine (1% solution) half an hour before operation.
6. Repeat this 15 minutes later.
7. Three drops cocaine (4%) at intervals of 2 minutes before operation—begin 10 minutes before section.
8. Boil instruments and plunge
9. Into alcohol—then
10. Into 1% carbolic solution.
11. Lint wrung out of 1-4,000 bichloride.
12. Withdraw the knife slowly.

Nothing should be rushed. Plenty of time should be taken. Operators at Moorefields frequently take two minutes in making the section alone.

The knife should be extremely sharp, with a tapering point, and used only once before resharpening. A good speculum is still a desideratum—one which is quickly and easily removable and applies closely to the temple, and is not in the way of the knife. In deeply sunken eyes a lid retractor held by an assistant is best. In grasping the conjunctiva below, a half turn with the fixation forceps anchors the eye more securely.

Half the battle lies in making a good section—if this is properly done, everything else is easy. Therefore have conditions such that you are at ease, in a sitting position, with the patient's head lying not more than 12 inches below the operator's eyes, with perfect control over and at ease of your hand. This cannot be secured with the patient lying in bed and the operator leaning over him with every muscle tense. An ordinary table brings the patient too high, but a table about 26 inches in height fulfils these conditions for the average operator. Most sections are made too small. The accompanying illustrations, from a noted work by a noted operator, shows how the counter-puncture should *not* be done. The latter is much higher than the former—the lens will not present and the wound must be enlarged by scissors or Graefe knife. Enter the knife slightly above the mid horizontal line of the cornea and make the counter-puncture at a *corresponding* point on the inner side, *i.e.*, section, almost one-half the circumference of the cornea. Hold the knife like a pen, lying upon the index and middle fingers and secured above by the thumb. The ulnar side of the hand should rest upon the patient's head, and the section made with a finger and not with a hand movement. In this way the point is absolutely controlled. The section should, if possible, be done in two movements—from point to heel and vice versa—cutting out very slowly. Sawing movements cause pain and imperfect co-aptation of the lips of the wound.

During the days following the operation, if the patient does not complain, rest assured he is doing well—" no news is good news " in eye surgery.

A watchful attendant should be on every case, day and night, for the first ten days. I well remember how this was brought home to me upon one of my first extractions. I had operated upon an old German lady of 76. She was doting, but her friends, who brought her to me, said nothing of the matter. On dressing the eye on the third day everything was well and I remarked we would soon have her sitting up. The next morning, on returning from a distant call, I found my brave German lady up, dressed, downstairs, and sitting out in the backyard, facing a blazing July sun, on one of the hottest and brightest days of a hot summer. I had difficulty in restraining myself from slapping her. Her excuse was, " Der Dokter hat gestern gesagt Ich kann bald aufstehen !! " I rushed her back to bed, and inside of a couple of hours iritis, with intense pain, set in, and for the next thirty-six hours I spent my time in making hot applications to eye, giving opiates, &c. Finally the eye quieted down, and the night following it, whilst watching her, I fell

asleep in the hall outside the room. On awakening from a nap, I noticed a disarray in the room, and on enquiry found she had been out of bed, to use the chamber. On stooping to open the washstand door, she had struck the eyebrow, immediately above the operated eye, a heavy blow against the corner of the washstand. It was a miracle the ball was not emptied of its contents. I then took strong measures and tied her to the bed with ropes, winding them around bed and body. She was a constant worry until her friends removed her home. Strange to say, after going through all this her vision was 20/50 !!

I have had one death from cataract extraction. It was in an aged Mennonite, in the Canadian Northwest. It occurs rarely and is preceded by delirium, and when this occurs, instant action is necessary, if life is to be saved. All bandages should be cast off and the patient gotten up and out of doors at once. Free exposure to light and air are imperative. The operative results will be nil but life may be saved.

Cocaine should not be used too freely. One of my earlier cases had a very patent canaliculus. The cocaine ran down the tear duct to the throat, affected the palate and caused retching, reopening the wound, with infection and suppuration, and the result was a shrunken and useless eyeball. I received some of my gray hairs in quieting down that eye.

Long-range doctoring of cataract cases is false economy and bad practice. To remove a cataract and leave the care of the eye to an inexperienced man is risky, and often ends in disaster.

WHOOPING COUGH.

Mehnert (*Jah. fur Kinder.*) contributes from Cape Colony an article on "Intercurrent Vaccination Aborts Whooping Cough in Infants." He states it is remarkable the way this disease disappears after an intercurrent vaccination. The effect of the vaccination does not seem to be modified by the presence of the pertussis. So convinced is Mehnert of its efficacy that he suggests the advisability of postponing vaccination of infants so as to utilize its dual action in case of an epidemic of the disease.

SYNOPSIS OF THE REPORT OF THE REGISTRAR-GENERAL OF ONTARIO, 1910

What the frivolous call "The hatches, matches and dispatches record" for the Province of Ontario for 1910, which has been compiled by the Registrar-General's Department, contains some interesting figures with regard to the vital statistics of the Province. The Report is in the hands of the printers, and will not be ready for the public for some weeks yet.

During the year there were 55,871 births, 24,036 marriages and 33,539 deaths, or 24.9, 10.7 and 14 per 1,000 of the estimated population respectively for the county municipalities of the Province (including cities and towns).

For the 18 cities the figures are: Births, 18,767, or 32.2 per 1,000; marriages, 11,793, or 20.2 per 1,000; and deaths, 12,303, or 21.1 per 1,000.

The towns of 5,000 population and over are 15 in number, and their statistics are as follows: Births, 2,918, ratio 21.6; marriages, 1,405, ratio 10.4; deaths, 1,109, ratio 14.7.

Of the 33,539 deaths there were 706 from typhoid fever, 2,287 from tuberculosis in all forms, as against 2,380 in 1909. Cancer was the cause of death in 1,077 cases; 222 died from diabetes, 327 from anemia, 355 meningitis, 923 apoplexy, 2,240 organic heart trouble, 464 broncho-pneumonia, 1,458 pneumonia.

Diarrhea among infants under two years of age was fatal in 1,374 cases, while 2,455 died when under four months of age, owing to weakness from birth or ignorance on the part of the mothers with regard to the care of children.

In 284 cases women lost their lives in child-birth.

Of the 1,626 deaths from affections produced by external causes, 91 persons took their lives by various methods, hanging being the favorite; 26.3 per cent. of this number selecting this means of exit from a weary world. Ninety-five persons were poisoned accidentally; 43 were burned to death; 112 died from burns received; 33 died from gas poisoning; 266 were drowned; 64 shot accidentally; 209 killed by motor cars, landslides, steam and electric railways, etc.; 13 were frozen to death; 8 died from effects of heat—sunstroke; 11 killed by lightning; 18 by electric shock; 17 homocides took place, and the balance, 645, died from various accidental causes.

Old age was the cause of death of 3,429 persons; 2,207 were still-born.

With regard to mortality among infants, it is found that among those under five years of age 6,649 died under one year of age; 917, one year old; 424, two years old; 321, three years old; and 247, four years old.

March was the favorite month for births, there being 5,033 in that month. Of the children born throughout the year, 28,664 were males and 27,207 were females. There were 370 pairs of twins, 264 boys and 376 girls. Triplets surprised the happy father in five cases, 9 boys and 6 girls.

June continues to hold favor with the bride. Of the 24,036 marriages, 3,555 were celebrated in the happy month, September and December following in the order named with 2,653 and 2,304 respectively.

There are two periods in a woman's life when friends are vastly interested in her age; when she marries and when she dies.

The Report goes rather deeply into some of these figures, and while all the secrets are not disclosed, yet there is some interesting information in its pages.

With regard to the age at which persons marry, it is of interest to learn that, so far as Ontario is concerned, men do not marry, to any great extent, at a later date than women, although it is popularly thought otherwise. Last year 8,168 grooms, or about one-third of the total number of men, married between the ages of 20 and 24, while 47 per cent., or nearly one-half, the women who entered the bonds of matrimony were between those ages. With both sexes the next greater number were in the 25-29 group, and then come the 30-34 for the grooms and 15-19 for the brides.

Under the age of 20, 453 men were married, one taking a bride in the 30-34 group, one selecting a lady whose age comes in the 35-39 class; one married a lady of the discreet age of 70, while two grooms showed a predilection for the same maturity of their brides.

Fifteen women between the ages of 15 and 19 married men between 40-44; two became brides of men between 45 and 49; one married a man over 55; two, men over 60, and one a man over 70, as did also a lady of 25-29.

Cupid drives his bolt athwart denomination and conventions. Just at the present time the question of mixed marriages is holding a certain amount of public attention, but many of the good people who discuss the matter of persons of different faiths marrying will be surprised to learn to what an extent such marriages are contracted in Ontario. It appears that in one year alone Methodists married Roman Catholics, Jews married Gentiles, while in many cases May wedded December.

Out of the total of 7,351 Roman Catholics, no less than 1,509 married out of their denomination. Of the grooms 665 married non-Catholic brides, and 844 professed Catholic girls became brides of non-Catholic grooms. Of these marriages, the larger number were between Catholics and Anglicans; then came Methodists, Presbyterians, Baptists, Lutherans, in the order named, but, rather strangely, no marriage between a Roman Catholic and a member of the Salvation Army is recorded, yet two married Jewesses, and five brides threw in their fate with as many Jews.

In addition to this, two Jews married Anglicans; two, Presbyterians; six, Methodists; two, Baptists; one, a Congregationalist. The Jewish ladies did not show such a variety of taste, but exhibited a strong Anglican leaning, for of the seven who married out of their faith five married Anglicans and two Roman Catholic husbands.

Analyzing the table still further, it appears that 631 Presbyterian ladies married Anglicans; 841, Methodists; 126, Roman Catholics; 41, Congregationalists; 55, Lutherans; and the selection of 74 are not classified.

Of the Methodist ladies, 678 married Anglicans; 910, Presbyterians; 157, Roman Catholics; 290, Baptists; 57, Congregationalists; 83, Lutherans; and six passed into the care of as many Salvationists, while 98 of their husbands have yet to be gathered into any particular fold which finds a place in the table, 25 frankly confessing to being of no denomination at all.

Roman Catholics have already been largely dealt with, and coming to the Baptists it is found that 200 chose their husbands from the Anglicans, 219 from the Presbyterians; 362 selected Methodists; 68, Roman Catholics; 21, Congregationalists; 26, Lutherans; 28, from the untabulated, and six of the gentlemen were unattached denominationally.

Fifty-seven Lutherans sought and got Anglican husbands; 71, Presbyterians; 78, Methodists; 85, Roman Catholics; one Hebrew and one Salvationist.

Altogether 87 Salvationists found their husbands in "the Army"; three married Anglicans; one, a Presbyterian; seven, Methodists; five, Baptists; and one is unclaimed.

Reviews

Catechism Series—Surgery. Part III. Second edition. Revised and enlarged. With plates. Price, 1 shilling. Edinburgh: E. & S. Livingstone.

This booklet embraces venereal diseases, scalp, cranium, brain, spine and spinal cord, face, mouth and tongue, pharynx, neck, goitre, oesophagus, larynx and trachea, ear. The questions are set out and the answers given in a clear, compact style. Students will appreciate going over, amongst themselves, these questions, in grind classes and just on the eve of examinations. We heartily recommend the entire series for this purpose.

Heart Sounds and Murmurs. Their Causation and Recognition. A handbook for students. By E. M. Brockbank, M.D. (Vict.), F.R.C.P., Senior Hon. Assistant Physician, Royal Infirmary, Manchester. With illustrations. Price 2s. 6d. London, 136 Gower St., W.C., H. K. Lewis.

As the title announces, this is a small book of 54 pages and index on the heart sounds and murmurs. It is designed for the use of medical students and, having examined it carefully, we can recommend it to them. As a means of gaining a rapid and compactly accurate knowledge of these conditions students will find the book of estimable value.

Webster's New International Dictionary. Editor-in-chief, Dr. W. T. Harris, late United States Commissioner of Education. Springfield, Mass.: G. & C. Merriam.

In this great volume, new from cover to cover a little over a year ago, we have developed the Webster tradition by modern scientific lexicography. It is the key to the literature of seven centuries. In it are defined over 400,000 words and phrases and the new information is practically doubled. The pages are divided. Thus on the upper three-quarters one will find the more important words, and the less important below. There are 2,700 pages and 6,000 illustrations. In scholarship, convenience, authority and util-

ity it easily stands the best. No college, school, library, business office, commercial house, doctor, lawyer, dentist, druggist can afford to be without a copy ever ready and handy to refer to on a moment's notice. In books it is one of the great productions of the day.

The Sensibility of the Alimentary Canal. By ARTHUR F. HERTZ, M.A., M.D., F.R.C.P., Assistant Physician and Physician in Charge of the Department for Nervous Diseases, Guy's Hospital. 83 pages. 1911. $1.50. London: Oxford University Press. Toronto: D. T. McAinsh & Co.

This little volume is another of those modern series, like "Mackenzie on the Heart," that is a necessary addition to each physician's library. On consideration, what do we know on the subject of the cause of the gastric sensations our patients call "emptiness," "fullness," "burning," and so on? Do we realize that there is true visceral pain and that it is dependent on the muscle of the bowel? And do we know anything about the sensitiveness of the rectum and its relation to constipation?

Hertz has added a new chapter to the information that makes a physician's work the most enthralling profession of all, if he is cognisant of the basic laws, which make difficult cases readily understood. G. W. H.

A Text-Book of the Practice of Medicine. By JAMES M. ANDERS, M.D., Ph.D., LL.D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia. Tenth Revised Edition. Octavo of 1,328 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, $5.50 net; half morocco, $7.00 net. Sole Canadian agents: The J. F. Hartz Co., Ltd., Toronto.

Dr. James Anders' ninth edition appeared in 1909, and the best recommendation for his text-book is given by the appearance of a new edition in two years.

There are a number of additions to different articles, including some more recent forms of treatment and new physical signs, but in the main the volume is the exact counterpart of the last edition.

In reviewing this some time ago the excellence of the book for senior students was emphasized, and one can well regard it as the equal of the "Medicine" it so much resembles, namely, Osler's.

The American Journal of Surgery, 92 William Street, New York, will issue in the early part of 1912 a special edition entitled "Special Western Number." This will be an exceptionally fine number. Our Canadian readers desiring a copy of same should enter their orders at an early date.

A Manual of the Practice of Medicine. By A. A. STEVENS, A.M., M.D., Professor of Therapeutics and Clinical Medicine in the Woman's Medical College of Pennsylvania. Ninth Edition, revised. 12mo of 573 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1911. Flexible leather, $2.50 net. Sole Canadian agents: The J. F. Hartz Co., Ltd., Toronto.

This manual of 573 pages is most attractive to the eye, and, in addition, is printed in clear, large type on good paper.

It is naturally only suited to junior students or nurses, or as a handbook for more advanced but inexperienced workers.

It fulfils its object as a manual, and its nine editions in nine years shows that it is well appreciated.

The Ontario Medical Association will meet in Toronto under the Presidency of Dr. Herbert A. Bruce, on May 21st, 22nd and 23rd, 1912. Dr. F. Arnold Clarkson, College and Markham Sts., is the General Secretary.

Dominion Medical Monthly

And Ontario Medical Journal

EDITED BY

Medicine: Graham Chambers, R. J. Dwyer, Goldwin Howland, Geo. W. Ross, Wm. D. Young.
Surgery: Walter McKeown, Herbert A Bruce, W. J. O. Malloch, Wallace A. Scott, George Ewart Wilson.
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Gynecology: F. W. Marlow, W. B Hendry.
Genito-Urinary Surgery: T. B. Richardson, W. Warner Jones.
Anesthetics: Samuel Johnston.

GEORGE ELLIOTT, MANAGING EDITOR.

Published on the 20th of each month for the succeeding month. Address all Communications and make all Cheques, Post Office Orders and Postal Notes payable to the Publisher, GEORGE ELLIOTT, 203 Beverley Street, Toronto, Canada.

VOL. XXXVIII. TORONTO, JANUARY, 1912. No. 1

COMMENT FROM MONTH TO MONTH.

Dr. James F. W. Ross, one of the leading and distinguished surgeons of Canada and America, died the 18th of November, at the residence of Dr. R. L. Langstaff, Richmond Hill. Two days before he was motoring to an out-of-town call, and while driving his own car with the chauffeur by his side the machine was suddenly flung into the ditch and Dr. Ross sustained injuries subsequently resulting in his death.

"In the midst of life we are in death" was never before so forcibly projected upon the minds of the medical fraternity: To some probably more so than others, for it was only a few weeks before, when Dr. Ross was temporarily occupying the chair at the Aesculapian Club, that deceased had launched a discussion upon the rights of the profession exceeding the speed limit in making emergency calls.

To Dr. Ross distinction in medical life came at an early age. A son of the late Dr. James Ross, a prominent general practitioner and obstetrician in his day, he began his medical studies at the old Toronto School of Medicine, having been graduated in 1886. He went abroad after graduation and studied gynecology under the celebrated Lawson Tait. In 1891 he returned to Toronto, entered practice upon the special branch of gynecology, later adding thereto abdominal surgery, and very soon became one of the recognized leaders in this work in America.

He took a prominent part in medical society work, not only in Toronto, Ontario and Canada, but as well in the United States. He could always be counted upon for a paper, an address or a discussion. He was a prominent member of the Canadian Medical Association, a past president of the Ontario Medical Association, of the Academy of Medicine, Toronto, and of the American Association of Obstetricians and Gynecologists.

When the Toronto Academy of Medicine was being promoted Dr. Ross took a leading part therein and did a great deal for the Academy at its foundation and subsequently.

Dr. Ross was well beloved by his immediate confreres in Toronto, scarcely one of whom but had had him either in consultation or for operation at some time or other.

In him Canadian medical journalism loses a generous contributor. His papers enriched the pages of our medical press.

"Jim" Ross will be remembered as an energetic man, a rapid operator, a skilled surgeon, a fluent lecturer, a lover and an ardent advocate of every measure tending to promote the welfare of the medical profession not only in his home city and province, but across the wide expanses of our great Dominion.

To the widow and family of deceased the DOMINION MEDICAL MONTHLY extends its heartfelt sympathy.

McGill University is to be congratulated upon the energetic and spirited campaign friends of that world-famous institution inaugurated and conducted during the week ending the 25th of November.

The total sum at first wanted was $1,000,000. The actual subscriptions amount to $1,540,873. This amount was received from 1,404 contributors.

It must be very gratifying to the promoters of this "whirlwind" campaign that such a large amount was realized. All good friends and well-wishers of the University will wish it further luck in securing the grant or annual subsidy of $100,000 requested of the Quebec Government.

Had McGill been forced to close some of its departments or to even curtail others, as it was feared, there would have been genuine sorrow all over Canada, not alone from graduates, but from many Canadians who are entitled to take just and patriotic pride in any of the great and famous institutions of our Dominion.

With two such munificent benefactors as Lord Strathcona and Sir William Macdonald, with the assurance that there are others sensible of their duty and vitally interested, with the prospective expression of sympathy on the part of the Provincial Government

later taking on tangible financial shape, McGill University may look forward to a future of almost imperial liberality.

McGill's work in British Columbia has recently been under discussion. There has been a great deal of misunderstanding regarding the part played by McGill University in educational matters on the Pacific coast, enough, in fact, to be sufficient to call for widespread dissemination of the truth.

At the outset it is necessary for emphasis to state McGill was invited to take up work in British Columbia and did not force itself upon the people of that province. By special Act of the Legislature of British Columbia in the year 1899, the Vancouver High School had its name changed to Vancouver College and began first year classes in Arts in affiliation with McGill University. So successful was this work that in 1902 affiliation was extended to embrace the second year.

Not considering this arrangement to be sufficiently substantial, the Legislature in 1906 empowered the McGill authorities to establish in that province the McGill University College of British Columbia. The same standards were to obtain and like subjects taught. The McGill authorities then took over the Arts work, extended the two years to embrace the third year, and added the two first years in Applied Science—McGill to conduct the examinations.

This College is entirely undenominational and is self-sustaining; and, therefore, the charge cannot lie that the College tended to financially cripple the home institution in Montreal, and must, perforce, fall to the ground.

There is a branch of the College in Victoria. In the Vancouver College there are 9 students in Arts and 33 in Applied Science, with a staff of twelve professors and lecturers. In Victoria there are 27 students with five teachers. It is expected that, at no very distant date, Vancouver will be in a position to support a complete Arts college. As years go on this will likely form the nucleus of a Canadian university on the Pacific coast, with Arts, Applied Science, Law and Medical faculties of its own. "Westward the course of empire takes its way."

The prevention of insanity, all will agree, is of the first magnitude. There is no disease to which the human flesh is heir that can compare to any one of those diseases of mentality commonly grouped under the single word—insanity. If this be not the age of preventive medicine, then we are on the threshold of it. If prevention can be applied to insanity, then the sooner there is

established a special society in this province—The Ontario Society for the Prevention of Insanity—the sooner will prevention take tangible form and the sooner will educational instruction take hold.

In the place of honor in the October issue of *The Bulletin of the Ontario Hospitals for the Insane* appears an article entitled—"Why Should Anyone Become Insane?"

The insane persons of Ontario number 6,803—one in every 367 of the population. In 1890 there were 4,210, the increase in the two decades being largely due to the desuetude of "asylum" and the ever-growing belief that these institutions are hospitals in the best sense and neither "asylums," places of refuge nor houses of detention. The misapplied word "asylum" has served its day just as surely as "lunatic" has been shoved over into limbo.

Setting aside all question of expense to the Province in caring for these unfortunate patients, and considering only the question of prevention of insanity as paramount, the writer of the article, we are sure, must have the best and most accurate ground for making the statement that fifty per cent. of the patients are so from avoidable causes. Then, clearly, there is a great field for prevention.

Syphilis was the cause and the antecedent of 32 male cases of paresis, an incurable form of insanity, admitted to the Toronto Provincial Hospital for the Insane during the year ending the 30th of September, 1911. Syphilis as a disease to be prevented would come under the purview of the health officer. Gonorrhea, too, in its train brings many disasters to innocent lives, but the people, especially the moralists, would scarcely consent to having these two diseases classed with other communicable diseases.

Alcohol and other poisons, physical diseases, worry and other mental bad habits, as well as heredity to a limited extent, are factors in the cause of insanity about which the people need educating.

How this education is to be brought about would be one of the early problems for an organization to determine. The passing of the knowledge from person to person, by teachers, the pulpit, the medical profession, the press, combined, would, in time, prove effective. The press would no doubt be the best means, as medical items are enticing morsels to most readers; and there is evidence in other countries, if not yet in Canada, that the way is being paved whereby the public press will be the great medium for the dissemination of knowledge of preventive medicine in all its various aspects. Of necessity this will mean the medical editor on the staff of the leading exponents of thought in the country.

News Items

Dr. Bromley, Pembroke, was visiting in Toronto recently.

Dr. Hutchison, Winnipeg, has returned from a visit to Europe.

Dr. Leeming, bacteriologist to the city of Winnipeg, has returned from Europe.

The medical students of Laval University, Montreal, held a banquet on the evening of the 14th of December.

Smallpox, which has been increasing in the Province of Quebec, has appeared in Montreal.

One woman physician and forty-four men were licensed by the Ontario Medical Council as a result of the fall examinations.

Drs. Lewis McMurtry and Chas. A. L. Reid of Louisville and Cincinnati, attended the funeral of the late Dr. J. F. W. Ross on the 20th of November.

St. Luke's Hospital, Montreal, treated 4,351 children in its dental department the past hospital year, and only 26 were found to have perfect dentition.

Dalhousie University, Halifax, has taken over the Halifax Medical College. All medical colleges in Canada are now administered under the authority of some university.

Dr. J. E. Dube, Montreal, has received a gold medal from the International Society Against Tuberculosis for his work in prosecuting a campaign against the "white plague."

Dr. J. D. Helmcken, Victoria, B.C., has been elected president of the British Columbia Medical Association; Dr. Chas. Doherty, New Westminster, Treasurer, and Dr. A. S. Monro, Vancouver, General Secretary.

The Montreal Maternity Hospital treated 802 patients during the past hospital year. The total receipts amounted to $27,057, being $4,000 more than for the preceding year.

The Quebec Government will give $3,500 annually towards the maintenance of a Hospital for Consumptives in that city. The cost of the new building will be $60,000, and it will be administered under the authority of the medical department of Laval University, that city.

Publishers' Department

COUGH OF PHTHISIS.—In the treatment of pulmonary tuberculosis the mitigation of cough is frequently of prime importance, since the repeated effort to expel accumulations of perverted secretions of suppurative materials is often of such degree that pleuritic pains are intensified and the patient is reduced to a state of extreme weakness. Furthermore, the interruption of sleep caused by frequent acts of coughing invariably brings about a marked depression of the vital forces.

The systematic administration of an agent which exerts a sedative influence upon the respiratory tract, modifies the pulmonary accumulations and invigorates the expulsive act is usually expedient, for the reason that the comfort and general well-being of the patient is substantially improved by such a course. It is, however, judicious to avoid the administration of any drug which is capable of producing by-effects that are detrimental, in any way, to the welfare of the patient. It is particularly important that the use of drugs which cause digestive disturbances, constipation or addictions should be eschewed, for such drugs always interfere to a very considerable extent with reparative processes.

Glyco-Heroin (Smith) is singularly serviceable in the treatment of cough of phthisis, since, while possessing extraordinary cough-ameliorating, dyspnea-relieving, repair-promoting, sedative and expectorant properties, it is completely incapable of producing the slightest untoward effects.

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