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## Original Articles.

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### THE TUBERCULOUS IMMIGRANT.\*

BY P. H. BRYCE, M.D., OTTAWA, ONT.

The Executive of the Association, in requesting me to discuss briefly the question of Tuberculosis in Immigrants coming to Canada, had not, I feel sure, any idea that a defence of the work done by the Medical Officers of the Immigration Department was necessary, but rather felt that I, as the Chief Medical Officer of that service, was naturally in a position to present any facts relating to this very important matter clearly before this Association, and through it before the people of Canada generally.

I have therefore to thank the Association for the honor conferred upon me, and shall endeavor to indicate the situation as it exists by referring to the immigrants during 1907, which had notably the largest immigration (196,143 being examined at sea-ports) to Canada ever arriving in any single year, and who came in any manner before the attention of public bodies, whether Federal, Provincial or Municipal, as being tuberculized. In

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\*Delivered before the Canadian Association for the Prevention of Tuberculosis.

addition to published reports, I have received answers from all provincial health officers, and from hospitals and charitable institutions, to a circular sent out to all such throughout Canada. From these replies I have been able to estimate very closely the number of immigrants who during 1907 became subjects of hospital treatment or official charity.

The circulars asked for the name, age, sex, nationality, date of arrival in Canada, the date of entering any institution, and the final disposition of every case. From Ontario I received answers from 61 institutions; from Quebec, 18; from Nova Scotia, 9 answers; and 40 institutions reported upon in the Provincial Charity Report; 5 from Manitoba; 3 from Saskatchewan, included in a total of 12 cases reported by the Provincial Health Officer; 9 from Alberta; 7 from British Columbia, and one from the Yukon. Of these only 10 institutions in Ontario reported any cases, there being 21 in all; 7 in Quebec reported 66 cases; 3 in Manitoba reported 25 cases; 12 were reported from Saskatchewan; 3 from Alberta and none from either British Columbia, Nova Scotia or the Yukon; or, in all, 127 cases were reported. By examining the names of these, so far as given, I find that, apart from 11 who died, those who remained in the institutions for any length of time were mostly reported to the Minister of Immigration, and where they had arrived in Canada within two years, such were returned to their own countries and friends. In all, this number amounted to 59. In addition to this number coming under the direct purview of the Immigration Department, 16 more were debarred on examination at the seaports and were not admitted to Canada. As it will be remembered that under the Immigration Act, as amended in 1906, any immigrant who becomes a charge in any public institution in Canada within three years after landing may be deported, and as 400 were deported during the eight months ending in November, 1907, in a total of 181,784, as compared with 925 on account of diseases in a total of 1,286,000 who entered the United States in the past fiscal year, it is apparent that the Act has been made use of to a very full extent. I have endeavored to analyze the cases dealt with by the Department, with a view to ascertaining the exact number who, from being unable to work very shortly after arrival, were evidently advanced cases on arrival; those who, though working for several months, became thereafter inmates of some institution or came under the notice of the Department, and the number who it would appear were well on arrival, but took the disease in Canada.

Divided up in this manner the results are:

Evidently tuberculized on admission to Canada....	25
Probably .....	17
Not tuberculized .....	15
No particulars .....	1
Died in hospital .....	1

Of other cases not deported and regarding whom particulars were obtained, I found two recent arrivals died in Hamilton, both tuberculized on arrival; two died at Port Arthur within a year of arrival and two others with no particulars, in hospital; 4 Austrians died in St. Thomas hospital; 1 died at Lethbridge. Of 22 cases in their homes visited by the Margaret Scott Nursing Mission in Winnipeg, it is stated "that none were visited who had not had the disease before leaving the Old Country," but how many of the 22 visited came from the Old Country is not given. Of 61 cases of various forms of tuberculosis treated in Victoria Hospital, Montreal, not born in Canada, 18 had arrived in Canada within three years, and 4 were in Notre Dame, Montreal, all of whom had arrived within one year.

Thus, taking the exact figures, and others more or less exact, I think it may be said that at least 100 immigrants who came to Canada did, within two years, develop tuberculosis and become public charges, of whom more than 50 were probably tuberculized on arrival, 25 badly so, and 25 probably contracted the disease after arrival. Taking in round numbers 350,000 as the total immigrants from amongst whom, during 1906 and 1907, these immigrants came, it means that 0.3 of all immigrants, who were examined before admission to Canada, became tuberculized within two years. Out of this number, at least 25 were probably in so advanced a stage as to have been diagnosable if yet greater care had been taken by Medical Inspectors, but when it is remembered that this means but one in every 14,000 examined who was overlooked, and that specialists tell us that the average existence of the disease before it is diagnosed in office examinations is at least eight months, it is plain that the official sins of omission have not been very great.

Perhaps the immunity of immigrants from tuberculosis may be best comprehended by comparison with an ordinary Canadian community. I find that almost exactly 100 deaths occurred last year in Ottawa from pulmonary tuberculosis, and that, as modern exact statistics have shown that the average duration of cases of consumption in Great Britain and the United States is five years,

this means in a population of, say, not more than 80,000, there were last year 500 cases, or 6.2 per 1,000, as compared with 0.3 immigrants, or 20 times as many.

Now, while I have shown by actual statistics how relatively small is the number of tuberculized immigrants, the fact does exist that of this number, a considerable proportion according to returns, actually knew they were tuberculized before coming to Canada, some indeed having been in hospitals or sanatoria mostly in England, while the larger proportion of those tuberculized were English. Others came, and in some instances were advised to come, with the hope that the climate would benefit them, or else came to relatives. In this we see nothing different from what physicians, parents and friends do amongst ourselves, in advising a change of climate and occupation for those who are *candidates for tuberculosis*, as Villemin calls them. Indeed, it is a very common practice in the east here for physicians to advise a change to Alberta or British Columbia, just as in former years patients were advised to go to Florida, Colorado, Arizona or California. If such then be the general practice here, we do not wonder that in the Old Country persons who are employed at indoor occupations are often advised to try Canada, the land of promise, both as a place to get well and to make a new start in life. And I am sure that none of us will object, provided always that it is understood distinctly that advanced cases do not come, and that those who do come here have means to maintain themselves for some months or a year in our climate. It will have been noted that all those deported have become public chargés. One is inclined to go even further, and say that if delicate, over-worked young men in the Old Country, who only require outdoor life to make them strong, would come to our illimitable Western Provinces or the Laurentian forests, with funds enough to maintain themselves while getting well, we ought not to deprive them of this chance of life.

I am just returned from a month's visit to the several Western Provinces, and last year was driving for two months over illimitable prairies, where there is not more than three people to the square mile, and imagine I understand the meaning in terms of health of these immense areas, with their condensed oxygen, unlimited sunshine, and relatively higher altitudes, and can comprehend how my friends, the Health Officers of Manitoba, Saskatchewan and Alberta and British Columbia have been so energetic and successful in establishing sanatoria.

Near Kamloops, within the dry belt, Dr. Fagan has established

a sanatorium, and within six months has thirty patients in old buildings and tents, and within a year or two will have on his 600 irrigated acres, and 8,000 of ranch land, room for several hundred patients to get well, and while doing so learn the agricultural and horticultural possibilities of the Province, and thereafter follow these in that lovely climate.

Dr. Seymour, Health Officer for Saskatchewan, is requiring, as a condition of getting a provincial grant, that each hospital arrange to receive a certain number of tubercularized patients in wards or hospital tents especially arranged for them, while Dr. Lafferty's Alberta Board is doing the same, while at the time searching for a sanatorium site, and outdoor camps are being established in the foothills of the Rockies. Already we have people little less than squatters on the Banff district sounding the tocsin, initiating the *tinnabulum sonum perpetuum* of the various wards of Ottawa City, lest the millions of mountain acres, which the Almighty has given Canada, shall be utilized for the health of the people instead of being held in the interests of a few land speculators, who happened to have camped there first. Manitoba has gone still further forward and has purchased a beautiful site near Ninette Lake, some 120 miles south-west of Winnipeg, whereon to erect a sanatorium for their people. The Government and people have conjointly raised a large sum for the purpose.

Now, while all this is being done by our Western Provinces for their own people, I think I see in all this progress a means whereby the Association may assist to carry out my day-dream of raising a fund, partly by public subscription, both in Canada and Britain, assisted by Government grants, whereby tubercular patients, as in France, who may not be doing well in our climate, may be transferred to another, assisted by this fund. Thus, there are many cases of the catarrhal type of disease, especially in young people with healthy hearts, who do not do well in our eastern moist climate, and could, with great advantage to themselves, be sent to the more elevated, drier, brighter and more reconstructive climates of the foothills and mountains; while, again, other cases, of the neurotic type, with irritable hearts and defective circulation, would be advantaged by coming east to the more sedative and less changeable climate of our Laurentians, and be guided back to health here. All that such a scheme requires is a business arrangement for carrying on this work, while making it a condition that all sanatoria receiving such patients would be open to such a Federal specialist officer as might be appointed to study the relations of climate and tuberculosis. These are but illustra-

tions of what yet will be done in the scientific study of the protean types of this ubiquitous disease. Imagine our task! Based upon comparative statistics already given, some 50,000 persons will this year in Canada be enrolled in the ranks of the tuberculized. Money can be found for almost any conceivable scheme for prospective money-making: Money to construct railways; money to experiment with every kind of plant and grain, to see which will produce most crop; money to develop the best types of cattle and horses, and to protect their health; money for the propagation of fish and lobsters; money for the protection of our forests; money to bring in hundreds of thousands of prospective producers of wealth and national strength in the shape of immigrants! Though if in all these illustrations given, the single motive is not the development of the aesthetic and beautiful, not the mere student's love of enquiry in pure science, but rather the prosaic aim of money-making—the mere daily routine of utilitarianism—yet we may for a moment set aside our altruistic endeavors, forget the sweetness of giving of ourselves rather than receiving, as did Sir Launcelot in his search for the Holy Grail, stifle our desire to dry human tears, and in this matter apply the same practical, utilitarian arguments, and say that in the name of Canadian patriotism we insist that at least a part of this army of 50,000 tuberculized Canadians, who certainly will die within the next five years, if not assisted at an early stage in the disease to receive thorough sanatorium treatment, be given a chance to live and remain as an asset many times greater than any prospective wealth gathered from the labor of any 50,000 immigrants, and who, if saved from the advanced stages, will proportionately lessen the dangers of infecting annually another brigade of 10,000. They are Canadians! They are our fellow-citizens! They are our own flesh and blood! Surely our cities and rural places will do something much more to stem this ever-advancing tide of death, whereof our Provincial Governments, partaking yet more yearly of revenues from our growing wealth, will be active in legislating and making grants to aid in work in the cities and countries, and cannot we hope that our Federal Government, which is doing so much in all these other indicated fields, while granting so much to fill up our empty spaces with industrious healthy immigrants from other lands, will directly assist financially in this scheme, or some other, by which a momentum shall be given to the awakening of this day of promise, seemingly now dawning, for every Province in Canada.

No longer can the attitude be that of the Eaters, "who lie

reclined on the hills like gods together, careless of mankind," but rather that having so many things to do that they forget, we shall now undertake this our last, our greatest task.

But I must not be too impatient, as an enthusiast for the coming of the Kingdom of Sanitation. Perhaps it may be like that other, which cometh not by observation. As Tennyson says, in "Love and Duty,"

"Wait and Love Himself

Will bring the drooping flowers of knowledge changed to fruit  
Of Wisdom."

Or as our ever-sweet singer says,

"Have patience, I replied; Ourselves are full  
Of social wrongs: This fine old world of ours  
Is but a child yet in the go-cart.  
Patience! Give it time to have its limbs—  
There is a hand that guides!"



## Clinical Department.

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**The Report of a Case of Retropharyngeal Abscess in a Girl Eleven Years Old.** HERBERT B. CARPENTER, M.D., Physician to the Medical Dispensary of the Children's Hospital, Philadelphia, in the *Archives of Pediatrics*.

As acute retropharyngeal abscess in children over three years is uncommon, I thought the following case of interest:—

Margaret W., aged eleven years. Her family history was negative. She was fed at the breast for six months, and afterward on modified milk. She had measles at four years, and whooping-cough at eight; otherwise was healthy, except for a tendency to catarrhal "colds."

During the first two weeks of March, 1906, the patient's entire household suffered from an epidemic of influenza. She was taken ill on the 6th of March, with high fever, sore throat, enlargement of the lymphatic glands of the neck, torticollis and general muscular pains. On the following day her tonsils were very much swollen, nearly closing the pharynx; the follicles were filled, and what little of the posterior wall of the pharynx could be seen exhibited a severe follicular inflammation. Within three days the inflammation and soreness began to subside, and at the end of a week the child seemed to have recovered except for torticollis and snoring at night. Inspection at this time showed a marked swelling of the posterior wall of the pharynx, a little to the right of the median line. On palpation, fluctuation was obtained. The posterior wall of the pharynx was pushed forward, and the abscess was just beneath the surface of the mucous membrane. She was seated in a chair facing a good light; the tongue was depressed; and, after cocainizing the parts, a bistoury, with its edge guarded by adhesive plaster (leaving about half an inch of the tip exposed), was introduced into the most prominent part of the tumor, and the incision enlarged from above downward. The head was thrown forward to allow the abscess to drain into a basin, and the cavity was washed out with Dobell's solution. The pain and rigidity of the muscles of the neck improved almost at once. The abscess healed within forty-eight hours. This abscess was probably due either to a streptococcus infection or to the influenza bacillus causing inflammation and suppuration of a retropharyngeal node. These nodes are most prominent in infancy, and diminish rapidly in size after the third year.

Retropharyngeal abscess is a disease of early life; more than 80 per cent. of the cases occurring before the second year. Lennox Brown says it is a rare affection. He noted but 6 cases in a service of over twenty years. This seems to have been the general experience of nose and throat specialists, whereas the pediatricians seem to have observed many more cases. Holt and Rotch say it is almost always seen in infancy, and that it is rare after the first year. Bokai reported 60 cases; 42 occurring during the first year, 11 during the second year, and only 7 at a later period.

Koplik says the disease is rare after the fifth year. Of his 70 cases, 4 occurred before the third month; 10 before the sixth month; 41 between the sixth and twelfth months; 19 between the first and fifth years; and only 3 after the fifth year.

The second case is a typical one, and is reported, as it affords a contrast to the first. It occurred in a seven-months-old breast-fed baby. The mother said it had always been a very healthy infant. It had a "cold" in the head, with some fever, for several days; and for three days had been very fretful and restless. The mother noticed that the child's breathing was somewhat labored during sleep, and that it did not nurse well. The difficulty in breathing and nursing was increasing, and when I saw the baby it had dyspnea, which seemed to be mostly inspiratory, and was worse in the recumbent position. It would nurse for only a few seconds at a time, and was growing weak evidently from lack of nourishment and from the labored breathing. The cry had a nasal twang. The head was thrown back and the mouth was open. The breathing was rattling and snoring, at times stertorous. Inspection of the throat, owing to the diminutive size, was difficult, and rendered more so by the accumulation of mucus. On introducing the finger a tense fluctuating swelling was detected in the posterior wall of the pharynx, nearly in the median line, reaching down to the larynx.

Using a finger as a guide, an opening in the abscess was made, and a large amount of creamy pus was evacuated. Pressure with the finger on the walls of the abscess was necessary to thoroughly empty it. The infant began to breathe easily at once, and made a perfect recovery in a few days. There has been no return of the disease.

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The injection into a ganglion of the wrist of phenol-camphor, two to ten minims, according to the size, and repeated once or twice if necessary, will cause its complete disappearance in most cases. No attempt at preliminary aspiration need be made.  
—*American Journal of Surgery.*

**Foreign Bodies in the Larynx and Trachea.** M. McTYEIRE CULLOM, A.B., M.D., Surgeon to St. Thomas's Hospital; President Nashville Academy of Medicine and Davidson County Medical Society, Nashville, Tenn., in the *International Journal of Surgery*.

When a foreign body becomes lodged in the air passages nature gives instant and unmistakable assurance that a grave accident has occurred. In his great article on "Foreign Bodies in the Larynx and Trachea," Roe quotes the immortal Gross as follows: "How many persons have perished, perhaps in an instant and in the midst of a hearty laugh, the recital of an amusing anecdote, or the utterance of a funny joke, from the interception at the glottis of a piece of meat, a crumb of bread, a morsel of cheese, or a bit of potato, without a suspicion of those around of the real nature of the case. Many a coroner's inquest has been held upon the bodies of the victims of such accidents and a verdict rendered that they died by the visitation of God, when the actual cause of death lay quietly and unobserved at the door of the windpipe of the deceased."

Foreign bodies in the larynx constitute one of the rare conditions which the physician is called upon to relieve. It is the testimony of many laryngologists that out of many thousands of patients applying for treatment, only a very few are so afflicted. The articles which most commonly find lodgment in the throat are, first, fish bones, chicken bones, and the bones of game birds. Pieces of toothpick, perhaps, come next; then pins, needles, tacks, toothbrush bristles, false teeth, thread, coins, grains of corn, wheat, or seeds of various kinds, as well as small objects that are liable to be put into the mouth by children or grown persons. When we realize how well guarded the larynx is, it is not surprising that so few objects find lodgment in it.

The symptoms of a foreign body in the larynx may be classified as immediate and remote. The immediate symptoms are apt to be all those of a most distressing spasm of the glottis. Respiration is interrupted, the patient giving a gasp or two, followed by prolonged stridulous inspiratory efforts, accompanied by a crowing noise, which is peculiar to spasm. The patient has an anxious expression, wide open eyes, livid lips, and if the paroxysm is prolonged, extreme cyanosis sets in and the patient may drop to the floor unconscious. In such cases death may occur almost at once from asphyxia. As a rule, however, the spasm ceases and respiration is resumed; it may be with difficulty. There is, however, a constant effort of nature to expel the intruder, and the spasm is apt to recur at intervals. There are always more or less pain and discomfort referred to the larynx.

The remote symptoms set up by foreign bodies in the larynx are inflammation, suppuration, or ulceration. If the foreign body becomes lodged in a bronchus a septic pneumonia is very apt to be set up, and a fatal result is almost sure to follow. There are instances, however, of very remarkable toleration shown by the larynx for foreign bodies. Coins have been carried in the larynx for a long time, and a case is reported of a toy locomotive being lodged in the larynx and remaining for some time without producing death.

The diagnosis is made with the laryngeal mirror, the x-ray, or from the history and symptoms. The diagnosis is a matter of the greatest importance, for it is in most cases an accident fraught with the gravest dangers to life. Many cases apply to us under the impression that they have a foreign body lodged in the throat when none can be found. The traumatism caused by its passage into the esophagus leaves an irritation which the patient mistakes for a foreign body. In Prof. Juaraz's clinic at Heidelberg, out of 4048 patients applying for throat treatment, 106 came under the impression that they had a foreign body in the throat, but in only four was one actually found. And, again, foreign bodies exist in children where none are suspected.

The lodgment of a foreign body in the air passages is always serious. Death may ensue immediately from suffocation, or inflammation and sepsis may occur as a result of retention, with death as a final result. Roe has collected 762 cases of foreign bodies in the larynx and trachea, of which 312 were in the larynx, and 450 in the trachea. In the 312 cases of foreign body in the larynx its removal by operation was undertaken in 124 cases with 17 deaths. Of the other 188 cases the foreign body was expelled spontaneously in 40 cases with 38 recoveries. In 101 cases it was removed by forceps through the mouth, all of which recovered. In 16 cases removal was accomplished by various means, such as inversion, the fingers, by emesis, etc., all of the patients recovering. In 31 cases no operation was attempted, and of these, 28 died. Of the 450 cases in which the foreign body was in the trachea it was removed by operation in 239 cases, with 201 recoveries. In 124 the foreign body was expelled spontaneously, with 112 recoveries; in 14 it was removed by forceps, in 9 by inversion, in 2 by emesis; all recovered. In 58 cases no operation was undertaken, with 56 deaths. So that in 312 cases of foreign bodies in the larynx there were 265 recoveries, or 84.9 per cent.; of 450 cases of foreign bodies in the trachea, 343 recovered, or 77 per cent. Combining the statistics of a number of investigators, comprising about 2,650 cases, the recoveries are 78 per cent. The significant fact which these statistics bring out is the almost certain death

of the patient when the foreign body is not removed spontaneously or otherwise.

The diagnosis of a foreign body having been made, the urgent indications are for its prompt removal. The only question is by what means is it to be accomplished. The means of removal are by expulsion through the natural passages; removal through the natural passages with instruments; removal with instruments or by expulsion through an artificial opening. It is needless to say that removal by the natural channels is the most desirable, and every effort should be made to accomplish it in this manner before resorting to operation, unless the urgency of the symptoms demands surgical interference. Perhaps the earliest effort made to relieve a patient with a foreign body in the air passages was to tickle the throat so as to induce coughing and emesis. This has no doubt been tried successfully in thousands of cases that have not been reported. Thought some authorities condemn it, it is the first thing to be thought of in the urgency of laryngeal spasms, and should be resorted to at once. No doubt many a life has been saved by some one inserting a finger or a feather into the throat in such a way as to provoke emesis or coughing. Foreign bodies have also been expelled by bringing on a paroxysm of sneezing.

The method of inversion and succussion has been successfully practised in many cases. This is available in the case of objects which have weight enough to be acted on by the force of gravity, such as coins, bullets, metal objects, etc. The best way to accomplish this is to place the patient on a bench with his legs flexed over the end, and then elevate the bench at an angle of 45 degrees. Vigorously shaking the patient is supposed to aid the expulsion. The patient should avoid speaking, as this brings the vocal cords together and prevents the expulsion of the foreign body.

The ideal method for removing foreign bodies from the trachea is by means of bronchoscopy, which within a few years has been brought to a high state of perfection in technic. To Gustav Killian, of Freiburg, belongs the credit of placing this epoch-making method upon a practical basis. To those who have seen this modest, unassuming gentleman explore the deep recesses of the trachea and bronchi under direct inspection the method is a surprise and a revelation. The instruments consist of a tube-spatula, which is used in inspecting the larynx, and through which the bronchoscope may be used. The bronchoscope proper consists of a hollow tube carrying its own illumination in the shape of a small electric light within the lumen of the tube. The tube is passed directly into the trachea, whereby the trachea and bronchi may be directly inspected, and by

means of suitable forceps foreign bodies may be removed without danger, without after-treatment, and without a scare, where available, and where indicated. It is the ideal method of extraction. In the comparatively small number of cases in which the method has been used the indicated mortality is 8 per cent., as against 22 per cent. for other methods. The instrument may also be inserted through the tracheotomy wound.

When attempts at removal of a foreign body through the natural channels have failed it is necessary to adopt surgical means, and the success of this treatment has been greatly facilitated by the use of the x-ray for diagnosing and locating the exact spot occupied by the foreign body. The character of the operation will be determined largely by the location and nature of the foreign body. When the trachea is opened, the foreign body is often expelled through the tracheal wound or through the larynx, or it may be thrown up into the trachea where it may be grasped with forceps. When it is not expelled at once, efforts should be made to extract it with forceps. Gross, Roe, and Cohen have devised flexible forceps, which can be bent at any angle for reaching into a bronchus.

I wish to report the following cases:

Case I. L. E., white, aged thirty-two, was brought to me by his physician June 19, 1904, with the following history: He was subject to a purulent discharge from the nose, which was characterized by an accumulation of crusts in the post-nasal space. These crusts were dislodged with great difficulty at times. Three days before, while hawking in an attempt to dislodge a crust, it was drawn into the larynx. He was seized with spasm, dyspnea, and all the symptoms of a foreign body in the larynx. His breathing had been very difficult ever since, with frequent attacks of urgent dyspnea. His distress was very apparent and his voice was practically gone. With the laryngeal mirror I discovered the crust in the trachea just below the vocal cords. I recognized the gravity of the condition, not only on account of the presence of the foreign body in the trachea, but also because being such a particularly foul one. I was unwilling to undertake its removal by endolaryngeal methods, for fear that I would dislodge it and cause it to drop into a bronchus with almost a certainty of septic pneumonia. I advised an immediate tracheotomy, which was agreed to. The patient was removed to St. Thomas's Hospital, and Dr. W. A. Bryan was called into the case. At four o'clock that afternoon Dr. Bryan did a high tracheotomy and removed the mass through the wound. The patient made an uneventful recovery.

Case II. I. M., female, white, aged eight. This patient was

brought to me by her family physician with this history: On the day before, while her mother was dressing her for school, the patient took a pin out of her clothes and thrust it into her mouth. It slipped down her throat and she was immediately seized with a spasm of the glottis. The spasmodic coughing and difficult respiration lasted about a half hour. As soon as she was able to speak she said the pin was sticking in her throat. The mother sent at once for her physician, who examined her throat as carefully as possible without instruments and told the mother that the pin was nowhere in sight, that he thought it had passed on into the stomach, and that what she complained of was probably the irritation caused by the scratching of the pin. He directed the mother to let him know if anything further developed. The child continued in a highly nervous state and insisted that the pin was sticking in the throat. The next afternoon the mother again called the physician, and he found that the child had neither swallowed nor slept since the accident. He at once brought her to my office. It was then about thirty-three hours since she had swallowed the pin. She was in great distress and carried the head bent forward at an angle, as any attempt to straighten it caused intense pain. I examined her throat with the laryngeal mirror and discovered the pin sticking in the posterior opening of the larynx by the side of the right arytenoid cartilage.

I carefully cocaineized the larynx, and after waiting ten minutes, proceeded to make the effort at extraction. I had just previously had made a modification of the Schroetter tube forceps, and this was my first opportunity to use the new instrument. Dr. Hale assisted me by holding the patient's tongue while I held the mirror with my left hand and managed the forceps with my right. After several attempts I succeeded in extracting the pin, which was buried to about half its length in the tissues. For a week the child had a temperature of between 100 and 101 degrees and was very nervous and restless. She was also quite hoarse and coughed considerably, but after ten days the symptoms cleared up and she has had no further trouble.

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**Potassium Cyanid Poisoning.** J. W. NOLAN, M.D., Chittabulbie, Korea, in *J.A.M.A.*

Cyanid of potassium poisoning is not infrequent among workmen who "clean up" in the cyaniding process of gold reduction, but is rare in private practice.

After the auriferous ore has been crushed to a fine sand through which an 0.5 per cent. solution of cyanid of potassium is allowed

to filter, the solution passes into boxes filled with zinc shavings on which gold is precipitated from the auro-potassic cyanid in the solution. It requires some little force to dislodge these gold particles, and consequently scrubbing the zinc shavings with the hands is the method usually employed. It is in this scrubbing process, while the hands and arms are necessarily bathed in the solution that poisoning occurs with greatest frequency. Different individuals exhibit different degrees of susceptibility, some being apparently immune. The temperature of the solution greatly modifies the ease with which the effect is produced, the greatest number of cases occurring during the cold season when the solution is, of course, very cold.

**Case 1.**—A husky young man of 23 was having his first experience in scrubbing the zinc shavings. An itching sensation immediately followed the immersion of his hands in the solution. Scarlet specks soon appeared, irregularly distributed over the area with which the solution was in contact. These scarlet specks quickly enlarged until a well defined circumscribed area was produced, these finally coalescing and forming a large scarlet area, but the initial specks or papules maintained their identity, being slightly elevated and of a deeper color than the neighboring skin. The itching continued for about two hours and a burning, uneasy sensation developed which persisted until the redness began to disappear, twelve hours later. Slight giddiness and headache were the only constitutional symptoms.

A similar case occurred in a well-nourished metallurgist. I put the hands and arms of these patients into a very dilute solution of hot sulphuric acid for several minutes every hour. The redness soon began to fade and had disappeared altogether in twelve hours. The following formula shows the chemical reaction:

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### **A Convenient Way of Keeping Tab When Counting in Opsonic Work.** C. C. BASS, M.D.

One of the drawbacks to opsonic index work is the large amount of very trying microscopic work required. Anything that would tend to reduce this time or the strain on the eyes would seem of value. Simon has proposed a technic according to which the percentage of phagocytting leucocytes is ascertained, no account being taken of the number of bacteria per leucocyte.

The following suggestion will apply whether the original technic



of Wright and Douglas is used or Simon's, with slight adjustment to the particular case. When counting in determining the Wright index, one observes the number of bacteria in each of several leucocytes, carrying the separate numbers "in his head" until he has as many as he can carry, say five to ten; then he jots them down, thus: 1, 2, 0, 5, 0, 0, 1, 0, 4, 2, etc., and after a sufficient number has been counted, the figures are added up and the calculations made. I take it that the most trying part on the eye is the frequent accommodation and reaccommodation of the eye to the microscopic field and tab figures, etc., as well as to the very different amounts and often qualities of light. I believe this is largely obviated by a method which has been used in my laboratory for several months.

A box containing 50 or 100 beans or beads (I use 50 beans) and a similar empty box (the boxes in which microscope slides come answer well) are placed on the table, at convenient places, on the right of the microscope. A handful of beans is taken up in the right hand, with which the mechanical stage is manipulated, and one bean is dropped into the empty box for each polymorphonuclear leucocyte observed, the left hand manipulating the fine adjustment, as usual. One counts the bacteria as observed; for example, with the above he would say: 1, 3, 8, 9, 13, 15, etc., until the box is empty. The number counted would be the number in 50 cells. There is no putting down and adding up of figures and the eye has not been removed from the field during the time. If more than 50 cells are to be counted, put down the number, or carry it on, as you preferred, exchange the position of the boxes and proceed as before.

When counting the phagocytizing cells only for the Simon index, one may proceed as before, dropping a counter for each "poly" seen and counting as one goes, only those cells phagocytizing, as 1, 2, 3, 4, 5, 6, etc. If 100 counters are used, the number counted phagocytizing would be the percentage of phagocytizing leucocytes.

If one does not use a mechanical stage he can modify the above to suit his convenience.

Crude as the method seems, only a trial is necessary to convince one of the advantages in time and eye saving.

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Nurses should be instructed not to massage the limbs of patients who complain of pain after operation or confinement, without the order of the attending surgeon. If phlebitis and thrombosis are present, the manipulation may loosen a clot and cause instant death.—*American Journal of Surgery.*

**A Displaced Sigmoid in a Case of Appendicitis.** W. A. KICKLAND, M.D., Fort Collins, Colo., in *J.A.M.A.*

The following case is an interesting one because of the position of the sigmoid and the failure of the usual rule for finding the appendix, that of following the longitudinal muscular band of the presenting large intestine to its pelvic end:

*Patient.*—J. A., aged 35, a lather by trade, was referred to me by a physician in a neighboring town with a diagnosis of appendicitis. The history was the usual one of an acute attack in mild form lasting four days with no improvement. Examination showed tenderness over McBurney's point with muscular rigidity; temperature was normal and pulse 85.

*Operation.*—In operating, the gridiron incision was used and the large intestine immediately presented itself in the wound. It was drawn out from the pelvic end, following the longitudinal band of muscular fibers, and search was made for the appendix. The lower end of the intestine seemed so deep in the pelvis that suspicions were aroused and the introduction of a rectal tube showed this portion of the intestine to be the sigmoid instead of the cecum. Tracing it upward, it was found that instead of going up to the liver region, as might be expected in a case of inverted viscera, the colon went across to the splenic region. The sigmoid was dropped and the opening enlarged so that the abdominal cavity could be inspected more freely, and the cecum with the inflamed appendix was seen lying up under the liver. The appendix was removed and the recovery was uneventful.

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Three or four drops of peroxid of hydrogen in the ear followed five minutes later by thorough syringing with boracic acid solution, will readily remove any impacted cerumen.

When there is a perforating wound of the cornea, necessitating enucleation of the eye, the wound should be closed so that the eyeball does not collapse during the operation.

Small stab wounds (one-half cm. long) in the course of a developing cellulitis of an arm or leg, followed by the application of a Martin bandage above for five to eight hours a day (Bier treatment), will relieve the patient more quickly than large incisions with drainage.—*American Journal of Surgery.*

## Proceedings of Societies.

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### INTERNATIONAL CONGRESS ON TUBERCULOSIS.

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The Central Committee of the International Congress on Tuberculosis has announced the offer of the following prizes:

1. A prize of \$1,000 is offered for the best evidence of effective work in the prevention or relief of tuberculosis by any voluntary Association since the last International Congress in 1905. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

Evidence is to include all forms of printed matter, educational leaflets, etc.; report showing increase of membership, organization, classes reached—such as labor unions, schools, churches, etc.; lectures given; influence in stimulating local Boards of Health, schools, dispensaries, hospitals for the care of tuberculosis; newspaper clippings of meetings held; methods of raising money; method of keeping accounts.

Each competitor must present a brief or report in printed form. No formal announcement of intention to compete is required.

2. A prize of \$1,000 is offered for the best exhibit of an existing sanatorium for the treatment of curable cases of tuberculosis among the working classes. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

3. A prize of \$1,000 is offered for the best exhibit of a furnished house, for a family or group of families of the working class, designed in the interest of the crusade against tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award. This prize is designed to stimulate efforts towards securing a maximum of sunlight, ventilation, proper heating, and general sanitary arrangement for an inexpensive home. A model of house and furnishing

is required. Each competitor must present a brief with drawings, specifications, estimates, etc., with an explanation of points of special excellence. Entry may be made under competitor's own name.

4. A prize of \$1,000 is offered for the best exhibit of a dispensary or kindred institution for the treatment of the tuberculous poor. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

5. A prize of \$1,000 is offered for the best exhibit of a hospital for the treatment of advanced pulmonary tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management and results obtained. Each competitor must present a brief or report in printed form.

6. The Hodgkins Fund Prize of \$1,500 is offered by the Smithsonian Institution for the best treatise that may be submitted on "The Relation of Atmospheric Air to Tuberculosis."

The detailed definition of this prize may be obtained from the Secretary-General of the International Congress or Secretary of the Smithsonian Institution, Chas. D. Walcott.

7. Prizes for Educational Leaflets:

A prize of \$100 is offered for the best educational leaflet submitted in each of the seven classes defined below. In addition to the prize of \$100, a gold medal and two silver medals will be awarded in each class. Each prize and medal will be accompanied by a diploma or certificate of award.

Competitors must be entered under assumed names.

- (a) For adults generally (not to exceed 1,000 words).
- (b) For teachers (not to exceed 2,000 words).
- (c) For mothers (not to exceed 1,000 words).
- (d) For indoor workers (not to exceed 1,000 words).
- (e) For dairy farmers (not to exceed 1,000 words).
- (f) For school children in grammar school grades (not to exceed 500 words).

In classes *a*, *b*, *c*, *d*, *e*, and *f*, brevity of statement without sacrifice of clearness will be of weight in awarding. All leaflets entered must be printed in the form they are designed to take.

(g) Pictorial booklet for school children in primary grades and for the nursery.

Class *g* is designed to produce an artistic picture-book for children, extolling the value of fresh air, sunlight, cleanliness, etc., and showing contrasting conditions. "Slovenly Peter" has been suggested as a possible type. Entry may be made in the form of original designs, without printing.

8. A gold medal and two silver medals are offered for the best exhibits sent in by any States of the United States, illustrating effective organization for the restriction of tuberculosis. Each medal will be accompanied by a diploma or certificate of award.

9. A gold medal and two silver medals are offered for the best exhibits sent in by any State or Country (the United States excluded), illustrating effective organization for the restriction of tuberculosis. Each medal will be accompanied by a diploma or certificate of award.

10. A gold medal and two silver medals are offered for each of the following exhibits; each medal will be accompanied by a diploma or certificate of award; wherever possible each competitor is required to file a brief or printed report:

(a) For the best contribution to the pathological exhibit.

(b) For the best exhibit of laws and ordinances in force June 1st, 1908, for the prevention of tuberculosis by any State of the United States. Brief required.

(c) For the best exhibit of laws and ordinances in force June 1st, 1908, for the prevention of tuberculosis by any State or Country (the United States excluded). Brief required.

(d) For the best exhibit of laws and ordinances in force June 1st, 1908, for the prevention of tuberculosis by any municipality in the world. Brief required.

(e) For the society engaged in the crusade against tuberculosis having the largest membership in relation to population. Brief required.

(f) For the plans which have been proven best for raising money for the crusade against tuberculosis. Brief required.

(g) For the best exhibit of a passenger railway car in the interest of the crusade against tuberculosis. Brief required.

(h) For the best plans for employment for arrested cases of tuberculosis. Brief required.

11. Prizes of two gold medals and three silver medals will be awarded for the best exhibit of a workshop or factory in the in-

terest of the crusade against tuberculosis. These medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

The following constitute the Committee on Prizes: Dr. Charles J. Hatfield, Philadelphia, *Chairman*; Dr. Thomas G. Ashton, Philadelphia, *Secretary*; Dr. Edward R. Baldwin, Saranac Lake; Dr. Sherman G. Bonney, Denver; Dr. John L. Dawson, Charleston, S.C.; Dr. H. B. Favill, Chicago; Dr. John B. Hawes, 2nd, Boston; Dr. H. D. Holton, Brattleboro; Dr. E. E. C. Levy, Richmond, Virginia; Dr. Charles L. Minor, Ashville, N.C.; Dr. Estes Nichols, Augusta, Me.; Dr. M. J. Rosenau, Washington; Dr. J. Madison Taylor, Philadelphia; Dr. William S. Thayer, Baltimore; Dr. Louis M. Warfield, St. Louis.

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### CANADIAN MEDICAL ASSOCIATION.

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At the Forty-first Annual Meeting of the Canadian Medical Association, to be held this year in Ottawa, on the 9th, 10th and 11th of June, it has been decided to have the following sections: General Medicine, General Surgery, and one session each, all going on at the same time, for these: Mental Diseases; Eye, Ear, Nose and Throat; Public Health; Obstetrics and Gynecology; Pathology; Military Surgery. Dr. J. T. Fotheringham, Toronto, and Dr. A. J. Mackenzie, Toronto, are respectively Chairman and Secretary of Medical section: in General Surgery, Dr. Geo. E. Armstrong and Dr. E. W. Archibald, Montreal; in Mental Diseases, Drs. W. H. Hattie, Halifax, and J. C. Mitchell, Brockville; in Public Health, Drs. Chas. A. Hodgetts, Toronto, and Law, Ottawa; Chairman of Obstetrics and Gynecology, Dr. F. A. Lockhart, Montreal; Eye, Ear, Nose and Throat, Drs. Birkett and McKee, Montreal; Pathology, Dr. W. T. Connell, Kingston; Military Surgery, Dr. G. Stirling Ryerson, Toronto, and Dr. Leggett, Ottawa. The address in Medicine will be delivered by Dr. Risien Russell, London, England.

The place of meeting will be in St. George's Church, Parish Hall, Metcalfe Street, and the Racquet Court just opposite for

exhibits and registration; also the Carnegie Library, close by, for any sectional meetings necessary.

Railway arrangements are completed for all points east of Fort William in the territory of the Eastern Canadian Passenger Association, and the standard certificate plan will prevail. Those as to Manitoba and west thereof, including British Columbia, the General Secretary is in constant communication with the proper people on the subject and hopes to be able to give a definite announcement soon. As early as possible the official circular will be sent out, with full information and provisional programme.

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## ONTARIO MEDICAL ASSOCIATION.

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### SECTION OF PREVENTIVE MEDICINE—10 A.M.

1. "Diphtheria Antitoxins as Prophylactic and Curative Agents"—W. Goldie, Toronto.
2. "Medical Inspection of Schools."—Helen MacMurchy, Toronto.
3. "Control of Minor Contagious Diseases."—M. Sinclair, Walkerton.
4. "Precautionary Measures Necessary to Prevent Infection in Typhoid Fever Patients."—J. A. Amyot, Toronto.
5. "Sewage System for Towns and Smaller Cities."—P. Aird Murray, C.E., late of Leeds, England.
6. "Anti-Variolous Vaccines"—Charles A. Hodgetts, Toronto.

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### SECTION FOR THE EYE, EAR, NOSE AND THROAT—9.30 A.M.

1. "Lateral Sinus Suppuration and Cerebellar Abscess."—J. P. Morton, Hamilton.
2. "Tubercular Uveitis."—J. W. Stirling, Montreal.
3. "Glaucoma."—R. A. Reeve, Toronto.
4. "Clinical Measurement of Relative Accommodation."—Lucien Howe, Buffalo.
5. "Accessory Sinus Disease."—Perry Goldsmith, Toronto.

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### SECTION OF OBSTETRICS AND DISEASES OF CHILDREN—9.30 A.M.

1. "A Fatal Form of Eclampsia."—K. C. McIlwraith, Toronto.  
Discussion to be led by J. D. Balfour, London.

2. "Obstetrical Technique."—Frederick Fenton, Toronto.
3. "Some Complications of the Puerperium, Report of a Case."—J. R. Stanley, St. Mary's.
4. "Missed Abortion."—H. Ferguson, London.
5. "Mole Pregnancy with Specimen."—C. R. Charteris, Chatham.
6. "A Case of Spasmodic Stenosis of the Pylorus in an Infant, with Recovery."—H. T. Machell, Toronto.
7. "Pyo-pneumo-thorax Due to a Fusiform Bacillus."—Allen Baines, Toronto.

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### MEETING OF THE ASSOCIATION OF AMERICAN TEACHERS' OF THE DISEASES OF CHILDREN.

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The Association of American Teachers of the Diseases of Children will hold its annual meeting in Chicago, at the Great Northern Hotel, corner of Jackson Boulevard and Dearborn, on June 1st.

Requirements for membership in this Association are somewhat unique. To be eligible one must be a regular physician resident in the United States, Canada or Mexico, who is in good professional standing and membership in his county or local medical society and actively engaged as Professor or Associate Professor or Clinical Professor of Pediatrics, or as adjunct to such a chair, or who holds the position of Lecturer on this branch or an equivalent position in a recognized medical college, or who is a member of a properly organized hospital or dispensary staff actively engaged in the treatment of children. All such are invited to join the Association; and all physicians and surgeons interested in children are invited to attend the meeting. Its objects are the study, the teaching and the practice of pediatrics.

The officers of the Association are as follows:

*President*—Samuel W. Kelley, M.D., Professor of Diseases of Children in Cleveland College of Physicians and Surgeons, Medical Department of Ohio Wesleyan University.

*Vice-President*—Chas. Douglas, M.D., Professor of Diseases of Children in Detroit College of Medicine.

*Secretary*—John C. Cook, M.D., Professor of Diseases of Children in Post-Graduate Medical School and Hospital of Chicago (deceased).

*Secretary Pro Tem.*—Robert A. Black, M.D., Chicago.



*Treasurer*—George G. Cattermole, M.D., Professor of Diseases of Children in Colorado School of Medicine.

*Senators*—W. C. Hollopeter, M.D., Professor of Diseases of Children in Medico-Chirurgical College of Philadelphia; H. M. McClanahan, M.D., Professor of Diseases of Children Medical Department of the University of Nebraska, Omaha; F. R. Gilbert, M.D., Professor of Diseases of Children Kentucky Medical College, Louisville, Ky.

The programme for the Chicago meeting is not completed, but in part it is here presented:

Address of Welcome—Arthur D. Bevan, M.D., Professor of Surgery, Medical Department University of Chicago, Chairman Council on Education A. M. A.

Address of the President, Samuel W. Kelley, M.D., Professor Diseases of Children, Cleveland College of Physicians and Surgeons Medical Department Ohio Wesleyan University, Cleveland, Ohio.

“The Teaching of Pediatrics as Seen by an Inspector of Medical Colleges.” Frederick C. Zapffe, M.D., Secretary American Medical College Association, Chicago, Ill.

“The Fallacy of Attempting to Teach Pediatrics in the Chair of Practice.” John A. Witherspoon, M.D., Professor Practice of Medicine, Vanderbilt University, Nashville, Tenn.

“The Teaching of Pediatrics in the European Schools.” H. E. McClanahan, M.D., Professor of Pediatrics, University of Medicine, Omaha, Neb.

“The Teaching of Pediatrics in The Medico-Chirurgical College of Philadelphia.” W. C. Hollopeter, M.D., Professor Pediatrics, Medico-Chirurgical College, Philadelphia, Pa.

“The Doctrine of Difficult Dentition.” Theodore J. Elterich, M.D., Diseases of Children, Western University of Penna., Medical Department, Pittsburg, Pa.

“Anatomical Peculiarities of Infants and Children.” Richard B. Gilbert, M.D., Professor Diseases of Children, Louisville University, Louisville, Ky.

“Uncinariasis in the Southern States.” J. Ross Snyder, M.D., Birmingham, Ala.

Paper, Wm. W. Butterworth, M.D., Associate Professor Diseases of Children, Tulane University, New Orleans.

“Some Points on Infants' Clothing.” Alfred C. Cotton, M.D., Professor Diseases of Children, Rush Medical College, Chicago.

Paper, Robert A. Black, M.D., Chicago, Ill.

Paper, Wm. J. Butler, M.D., Chicago, Ill.

Paper, J. W. Van Derslice, M.D., Chicago, Ill.

**PRESENTATION—DR. GEIKIE'S PORTRAIT.**

*To the President and Fellows of The Academy of Medicine, Toronto:*

Gentlemen,—I accept with much pleasure the portrait just presented to me by Dr. Bingham on behalf of the Graduates of Trinity Medical College in such kind and pleasing terms, representing the more than warm feelings entertained towards me personally, by the Graduates of my old College. Fifty-one of the best years of my life were spent as an earnest Medical educationist. Thirty-two of these, from April, 1871, till June, 1903, were specially devoted to the founding—establishing on as firm a foundation as possible—and building up, of Trinity Medical College, with all the energy I possessed, ever keeping in view, and promoting, as far as was in my power, the best interests of every student, who entered the College during that long period.

I therefore appreciate this presentation coming from her graduates very highly. It vividly recalls many past and most pleasing years—years to me of continuous delight in daily meeting my classes. With all my heart I thank every graduate, who has had a share in this presentation, who was as loyal to his College as I was, and who now cherishes as sincerely as I do her glorious memory.

I regard this presentation as a fresh and marked evidence that the hearts of our graduates continue to beat, as my own does, with mingled pleasure and pride, as we think of the magnificent work Trinity Medical College did for Practical Medical Education during the long and useful years of her existence. No wonder that my whole heart was given to promoting and stimulating so great and so grand a work. It is, however, and I think our graduates will all agree with me, very largely, perhaps chiefly, to commemorate the glorious and long continued usefulness of our College, that this presentation is now made. The numerous high positions our graduates occupy where they are practising their profession, and the eminence attained by so many of them, in Canada and elsewhere, bear testimony stronger than any words of mine can do, to the excellence of the professional training they received within her walls.

I may here mention as illustrative of the fact just stated, the well-known names of Professors Alex. H. Ferguson, of Chicago, Teskey and G. A. Bingham, of Toronto, who with many others are eminent surgeons, and did time permit, the names of many others

might be given who are distinguishing themselves in all the various branches of the medical profession in Canada and in other Countries.

It is not surprising, therefore, that with hardly an exception the graduates are as loyal to the memory of their College, and that her name is, and always will be, as dear to them as it is to me. Great and long continued as my work in connection with the College was, the general success of her graduates has always been to me an inspiration and a joy.

In this connection I have only one regret and one wish—the regret is, at my not having done more than I did for my College and for her students. The wish is, that, what I did do, had been done very much better.

A College like ours was worth the labor of many a life, as her teaching was a blessing to the men she taught—a credit to our City and Country and a boon to the public who require and deserve to have the very best and most practically taught medical men we can produce sent out to practise their profession—men who are capable of successfully coping with the frequent and great responsibilities so often met with at the bed side.

While to-night my remarks have necessarily referred to my own College and her graduates only, it goes without saying, that I entertain no feelings other than those of kindness and sympathy, towards all well conducted medical Colleges which now exist, or which may hereafter be established amongst us, and nothing pleases me better than to hear of their full success.

Gentleman, I again thank you for the Portrait and have pleasure in presenting it to the Toronto Academy of Medicine.

WALTER B. GEIKIE.

Toronto, April 7th, 1908.

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## ANNUAL CONVENTION OF CANADIAN HOSPITAL ASSOCIATION.

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The value of fumigation as a means of preventing the spread of disease was somewhat discredited by a paper read by Dr. A. D. MacIntyre, Superintendent of the Kingston General Hospital, at the annual convention of the Canadian Hospital Association, which was held at the Parliament buildings April 20 and 21st. Dr. MacIntyre quoted a number of experiments which had been made at the Kingston Hospital, and, in conclusion, said that he believed more in God's sun and fresh air than anything else. In this remark he

was supported by Miss L. C. Brent, Superintendent of the Toronto Hospital for Sick Children, and President of the Association, who, however, coupled soap and water with sun and fresh air.

Miss L. C. Brent in her Presidential address advocated that the membership of the Association should be extended so as to include trustees of hospitals and other laymen interested in hospital work.

Among those present were:—Dr. W. B. Kendall, Gravenhurst; M. A. Jackson, Chatham; Miss Jessie Duncan, Owen Sound; J. K. M. Gordon, Gravenhurst; Dr. W. J. Dobbie, Weston; Miss E. MacPherson Dickson, Weston; Miss M. G. V. McKnight, Walkerton; Miss N. McLene, Barrie; Miss A. J. Robinson, Galt; M. J. E. Morton, Collingwood; Catherine Lawrence, Sarnia; W. F. Backach, Detroit; Dr. T. Sutton, Detroit; Lila J. MacAdam, Renfrew; Hannah Collingsworth, St. Catharines; H. M. Hurd, Superintendent Johns Hopkins Hospital, Baltimore; H. D. McIntyre, Kingston; Francis Sharpe, Woodstock; Dr. Brown, Superintendent Toronto General Hospital; Dr. Bruce.

Dr. W. J. Dobbie, Superintendent of Toronto Free Hospital and King Edward Sanitarium, Weston, read an interesting paper on tuberculosis as a social problem. As have many other medical men who have dealt with this subject, he pointed out that from 1896 consumption was accountable for 11 per cent. of the deaths in Ontario. The cash loss to the Dominion by the cutting short of the wage-earning ability of victims of the disease, coupled with the cost of treatment, he estimated at \$24,000,000 annually. He urged the importance of the adoption of educational methods to stir up public opinion and suggested that centres of activity should be established in every town and county, and committees appointed to inquire into every branch of the work of establishing and maintaining hospitals. Compulsory notification of cases was also advocated by Dr. Dobbie, and registration after notification.

Dr. Gordon urged also the importance of educating the public in this matter, commencing with the children in the public schools. At present in many gymnasiums, he said, they found overtrained consumptives. Similar views were also expressed by Dr. Kendall. "Unfortunately," he said, "we do not know much about the really poor classes, but we should be careful to prevent the arrival of tubercular immigrants."

Dr. Bruce Smith did not consider that general hospitals were doing all they could in this matter, and he suggested that in connection with them, especially in rural districts, a separate building should be erected for the treatment of tubercular cases. He mentioned also that in future any immigrant showing signs of tuber-

culosis would not be allowed to land. He believed that the Provincial Government would be willing to aid in the carrying out of the suggestion he had made.

Mr. J. Ross Robertson pointed out that the financial position of general hospitals prevented them doing more in the direction indicated by Dr. Bruce Smith. Personally he had to work overtime to get funds for the Hospital for Sick Children. Still if the Government would provide the funds he had no doubt the hospital authorities would be willing to undertake the work. "At present," he said, "sanitariums have empty beds, but no money for maintenance." Too much was being left to private philanthropy, and he thought the Government should grant at least \$100,000 more annually in aid of hospitals.

Dr. Helen MacMurchy read a very practical paper on "The Milk Supply." At the outset she pointed out that Toronto's milk supply was now drawn from many farms far distant from the city. Still the people stuck to the old idea that milk should be delivered early in the morning, acting under the impression that they were getting it thereby direct from the cow with the smallest possible delay. It was impossible to milk cows at 4 o'clock in the morning on farms fifty or a hundred miles away and have it delivered in Toronto in time for an 8 o'clock breakfast. Consequently the milk brought by the early delivery was more or less old, and had been exposed to infection and contamination. Three samples of milk taken at Toronto hospitals at 7 o'clock in the morning showed respectively five million bacteria to the cubic centimetre, eight million and three hundred and eighty-four thousand. Other samples taken at noon showed 14,000 bacteria to the cubic centimetre, six millions, 1,250,000, and three millions. Uncleanliness was, said Dr. MacMurchy, the greatest evil which had to be contended with. In the course of her address, Dr. MacMurchy said that she had no doubt Toronto's milk was adulterated. She herself had seen on the platform of a railway station not a hundred miles away a pile of cases bearing the inscription "coloring matter for dairy purposes."

In the evening the delegates attended a reception held by the President at the Sick Children's Hospital. The Association will meet again, when papers will be read on "Contagious diseases in relation to hospital management," by Dr. Sheard; "Some observations in European psychiatric hospitals," by Dr. C. K. Clarke; "The hospital and the public," by Mr. D. T. Sutton; "A new typhoid hopper," by Dr. H. E. Webster; "The nursing of incurable patients," by Miss M. M. Grey, Superintendent of the Hospital for

Incurables," and "The proper length of study for nurses," by Dr. H. M. Hurd, Superintendent of Johns Hopkins Hospital, Baltimore.

"It is absolutely unavoidable that patients in hospitals should at times contract contagious diseases when in hospitals," said Dr. Charles Sheard, addressing the Canadian Hospital Association at the Parliament buildings yesterday morning. Sometimes by mistaken diagnosis contagious cases were sent to the ordinary wards when they should have been isolated, and vice versa, and frequently patients suffering from a non-contagious disease were hurried to an hospital by a doctor who forgot that they came from an infected house, and were mediums for carrying the disease.

"No Visitors Allowed," was another text taken up by Dr. Sheard. They were, he said, a nuisance, bringing infection into the hospital. A mother might have one child in the hospital and another sick with measles at home. When that mother visited the hospital she was taking tremendous chances of spreading infection.

Miss L. C. Brent, Superintendent of the Children's Hospital, echoed the remarks of Dr. Sheard with regard to visitors, and Mr. J. Ross Robertson said that it had cost the Hospital for Sick Children \$15,000 to deal with infection brought in by visitors.

"The nursing methods of America, and I use the term in its broad sense, are in advance of those of Germany," said Dr. C. R. Clarke, Superintendent of the Toronto Hospital for Insane, in the course of his paper on "European Psychiatric Hospitals." He urged that there should be a closer relation between psychiatric and general hospitals. The training to be gained in a psychiatric clinic would be of great value to the general nurse, while at the same time the psychiatric nurse could not rise to the highest point of her profession without training in medical and surgical nursing. Therefore, when the new Provincial psychiatric clinic was established he urged that there should be the greatest reciprocity between that institution and the general hospitals in regard to affording opportunities to nurses to obtain training.

Dr. H. M. Hurd, Superintendent of the Johns Hopkins Hospital, Baltimore, regretted that general practitioners did not take a greater interest in mental diseases. He congratulated Ontario upon the proposal to establish the new clinic, which would awaken a new interest in this important subject among both nurses and medical men.

Dr. D. C. Meyers thought that few yet realized what a boon to society the establishment of the new clinic would be. He thought,

however, that it would be a mistake to send to that institution all acute nervous cases. He thought that in many cases it would be absolutely wrong to send nervous cases of a certain kind to a hospital for the insane.

Closer relation between the institutions for the insane and the general hospitals was also urged by Dr. Bruce Smith, Provincial Inspector of Prisons. The abandonment of the practice of sending insane persons to prison pending their transfer to hospitals for the insane was, he considered, a distinct advance.

Dr. W. C. Herriman, Mimico, thought it was impossible to draw a hard and fast line. In every nervous clinic cases of insanity would be found.

At the afternoon session exceedingly practical papers were read by Miss M. M. Gray, Superintendent of the Hospital for Incurables, on the nursing of incurables, and Dr. H. M. Hurd, Superintendent of the Johns Hopkins Hospital, Baltimore, on the proper length of the period of study for nurses.

The following officers were elected:—President, Dr. W. J. Dobbie, Weston; First Vice-President, Dr. A. D. MacIntyre, Kingston; Second Vice-President, H. E. Webster, Montreal; Third Vice-President, Miss I. C. Brent, Toronto; Fourth Vice-President, W. W. Kenny, Halifax; Fifth Vice-President, L. L. Cosgrove, Winnipeg; Secretary, Dr. J. N. E. Brown, Toronto; Treasurer, Miss Patton, Toronto.

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### EX-HOUSE SURGEONS GENERAL HOSPITAL FOREGATHER.

The third annual dinner of the ex-House Surgeons' Association of the Toronto General Hospital was held at the King Edward Hotel, Toronto, recently. Dr. Alexander Taylor, Vice-President, occupied the chair in the absence of Dr. W. P. Caven, who was unable to be present. Forty guests from the city and province were in attendance. One of the prominent speakers was Dr. T. B. Futeher, Associate Professor of Medicine in Johns Hopkins University, Baltimore, who is a member of the organization, and was a house surgeon at the "General" in 1893.

In his address Dr. Futeher referred to the "gold-headed cane" carried by eminent doctors of the 17th and 18th centuries as a mark of distinction, and he reviewed the lives of notable members of the medical profession from that day to this, tracing thereby the progress of medical science. Dr. O'Reilly, former Superintendent at the General Hospital, and Mr. P. C. Larkin, Vice-Chairman of

the Board of Trustees, responded to the toast of "Our Guests." Mr. Larkin announced that he would give a prize to the ex-house officer who made the best contribution to medical literature between now and the time of the next meeting.

Among those present were: Dr. J. F. W. Ross, Dr. J. N. E. Brown, Superintendent of the General Hospital; Dr. H. A. Bruce, Dr. C. Trow, Dr. H. Parsons, Dr. Hillary, Aurora; Dr. Chas. Temple, Dr. Edw. Gallie, Dr. T. D. Meikle, Mount Forest; Dr. C. Campbell, Dr. H. Hutchinson, Dr. G. Boyd, Dr. W. B. Hendry, Dr. Taylor, Goderich; Dr. Winnett, Dr. Burrows, Seaforth; Dr. Donald McGillivray, Dr. Fred Rolph, Dr. A. Caulfield, Dr. W. Charlton, Weston; Dr. W. Carswell, Dr. Harris, Dr. Canfield, Dr. J. A. Kinneer, Dr. John Malloch, Dr. A. Davies.

The annual election of officers resulted as follows: President, Dr. A. Taylor, Goderich; Vice-President, Dr. Fred Fenton; Secretary, Dr. J. N. E. Brown; Treasurer, Dr. W. B. Hendry; General Council, Dr. W. J. Charlton, Dr. H. A. Bruce, and Dr. Stanley Ryerson.

Dr. Fatcher conducted a clinic open to the medical profession at the General Hospital.

Dr. J. F. W. Ross presented to the Association a framed picture, showing the Toronto General Hospital as it was 50 years ago and as it is at present.

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### AMERICAN MEDICAL EDITORS' ASSOCIATION.

The annual meeting of this Society will be held at the Auditorium Hotel, Chicago, on May 30th and June 1st. An extensive and interesting programme has been prepared and every member of the Association is urged to be present, and editors of medical magazines, not now affiliated with this Society, are also invited to meet with them.

Do not forget the date, Saturday, May 30th and Monday, June 1st.

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### BRITISH COLUMBIA MEDICAL ASSOCIATION.

The Ninth Annual Meeting of the British Columbia Medical Association will be held in Vancouver on the 20th and 21st of August next, and we should be very pleased to have any members of the profession present from the Eastern Provinces.



A number of papers have been promised, and some interesting discussions are expected, especially on the question of School Hygiene.

The officers of the Association are:— President, Dr. J. M. Pearson, Vancouver, B.C.; Vice-President, Dr. D. Corsan, Fernie; Treasurer, Dr. J. D. Helmcken, Victoria; Secretary, Dr. R. Eden Walker, New Westminster, B. C.

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Hot bricks or stones retain their heat much longer than hot water bags.

Persistent suppuration in a mastoid wound in most cases, means dead bone at the bottom of the cavity.

An opaque growth on the eyeball in a child is likely to be a dermoid growth—that is a growth of skin epithelium on the conjunctiva.

A sty is often most easily treated by the removal of the hair in the infected follicle and the subsequent application of iced boracic acid compresses.

Syphilitic interstitial orchitis resembles closely in appearance new growth of the testicle. Unless the diagnosis of neoplasm is beyond all doubt, an active course of specific treatment should be tried before removing the organ.

AN abscess of the right ovary may give the same signs and symptoms as acute fulminating appendicitis. If an incision for appendicetomy is made, it should be of sufficient length and low enough down to allow of careful examination of the right adnexa.—  
*American Journal of Surgery.*

## Physician's Library.

*Cosmetic Surgery: The Correction of Featural Imperfections.* By CHARLES C. MILLER, M.D. Second Edition Enlarged. Including the description of numerous operations for improving the appearance of the face. 160 pages. 96 illustrations. Prepaid \$1.50. Published by the author, 70 State St., Chicago.

That a second edition of this little book has been called for in so short a space of time, shows that it has been received with encouragement. The little book is profusely illustrated for an effort of its size and scope. No doubt it fills a niche of its own in the minor realms of surgery, which has to do with the corrections of featural defects.

*International Clinics.* Volume I, Eighteenth Series, 1908.

This admirable and well-received quarterly by the profession, starts 1908 exceedingly well. There is a splendid article on the Sanatorium, by Dr. L. Brown, of Saranac Lake, quite appropriate at this time when the sanatorial treatment of tuberculosis is so much to the fore; another of equally good production on the opsonic test for diagnosis and of the employment of vaccines in certain infective conditions in children. Two in the department of medicine, the para-typhoid fevers and mucous colitis, are educating, and one by Dr. Rudolf, of Toronto, decidedly interesting—the normal temperature of the body. Several articles on surgery, gynecology, neurology and pathology, with a concise, up-to-date review of medicine in 1907, completes a good volume.

*Diseases of the Nose and Throat.* By HERBERT TILLEY, B.S. (Lond), F.R.C.S. (Eng.), surgeon to the Ear and Throat Department, University College Hospital; teacher of Laryngology and Otology, University of London; formerly surgeon to the Golden Square Throat Hospital, London. Third Edition; with one hundred and twenty-six illustrations. Price, 14 shillings. London: H. K. Lewis, 136 Gower St., W.C., 1908.

This third edition of what was formerly known as Hall and Tilley's Diseases of Nose and Throat, has been prepared by Mr.

Tilley alone, along the lines of the two former editions. The author has, we think, wisely refrained from entering upon a lengthy description of the anatomy of the parts under discussion, contenting himself with a very brief and very-much-to-the-point resume of these details. For the rest we can only say the work is thoroughly complete and up-to-date as far as it goes, but we are inclined to think that the time honored rule of associating only disease of nose and throat together, should give way to the association of diseases of nose, throat and ear, since in every day practice they are so often associated. The text and illustrations are very clear and probably above the average of those met with in similar works.

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*Wellcome's Photographic Exposure Record and Diary, 1908.*

Wellcome's Photographic Exposure Record and Diary banishes the greatest obstacle to success in photography—that of correctly estimating exposure. The actual determination of correct exposure is made by means of an ingenious little mechanical calculator attached to the cover of the book. A single turn of a single scale is all that is necessary. This little instrument with its accompanying tables giving the value of the light at all times of the day and year, and its list of the relative speeds of more than 180 plates and films, is alone worth more than the cost of the whole book. It certainly saves dozens of plates which would otherwise be wasted owing to errors in exposure.

This calculator is, however, but part of the book, which contains a full article explaining all the conditions governing exposure, with special illustrations and tables for interior work, for telephotography, for copying, enlarging and reducing, for moving objects, for night photography, and for printing by artificial light. In addition, there are tables of weights and measures—imperial and metric—notes on focussing by scale, customs regulations, a temperature chart, a full article on development, and directions for toning, intensification, reduction and similar photographic operations, by the simplest and most satisfactory methods available.

Bound up with these printed pages of condensed photographic information is a complete diary for 1908, together with ruled pages for systematically recording the details of over 300 exposures; also pages for memoranda, and for recording the exposures when printing on bromide, platinotype, carbon and other printing papers.

The book is enclosed in a neat wallet cover, lettered in gold, and fitted with a pencil and a pocket for storing proofs, etc. A new and important feature of the 1908 edition is, that it entitles purchasers to a hanging card for the dark room, giving the relative exposures required when using any one of 84 varieties of bromide paper or lantern slides.

The addition of a handy table for calculating exposures in photography at night is another new and useful feature. Price in Montreal, 30 cents.

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*Bier's Hyperemic Treatment* in Surgery, Medicine, and all the Specialties: A Manual of Its Practical Application. BY WILLY MEYER, M.D., Professor of Surgery at the New York Post-Graduate Medical School and Hospital; and Professor Dr. VICTOR SCHMIEDEN, Assistant to Professor Bier at Berlin University, Germany. Octavo of 209 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1908. Cloth, \$3.00 net. Canadian Agents: J. A. Carveth & Co., Ltd., Toronto.

The medical profession will be glad to hear this book has been issued, as they are daily more and more interesting themselves in the Bier treatment, in medicine, surgery, and specialties. As the American author, one of the country's well-known surgeons, has been interested in, and has employed, this treatment ever since its introduction into America, fifteen years ago, his practical results will carry with them a good measure of weight. It apparently seems there is a wide field for the employment of the treatment; so the book, as a pioneer, will be heartily received. From the standpoint of the bookmaker's art, it is a high-class production.

# The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

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

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

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

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

The annual fee is only \$3.00 at present, payable in January of each year.

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

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

## EXECUTIVE.

President—R. W. POWELL, M.D., Ottawa.

Vice-President—J. O. CAMARIND, M.D., Sherbrooke.

Secretary-Treasurer—J. F. ARGUE, M.D., Ottawa.

## SOLICITOR,

F. H. CHRYSLER, K.C., Ottawa.

Send fees to the Secretary-Treasurer by Express Order, Money Order, Postal Note or Registered letter. If cheques are sent please add commission.

## PROVINCIAL EXECUTIVES.

ONTARIO—E. E. King, Toronto; I. Olmsted, Hamilton; D. H. Arnott, London; J. C. Connell, Kingston; J. D. Courtenay, Ottawa.

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BRITISH COLUMBIA—S. J. Tunstall, Vancouver; O. M. Jones, Victoria; Dr. King, Cranbrooke.

# Dominion Medical Monthly

And Ontario Medical Journal

EDITORS:

GRAHAM CHAMBERS, B.A., M.B.      WALTER McKEOWN, B.A., M.D.

ASSOCIATE EDITOR:

T. B. RICHARDSON, M.D.

MANAGING EDITOR:

GEORGE ELLIOTT, M.D.

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## COMMENT FROM MONTH TO MONTH.

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**William S. England, M.D.C.M.**, McGill University, died suddenly at his home in Winnipeg, Manitoba, on the morning of the 24th of April, the cause of death being cerebral haemorrhage. He was forty years of age. Dr. England matriculated at McGill in 1885 and received his degree with high honors in 1889. After a year, as house-surgeon in the Montreal General Hospital, he located in Winnipeg, where he soon advanced to the front ranks and became one of the leading surgeons of the West. At the time of his death he was Professor of Anatomy in Manitoba Medical College, Chief Surgeon to the Winnipeg General Hospital, as well as being Consulting Surgeon to St. Boniface Hospital of the same city. The late Dr. England was a man of first-class attainment, thorough in his work, and of a quiet, unassuming demeanour. He was a member of the Canadian Medical Association and took a deep and genuine interest in its welfare. We deeply deplore his untimely demise and desire to express our sincere sympathy to his widow, his brother, Dr. Frank R. England, Montreal, as well as to the institutions he was connected with.

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**The Opportunity of Fraternal Societies to Co-operate in the Campaign Against Tuberculosis** is not being neglected. The Canadian Fraternal Congress recently met in Toronto, and it

was brought out that something has already been done in this direction. Strong resolutions were passed, calling upon governmental authorities to be up and doing, and it was particularly emphasized that the importance of a leader should not be overlooked nor any longer delayed. That is to say, the campaign against disease in all its various forms, which could be prevented, demanded recognition from Governments in the way of Departments of Public Health, for without a head no material or direct progress could be secured.

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**Newspaper Propaganda in the Local Press** was suggested by one member of the medical section of the recent meeting of the Fraternal Congress, under the supervision of the Provincial Government, which should set aside funds for the purpose: That practitioners should report cases to local medical health officers, not necessarily for the purpose of placarding houses or for the means of directing people to give tuberculosis cases a wide berth, but for the purpose of educating the immediate family as to what they should do and when they should do it.

The suggestion appears to us a good one and would be a strong factor in any plan of campaign. In most homes is to be found the weekly country newspaper, and if a part of the front page of this were bought by the Government, the constancy and regularity of authorized essays or instructions would soon appeal to the readers thereof.

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**The Appointment of a Travelling Medical Secretary on the Part of the National Association for the Prevention of Tuberculosis** is a wise move. In many places where branch associations of the parent organization were instituted they have been allowed to die of dry rot. Already all over the country there are live, active organizations, and a great many physicians are interested in them. These fraternal societies have many lodges in the cities, towns and villages of Canada. All of them have doctors connected with them who would no doubt interest himself sufficiently to create a wholesome, intelligent and enthusiastic interest in the campaign to be waged. Without enthusiasm in any work not much will be accomplished. The army of tubercular germs to be fought is a stupendous one, and it will take the entire forces of human kind to compass its defeat. All that a portion of human kind will accomplish will simply stay its ravages.

**To Educate School Children** from the beginning of their school lives seems to be proper and right, in matters of sanitary science. Indeed, we have long ago pointed out that physiology should be abolished in connection where it is taught in ordinary school curricula, and sanitary science substituted. Good results will only accrue in years to come when the children are brought up to the right principles of hygiene. All this emphasizes the importance of leadership. Leadership means governmental departments of health.

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**Were Confederation** again to be inaugurated a Minister of Health would be, as he should be, one of the very first of the Ministers to be chosen. A Minister of Health should walk hand in hand with a Minister of Finance. He is of far more importance than a Minister of Justice or any subordinate Minister. If, in a given household, a member is to die, say of tuberculosis, the head of that household would willingly give up all his financial increment for the health of the individual threatened with destruction. If health in a household is of more importance than finances, in the unit of society, the home, is it not of just as much value in the congregation of households, the state? Given good health and finances to all, the importance of a Department of Justice is greatly diminished. Give the people good health and finances, and crime will diminish.

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**Anything New in Appendicitis is Always Interesting.**—Now it is discovered that our method of defecation is the cause. A short time ago the introduction of steel rollers for the milling of flour, and the small particles of steel which got into the flour, and in process of time got into the appendix, with resultant irritation and inflammation, was cited as the cause. This is scouted, however, by the new aspirant to appendicitis fame. We are taken to India and are told how they do it in India—and the new suggestion as to cause may have a measure of truth in it, as it seems to be well-established that in India there is very little appendicitis. There are said to be two factors at work in India, namely, the free purgation for everyone with anything and the posture assumed in defecation. To appreciate the latter, the method of defecating by the native needs to be described. Here is the description in the words of *The Lancet*: "The native gathers up the fringes of his cloth into a ball and presses it upon the ilio-hypogastric region. He then squats down, the right foot pressed firmly on the ground



and the right thigh pressing firmly on the right ilio-hypogastric region. The left foot is placed behind, resting on the toes, so that the left thigh forms a large angle with the left abdominal wall. In this attitude the cecum is well compressed, the regurgitation of faeces or gas from the bowel prevented, and a stimulus to downward peristalsis is kept up; thus the cecum is thoroughly emptied and the contents are driven lower. Then the native changes so that the position of the lower limbs is reversed, the left thigh being sharply flexed and the right thigh extended; in this way the lower bowel is emptied." If there is any weight to this theory—and we have heard of it before in connection with hernia, that the sitting rather than the squatting posture favored hernia—then, another field opens itself up for preventive medicine. The sitting urinal will have to be abolished, and one to facilitate squatting, as they do it in India, substituted.

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**The Splendid Programme the Committee on Papers of the Ontario Medical Association**, which meets in Hamilton on May 26th, 27th and 28th, reflects a great deal of credit on the energy and ability of the Committee to provide a programme rarely excelled in medical society work in Canada. We printed this programme and other particulars in our March issue. The scientific side promises so well that it will be difficult to equal it in coming years. Then the Entertainment Committee has not allowed themselves to be outshone by the other aggregation. The entertainments of the social side are going to be of a high order. The two combined cannot afford to be missed by anyone. Remember in purchasing a single first-class ticket to Hamilton to ask the ticket agent for a Standard Convention Certificate, and as soon as you get to the meeting and register, your next duty is to hand that certificate to the General Secretary who will do the rest.

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**The Provisional Programme of the Coming Forty-first Annual Meeting of the Canadian Medical Association** will be sent out early in May in the General Secretary's annual circular. Keep the dates in mind, 9th, 10th and 11th of June.

## News Items.

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WEST Toronto is to have a new hospital in the near future.

NORTH Vancouver is to have a new hospital to cost \$10,000 and accommodate 12 patients.

THE British Columbia Government has granted \$15,000 to the Royal Jubilee Hospital, Victoria, for the current hospital year.

THE death is announced of Dr. James Stephenson, of Iroquois, Ont., at the age of 73 years. At one time he enjoyed one of the largest practices in Eastern Ontario.

WINNIPEG City Council, believing it would be acting outside its powers, has refused to submit a by-law for \$225,000 for the purposes of the Winnipeg General Hospital.

LT.-COL J. T. FOTHERINGHAM, M.D., Toronto, will represent the Canadian Army Medical Corps at the Navy, Army and Ambulance section of the British Medical Association in Sheffield, England, in July.

DR. MCNEILL, of Prince Edward Island, was recently proceeded against under the Prohibition Act, for writing prescriptions for alcohol alleged to be for other than medicinal purposes. This is the first case of its kind ever before the Canadian Courts.

THE new University of Alberta has been organized, the seat of same to be at Edmonton. Prof. H. M. Tory, LL.D., formerly of McGill, is the President. Work will be commenced in September with forty students. There will be a course in arts and one in applied science.

DR. R. TAIT MCKENZIE, Director of Physical Education at the University of Pennsylvania, has an exhibition of statuettes, bas-reliefs and medals in bronze in the Art Gallery in Montreal. This same work has been exhibited in most of the large cities of the United States and in Europe.

## Publishers' Department

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**INFECTIOUS DISEASES.**—As the kidneys are the most active channel of elimination, not only of leucomaines and ptomaines, but also the micro-organisms of infectious and other diseases, it is specially important that elimination be constantly favored by the administration of a soothing and healing diuretic resolvent. This indication is met by administering sanmetto in teaspoonful doses four times a day. This explains why this remedy is so valuable as adjuvant treatment in la grippe, scarlet fever, gonorrhoea and other diseases.

**INSTEAD OF MORPHIA OR OPIUM.**—We meet with many cases in practice suffering intensely from pain, where because of an idiosyncrasy or some other reason it is not advisable to give morphine or opium by the mouth, or morphine hypodermically, but frequently these very cases take kindly to codeia, and when assisted by antikamnia its action is all that could be desired. In the grinding pains which precede and follow labor, and the uterine contractions which often lead to abortion, in tic douloureux, brachialgia, cardialgia, gastralgia, hepatalgia, nephralgia and dysmenorrhoea, immediate relief is afforded by the use of this combination, and the relief is not merely temporary and palliative but in very many cases curative. The most available form in which to exhibit these remedies is in antikamnia and codeine tablets. The physician cannot be too careful in the selection of the kind of codeia he administers. The manufacturers of antikamnia and codeine tablets guarantee the purity of every grain of codeia which enters into their tablets. This not only prevents habit and the consequent irritation which follows the use of impure codeia, but it does away with constipation or any other untoward effect.

**THE NECESSITY FOR HEMATICS AFTER MISCARRIAGES.**—The more one studies the pathological conditions which follow premature expulsion of a fetus, the more evident it becomes that changes and complications which result from such unnatural termination of a natural process, are little appreciated. There can be little wonder, therefore, that abortions and miscarriages so often give rise to countless female ills, and so frequently lead to lives of more or less chronic invalidism.

Take, for instance, the average case. The whole female organism, as soon as conception takes place, makes preparations to