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MONTREAL

A Monthly Journal of Medicine and Surgery.

EDITOR

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CANADA

MEDICAL RECORD

APRIL, 1903.

Original Communications.

THE MEDICAL EXAMINATION OF CHILDREN.

*A Clinical Lecture delivered at the Montreal General Hospital
14th January 1903.*

By FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P., Lond., D.C.L.

Professor of Medicine in, and Dean of the Medical Faculty, University of
Bishop's College.

GENTLEMEN,—The clinical examination of infants and young children is full of difficulty to the inexperienced. It has to be carried out, not merely without the help of the patient, but often in spite of his strenuous opposition. In a brief manner I propose to tell you of the best methods of ascertaining the necessary facts and also the chief points in which the child differs, in a clinical sense, from the adult. From the mother or friends you must get the history of the patient and his illness, and to that end the following questions should be put:—

1. How many other children are there?
2. Any dead, and of what?
3. Where does the patient come in the family?
4. Have there been any miscarriages? If so, when?
5. Health of father's and mother's family?
6. Mother's health during pregnancy?
7. Was this a full time child?

8. Was the labour normal ?
9. Was the child breast fed ? If so, how long ?
10. If not, how was it fed ?
11. What food does it get now ?
12. Had it any rash after birth, or the snuffles ?
13. When did it begin to teeth and to walk ?
14. What is the usual state of digestion and bowels ?
15. Inquire regarding previous illnesses, such as fits (number and dates), attacks of diarrhœa, vomiting, sore throat, bronchitis ; infectious diseases (scarlatina, measles, whooping cough, chicken-pox), when they occurred ?
16. Any discharge from the ears ?

If the child has a cough, enquire if it ever whoops, when the attacks are worst, and if the cough is ever followed by vomiting.

While getting this history, opportunity should be taken to cultivate friendship with the child. You then should proceed to examine the little patient. This requires gentleness combined with infinite patience and good temper. If you, hurry or be rough the child at once begins to cry, and your subsequent work is rendered a thousandfold more difficult, if not impossible. It is almost out of question to be systematic. In the first place, before the child is undressed a number of points can be ascertained. We can study the features, note its complexion, colour of its lips, and whether the *ali nasi* are acting. At this period of the examination count the respiration and pulse. It is very important to get these noted while the child is still undisturbed.

The respirations can be counted by watching the movements of the child's abdomen, that being much more affected by respiration in young children than is the chest. The normal rate of a new born child is about 40 per minute. During the first year they decrease slowly, till at the second year they stand at 30. At the fifth year 25 is about the number. A much more important point is the ratio of respiration to pulse. Normally this should be as 1 to $3\frac{1}{2}$ or 4.

The pulse is best counted by allowing the mother to

hold the child's hands in hers; the fingers of the medical man are then quietly slipped over the mother's hand on to the child's wrist, and the pulse counted. If the child begins to cry and wriggle it is useless to continue the attempt, for the pulse will soon rise twenty or more beats. At birth the pulse rate is about 130. By the second year it has fallen to 110, by the fifth year to about 100. It then falls year by year till the age of 12, when it is 80. As a matter of fact the pulse of a young child is of comparatively little clinical value. The vessels being very small, the characters of the pulse wave can hardly be ascertained. Irregularity is very common and has little significance. In sleep it is almost the rule, but a pulse which is continuously *slow* and irregular is, however, of great significance. During sleep an infant's pulse always falls from 10 to 20 beats.

These preliminary facts having been noted, the child should be undressed and placed in a blanket on the knee of its mother. Examination must then be proceeded with by the usual methods of inspection—palpation, auscultation and percussion. In the clinical investigation of children the two former methods are of much the greatest assistance. Begin by looking and feeling the child all over; the latter must be done gently and cautiously or the child might get frightened and further investigation will be, in many ways, absolutely impossible. If he shows marked timidity keep him covered with the blanket, show him your watch, let him take it in his hands, and get him to place it to his ear; let him pull at your watch-chain. You will soon make friends and your further work will be reasonably easy of accomplishment. As to how you should act when you begin practice on your own account. To a large extent, children will be your patients; from the outset make friends of them, even the youngest. Never let the mother when they deserve correction threaten to send for the doctor to give them a dose of nasty medicine. I have known hundreds of mothers do this and thus render most difficult the work of the physician. Note the general state of development and nutrition, the

state of the skin, whether hot, dry or moist; the presence or absence of any rash or skin eruptions; the shape of the chest and the degree of abdominal prominence. It must be borne in mind that pigeon-breasted chests are very common in diseased children. A protuberant abdomen is regarded as normal. Pass the hand over the head; first investigate the state of the *anterior fontanelle*. This closes normally between the fifteenth and twenty-fourth month. If it remains open after the second year, it is often a sign of disease, most usually of rickets. Too early closing of the fontanelle occurs in some forms of microcephaly and idiocy. The degree of tension of the fontanelle is of much importance. In health it pulsates distinctly and is on about the level of the bones, neither shrunken nor unduly elevated. When we find a depressed fontanelle it is a sign of exhaustion; a tense fontanelle indicates increased intracranial pressure. It must, however, always be borne in mind that a crying child has a tense fontanelle. If you place your ear over the fontanelle, a systolic bruit is heard, but it is of no clinical importance. Investigate the shape of the head. Nodes on the frontal and parietal bones is a common occurrence in rickets, especially in syphilitic children. We ought also in infants to look for craniotabes (thinning of the bones of the skull) and in older children for rheumatic nodules. The general shape of the head must be noted. In rickets it is box-shaped, in hydrocephalus it is globular. It may be abnormally large or small or asymmetrical. In children, it is of great importance to examine the long bones, as many of the commonest and most serious diseases of infancy affect these bones more prominently than any other part of the body. Look for thickening or tenderness along the shafts of the body. This may be due to the following causes: scurvy, syphilis, suppurative periostitis or to tumours. Examine carefully the *epiphyses*. In rickets they become enlarged. This is most easily seen where the ribs join their cartilages, the thickening there forming a bead-like row of prominences called rickety rosary. It is also easily seen at the wrists.

Bear in mind also the frequency of inflammatory affections at the epiphyses ; note the presence or absence of "rheumatic nodules." These are little fibrous bodies, the size of a large pin-head to a pea, sometimes larger, and are not met with in the periosteum, but in the deep fascia, where it covers superficial bones, and in the sheaths of tendons. They are especially common over the olecranon and patella. Generally they are movable, but are not tender. If found, they are pathognomonic of rheumatism. The vertebral column should always be examined for curvature or tubercular disease. Now proceed to take the child's temperature. It is recommended in very young children to take it in the rectum. Personally I have not found this method advisable, and for years have not used it except in very young infants. I generally use a half-minute thermometer, and though it may occasionally be difficult, I generally have not found much difficulty in taking the temperature either in the groin or axilla. In older children it can be taken in the mouth. Remember that temperature in children is much more variable than in adults ; very slight provocation sends it up.

Now make examination of the anterior thorax and abdomen. Adopt the following order:—1st. Inspection and palpation ; 2nd. Auscultation ; 3rd. Percussion. This is left to the last as it frequently frightens the child, and makes him cry, even although up to this point you have had him quiet.

In palpation be sure that the hand is quite warm. In auscultation use either the immediate method, i.e., the ear being applied directly to the skin with a towel or handkerchief between. This method I have often explained to you and have taught you to use it. Occasionally you will be able to use a bin-aural stethoscope. It will enable you to follow the movements of the child. As regards percussion, there is one point to note and it is important. The stroke must be light. This is not simply to avoid frightening the child, but also to escape the confusion which is apt to

arise from the excessive resonance of the child's chest. Now proceed to examine the posterior part of the chest; for this the child should be held against the mother's chest with his head looking over her shoulder. In this way the whole of the back of the chest can be easily examined. Last, but by no means least, comes the examination of the mouth and throat. It is impossible to exaggerate the importance of examining systematically the mouth and throat of all sick children. It is left to the last because it is here we are almost certain to meet with opposition. It may be necessary to use coercion in order to get it carried out. Commence by looking at the tongue. Sometimes the child will put it out when asked. It is a good plan to commence early to get mothers to educate their children to put out their tongue when asked. In very young children gentle pressure on the chin will often cause the mouth to be opened, when a view of the tongue can be obtained; or place a drop of cream or a little sugar just outside the lips; the child will often put out its tongue to lick it off. In more refractory children it may be necessary to put the lower lip over the teeth and then press it down. Often the child will open its mouth so as to avoid having its lip cut. Sometimes, however, even this will fail, and you should not push the matter further; now you should try forcing it open at the side with the handle of a tooth brush wrapped around with a portion of a small handkerchief, or you may compress the nostrils until the mouth is opened to get breath. Once you get an insight into the mouth note the state of the bucal mucous membrane, remembering that thrush, stomatitis and ulcerations are common in children. Note the number and character of the teeth, run the fingers along the gum so as to ascertain if there are any about ready to come through. If you can also use your eyes for the same purpose, you should do so. If there are, I would bear this fact in mind and assist them through.

Now proceed to examine the throat. The child should be wrapped in a good sized towel to restrain the movements

of the arms ; another should envelop the legs. This latter is not alluded to by authorities or writers, but a large experience makes me think it a necessity. The mother or person in charge must sit down opposite a good light with the child on her lap, an assistant steadies the child's head from behind. It must then be induced or compelled to open its mouth. The latter, most likely, will be your course, for the pinioning which has been going on is not calculated to put it in a mood for persuasion. At once introduce into the mouth a small sized tongue depressor and hold down the tongue, thus exposing the pharynx. Very often a finger may be used to depress the tongue ; try it, for it frightens the child less. Look for enlarged tonsils, redness of the mucous membrane, or any membranous patches on it. In many cases it will be necessary to make palpation of the pharynx. To do this you must stand behind the child ; when its mouth is open push in the cheek of one side between the molar teeth. This serves as a gag and prevents biting of your finger. Pass the forefinger to the back of the pharynx and up behind the soft palate ; note the presence of any adenoids or any bulging into the posterior wall of the pharynx, which may be indication of the presence of a retro-pharyngeal abscess.

This is the general routine followed in examining a child. There are some special points to which I will now draw your attention.

1. *General condition.*—The child should be regularly weighed. Alterations in weight from time to time are useful in prognosis and treatment. The average weight of an infant at birth is about seven pounds. By the fifth month this should be doubled, and trebled by the first year. By the sixth year it should again be doubled, so that a healthy child at that period ought to weigh forty-two pounds. At the fourteenth year this is again doubled.

Measurement of the head is often of importance. Two measurements are generally made : a coronal measurement from one auditory meatus to the other and a circumferential

measurement at the level of the root of the nose and the external occipital protuberance. The circumference of the head at nine months should be about seventeen inches, at twelve months about nineteen inches, at twenty years, twenty to twenty-one inches ; after these years a circumference of nineteen inches is too small.

Alimentary system.—The liver is normally large in children, and usually reaches at least half an inch below the costal margin. The spleen is frequently enlarged in infantile diseases. It is best made out by palpation, the hand being passed across the abdomen from right to left. By depressing the finger tips opposite the eleventh interspace, the edge of the spleen, if it be enlarged, may be felt, as it descends during inspiration.

Inspection of the *stools* should never be omitted. A healthy infant on the breast or bottle only has about three stools daily and they should be of the colour and consistence of beaten up-eggs. Any alteration in frequency, colour or consistence should be carefully noted. A stool like putty shows intestinal indigestion. A green stool will follow colic. It is called the chopped spinach stool.

Circulatory system.—The apex beat is higher than in the adult. Usually it is in the fourth intercostal space just outside the mammary line. The general contour of the *præcordia* is often altered in children after heart disease, more so than in adults. The pulmonary second sound in a young child is normally somewhat louder than the aortic, and if permanently louder is accentuated. The aortic second is accentuated, if it be as loud as the pulmonary. Remember that hæmic bruits are rare in young children, while congenital bruits are very common. The cardiac rhythm is, even in health, irregular.

If you desire to examine the blood of a child it can easily be obtained by twisting a piece of woollen thread round the thumb, not too tightly, and then with a triangular needle puncture at the root of the nail.

In respiration, a child uses its diaphragm much more

than its intercostals in breathing. There is very little chest expansion, the movements being principally abdominal. Watch for any indrawing of the lower interspaces on inspiration. This occurs where there is obstruction to the entrance of air as in pharyngeal obstruction in diphtheria; also where there is collapse of the lower parts of the lungs, and in pneumonia. In the adult the normal cycle of respiration is inspiration, expiration; pause. In the child this is often reversed, so that one gets, first, a short respiration, succeeded by a longer inspiration, and then by a pause. This reversal is especially frequent in respiratory disease or embarrassment. The respiratory pauses are often very prolonged, so that one has to wait a long time, if you are auscultating, before the next inspiration is heard. In an infant about six months the normal breath sound is puerile in type, that is, somewhat exaggerated. Vocal resonance is often difficult to estimate. In babies one may make use of the cry as a producer of vocal resonance. If children are older you may attain the same object by getting them to state their name. It should be remembered that, as a general rule, if the breath sounds are more harsh on one side than on the other, the harsher side is most likely the normal one. Children's chests conduct sounds very readily. Hence abnormal sounds, especially crepitations, are very apt to be heard on both sides while, as a matter of fact, they are only produced on one. In percussing the lungs in children, a very light stroke must be used; also only percuss when the chest has been filled by an inspiration, otherwise we may be led to thinking that there is dulness present. Remember also that the chest wall of a young child is so elastic that one can often obtain the "cracked pot" sound on heavy percussion even although the lung is perfectly healthy. This is especially apt to occur if the child is crying.

Urinary system.—It is impossible, or well nigh so, to collect the total quantity of urine passed by a child *per diem*. It is estimated that during the first twenty-four hours two ounces; during the second day, three ounces; on the

sixth day, eight ounces, at two months it has reached thirteen ounces, at six months, to sixteen ounces, at two years to twenty ounces. After the age of fifteen years has been reached, the quantity passed is about up to the adult standard, viz., 45 to 50 ounces. Sugar is rarely present in the urine of young children, but even in healthy babies albumin is often met with.

The *nervous* system of a young child is always in a condition of exaltation. No matter under what circumstances you are called upon to examine him, bear this fact always in mind. Motor paralysis can be made out by watching whether the child ever moves the suspected limb. One cannot estimate the paralysis as one does in adults by means of passive resistance. Remember that inability to walk is not necessarily a sign of paralysis of the legs. One must note whether the legs are moved when the child is sitting or lying. Thus a rickety child may not be able to walk, but it moves the legs freely if you tickle the soles. A child with infantile paralysis of the legs cannot move the limbs under any circumstances.

The knee jerks in young children are best elicited by placing the child's foot on one's hand, as a stirrup, and then gradually percussing the tendon. This lies rather to the outer side in a child. It is comparatively narrow, so is easily missed. The superficial reflexes are usually more brisk in healthy children than in adults. The exact location of *sensory* paralysis is extremely difficult in children, but sensory lesions are rarely met with in young children.

In examining the eyes of young children with the ophthalmoscope, it should be done with the child lying on its back; a lamp should be held alongside of the head, but at a slightly lower level. It may become necessary to open the lids, but as far as possible avoid doing so. As a rule, we will have to rest satisfied with fleeting glimpses of the disc. In testing light perception in children it is best to hold a candle or lamp in front of the eyes and notice if they attempt to follow its movements. One may also threaten

the cornea by suddenly bringing the fingers near it and observing whether the child winks before it is touched.

In examining the ears remember the shortness of the auditory meatus in a child, and the great obliquity of the drum membrane. The magnification of the view by means of the ophthalmoscopic lens is a useful aid in these cases. It is always a difficult matter to gauge the intellectual capacity of a young child. Early signs of idiotcy are—inability to support the head—which often rolls about helplessly, causeless screaming, not taking any notice of surrounding objects, or staring listlessly at them, backwardness in taking hold of objects. In older children this task is more easily performed; note its progress at school; get it to count and multiply. Books tell us that the position of a child at school is a rough guide to its intelligence; I admit it—it is a rough but not, in my opinion, a correct guide. Intellect will, I think, bear to be called a comparative quality. At certain ages it is precocious—a bad sign—for if pressed it is soon snuffed out and exists no more, its frail medium having passed to the great majority. On the contrary we find that those who learn slowly, learn wisely and live to evolve from their slowly developed brain, problems in business and finance which have made them masters in their world. We are, in a recent work, told that a child remains in the infant school until he is seven years of age, after which he enters the standards—eight different standards being arranged—extending from the seventh to the fourteenth year. In my opinion it is as outrageous to send a child to school before it is seven years as it is to put a child ten years of age to work in a manufactory. Again, gentlemen, let me proclaim and if, after thought, you endorse my views you also proclaim it—that a child's study should alone be embraced within the the school hours. I would not have a child open a book after it left the school-room—no home studies. The hours now devoted to them should be passed in play and reading of books of travel, thus developing the body and with continued health, the brain will be supplied with

healthy blood and later be prepared to receive and retain with ease problems which, earlier, would be impossible. The education of to-day is too high in its pressure; even medical education is joining in the procession. Female education is being pushed to the extreme, to such an extreme that I fear the legitimate function of women, the procreation of the race, is forgotten, for it does not tend to produce women fit to be mothers. This, however, is a digression, but not foreign to the subject of my lecture. In the mad rush of the present day, there is high pressure everywhere; education has not escaped being smitten and drawn into the vortex. At the moment it is in a whirlpool—some there be who think that escape seems well nigh impossible; yet a possible escape is seen, I am sure, by a few. They are struggling, valiantly struggling, to get beyond the current which is slowly, I believe, sending them to educational perdition. I hope they may reach the shore. If they do, a new era of education will be evolved; old measures will be revived, and the human race saved from the fate which, at this moment, would seem to be impending.

LIGHT AS A THERAPEUTIC AGENT.

By **W. H. DALPE, B.A., M.D.**

Being a series of three lectures delivered to the students of the Class in Pharmacology and Therapeutics, University of Bishop's College, Faculty of Medicine, Montreal, March, 1903.

LECTURE II.

THE ARC-LAMPS.

To-day, gentlemen, I purpose considering with you the ordinary form of radiant energy generated by the arc-lamp as used by Professor Finsen, and, if we have time, also a few of the many modified forms of this instrument which are now used everywhere for the same purpose.

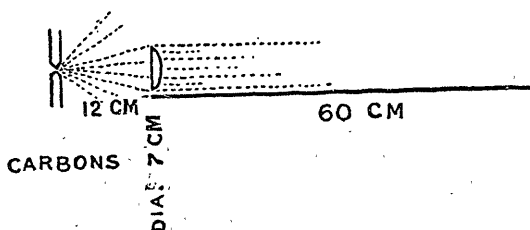
The Finsen apparatus consists of a voltaic arc-lamp actuated by a continuous current, I mean non-alternating, of

about 60-80 ampères (the ordinary street lamps consuming about 8-10 ampères only) and having a voltage of 45-50.

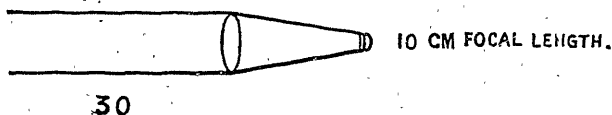
Around this lamp, on a metallic circle, four *light-accumulators* are fixed in such a way as to converge towards the source of radiant energy, these accumulators being provided with sets of screws by means of which their disposition may be altered at will.

Each of these accumulators is made up of two tubes fitting one on the other and capable of a gliding movement as a telescope, the upper and outer being about 60 cm in length.

At the upper end of this tube, which is exactly 12 cm from the arc-lamp, there are a system of lenses, two in all, with a focal length of exactly 12 cm, so that these lenses can collect the divergent rays and give them a parallel direction down the cavity of the accumulators.



At the lower end two small plano-convex lenses are arranged in such a way as to form a converging lens with a focal length of 10 cm from the lower one.



The space contained between these two lenses is filled with distilled water for the purpose of causing the absorption of the infra-red rays, while outside of this there is a

metallic case whose cavity is fitted with afferent and efferent canulae through which a stream of cold water is kept in circulation; the evident purpose of this cold stream of water is to cool the distilled water in the lens cavity itself.

On the other hand, this series of lenses is made of rock crystal, which has the faculty of gathering in the ultra-violet rays which are the most useful for the treatment of diseases. Instead of pure distilled water in the compound lens at the lower end of the accumulator, a blue-coloured solution would (theoretically) have eliminated the caloric rays found in the visible spectrum, but would have had the disadvantage of making us lose the usefulness of the rock crystal lenses, in that all radiations inferior to 300μ (violet rays being from 392μ downwards) would have been absorbed and thus have been of no utility.

We have already spoken about the focal length of the compound lens at the lower end of the accumulator; this must be constantly kept in mind when placing your patient in the proper attitude for treatment. The part to be treated must be exactly 10 cm from the inferior surface of this lens and in such a way that the light will fall as nearly as possible at right angles to the sore. The distance is regulated by the telescope-like disposition of the accumulator, while the other necessary adjustment of the patient is made, as a rule, with specially fitted tables or chairs.

Now, in this form of treatment, as in the one by sunlight, we also need a compressor, the use and the description of which has already been given in our first lecture. Perhaps it might not be out of place to repeat what we have said about both. As the name of the instrument indicates it is used for the purpose of compression of the part to be treated in order to render it ischaemic, and thus give the light waves a greater degree of penetration. The next purpose not indicated by its name is for the absorption of the caloric rays which may have escaped the barriers placed in their course above; this is done by a current of cold water, as you shall see.

This compressor is made of a metallic band, on each side of which is encased a disc made of rock-crystal, both being concavo-convex, but the compressing side being of a greater degree of concavo-convexity. Two canulae fixed through the band holding these lenses are used for an inlet and outlet for the water which fills the space between these lenses and which is used, as already said, for the absorption of caloric rays. As manual compression would become a most tedious work, this instrument is fitted with four metallic *armatures*, at the free end of which a small orifice enables us to fix the compressor with elastic bands. These compressors are made in a great many varieties of shapes so as to fit to any part of the body to be treated.

By this complex instrumentation we obtain a small zone of about the size of a 25 cent piece or less, of very *concentrated* and *selected* chemical rays, with a powerful germicidal and alterative action on morbid cutaneous processes. While the action of the sunlight condensor requires one hour to one hour and a quarter to show its most beneficent results, this voltaic arc-lamp apparatus only requires one hour at most and often less. Yet occasions often arise where the dosage, as it were, may be very greatly increased in certain very resistant conditions, as we may have further occasion to show.

There are however in this very efficient method of Professor Finsen several drawbacks to which I will draw your attention. The installation is a very expensive one, costing at the makers (N. A. Schjorring, Copenhagen) very nearly \$700, and when transportation and setting up are added to original cost a grand total of at least \$1,000 can be figured on. Next comes the expense of running; the high ampérage of the voltaic arc-lamp consumes a frightful amount of electric watts, about 6 to 7 times as much as the ordinary street arc-lamp, the cost of which varies from \$80 to \$115 per year on large contracts; at that rate the use of this voltaic arc-lamp must cost here from \$300 to \$500 per year, whether you use it on 1 or 4 patients.

The other incidentals in running the apparatus would not vary much from those incurred in the use of the solar condenser.

This question of expense has made it well nigh prohibitive for the less fortunate members of our noble profession, so that utility combining with necessity, that mother of inventions, has set the inventive genius of many experimenters at work, and, as a result of this, the varieties of the modified machines made and now in use, may be said to be legion.

I can only describe a few of these, and among them I may mention the Foveau-Trouvé type of the machine or lamp in use in the St. Louis Hospital, Paris.

Radiant energy varies inversely as the square of the distance from the seat of this energy, thus it has been devised to bring the patient closer to the voltaic-arc-lamp, or the latter closer to the patient, to increase the efficiency of irradiation. The apparatus consists in the main of either an arc-lamp, of 5-15 ampères, or even a powerful incandescent, lamp placed at the focus of a parabolic mirror, the whole being placed within a double conical ray-concentrator, at the apex of which an aperture is fitted with a double rock crystal lens to be used as a compressor. The arc-lamp used belongs to the variety of so-called hand-feed ; that is, the carbons must be by means of a thumb-screw, brought nearer together or separated to regulate the light with the voltage. After the carbons are properly adjusted, the lamp may continue burning actively for from five to fifteen minutes, and would then require further attention. The apparatus is cooled by a very active current of water.

Compression is made by the patient applying the part to be treated upon the compressor, so that in this method the patient is an active participant in his own cure (it is well to keep your patients ever busy, for they will then forget their condition and will grumble less). In the Finsen method the patient is purely passive. The reaction thus obtained is rapid, intense, and greatly curative, sittings of

fifteen minutes, everything being attended to, will be sufficient to do the work done by the Finsen apparatus in one hour, while, on the other hand, the reduction in the ampèrage required brings about a great reduction in the ampèrvolts used (Finsen 50-60 amp., Foveau - Trouvé 5-15 amp.)

Besides, the saving in labour to the attendant is enormous, leaving the operator free to attend to several lamps at the same time, or to relax his attention to attend to any other duties. Thus, I have frequently operated this machine, the static machine and attended to some other examination at once, every few minutes casting a glance at my machines and making any needed change in the position of the patients or in the disposition of the apparatus.

The apparatus that I am now using in my routine work is of the Foveau-Trouvé type, but greatly modified, and has been made under my direction and expressly for me. It consists of a voltaic arc-lamp, having carbons of the soft core variety 9-16 of an inch dia., and used on a 110 volts alternating circuit of twenty ampère-fuse; the carbons being placed so as to form a straight line, and being actuated by a long screw, both ends of which are inversely threaded, as we say, right and left. The light is placed exactly in the centre of a hollow, double ball-like protection, which combines the functions of reflector and refrigerator, and being pierced with four circular apertures, two being to admit the carbons, provided with insulating glazed earthenware tubes, and two other apertures to the rim of which are screwed compressors of two different sizes.

In this type of the machine as the apertures for the compressors are on opposite sides, if it were necessary, two patients might be treated at the same time, and I suppose if two patients of different sex were thus placed in such close juxtaposition, it might tend to make the machine a very popular form of medication. The other details of the machine might perhaps best be learned by a personal inspection, to which you are invited.

The *rheostat*. Gentlemen, you must not think for one moment that you can attach the wires of any circuit direct to such a lamp without interrupting one of your wires by a rheostat, of which there are a great many varieties, from the common *kicking coil* to the more elaborate and expensive, and even the water-rheostat. My experience of these devices has led me to prefer the last, for reasons of economy in construction, the ease with which it is operated, and the dazzling whiteness of the light which it gives. This rheostat is easily made, from any vessel or container having no electrical conductivity and may be made of wood (bucket) woodpulp or earthenware, etc."

The two ends of the interrupted wire are fastened to two zinc plates which are kept immersed in water within the receptacle and in which a certain quantity of NaCl has been dissolved. The strength of the current (and therefore the light) can be regulated by modifying the distance between the zinc plates. The devices for this purpose are many, but any wood clamp with sliding attachment will answer the purpose. "By experience I have found that 4 to 5 inches between the plates is the one best suited for my own purpose, so that I kept my plates at that distance, but any further modification of the light needed I obtained by regulating the degree of immersion of the zinc plates in the salt solution.

Gentlemen, I would not for one moment lead you to think that this type of the arc-lamp has any pre-eminent merit over the large number made and sold; for any good hand-fed arc-lamp such as those used for ordinary projections would do. Messrs. Baker & Fox, of 83 Schermerhorn street-Brooklyn, N.Y., make a lamp which might be utilized. You will note that the carbons are placed at right angles to each other; the advantage is a doubtful one, if it exist.

Gentlemen, a review of a few of these diverse instruments would be incomplete, without some adequate mention of a form of portable arc-lamp with rheostat (resistance) called the actinolite, made by Kliegl Bros., 1393-1395 Broad

way, N.Y. These lamps are made in three sizes, varying as to price, ampère, and the size of the condensers, as follows:

No. 1. 10 in. condenser 50-100 ampères, \$500.

No. 2. 8 in. " 25-55 " 300.

No. 3. 6 in. " 15-35 " 200.

It consists in the main of an electric arc lamp of such power and so constructed as to give the greatest amount of actinic rays, compact and allowing very free adjustment.

I may state that the condenser, as may be seen in the illustration, is suspended on two metallic rods, and thus the focal length may be easily varied. The caloric rays are absorbed by a filter made of two plates of glass firmly held together and between which a current of water is kept in circulation.

The material used in the construction of this bath as well as in that of the lens used as condenser is not mentioned and is, no doubt, very much open to objection. Rock crystal has certainly not been used for either or both, and you remember what was said about this at the beginning of this lecture.

The Cox lupu lamps does not materially differ from the model I have used for the same purpose, except that the carbons are water-cooled and thus allow of placing the condensing lens much nearer to the source of radiant energy. In other respects, the lamp is not inferior to any other model in use.

LENSES:—I might say that having experimented largely with all sorts of glass, I have found that of all, the so-called Dutch flint glass is the best, capable in all respects of replacing rock crystal lenses, and is much less expensive. I have found ordinary glass less efficient in allowing the actinic rays to pass through, probably owing to the presence of some of the oxides of Pb., etc. I may have more to say about this when speaking of the X-Rays.

In conclusion, gentlemen, I might say that very good results are obtained by a very high candle-power lamp of the incandescent variety, perhaps as good as with the arc-

lamp. I have personal experience with two varieties of this form of apparatus, and with a 100 candle-power incandescent lamp and compressor, I have cured in about four weeks a severe case of lupus in a man of 80; I think it only right to say there was, however, a recurrence, for which I used other modes of treatment beneficially. The main trouble with these lamps is that they are short-lived, and their renewal is a considerable item, about \$4.00. Later on I found a 200 c. p. incandescent lamp for \$2.50, but I have not given it any trial.

Belonging to this type is the violet-ray outfit as made by Frank S. Betz, of 37 Randolph Street, Chicago, and which is sold for the comparatively low price of \$25.

In a subsequent lecture I intend going more deeply into the therapeutic uses of these diverse forms of medication, but I may say in a few words that both varieties of lupus have claimed the attention of operators and have given the best results. In Paris they claim admirable results in lupus erythematosus in 4 to 5 sittings. My own experience has not been so happy. In cold abscess, rapid fistulation or reabsorption of broken-down tissues; cheloids tend to soften and to flatten as claimed by Foveau, whilst I can corroborate the first statement from 2 or 3 cases of tuberculosis cutis and King's evil which I have treated by this method. The actinolite is used for all these and for deeper conditions of the body, namely, deeper chest trouble of the tuberculous variety. You have no doubt noted that the compressor is dispensed with.

I may say, gentlemen, that we have entered into a new era of therapeutic agency pregnant with results, the full merit of which we cannot and dare not even estimate.

Selected Articles.

CONGENITAL DISLOCATION OF THE HIP.*

BY PROF. ADOLPH LORENZ,

Of the University of Vienna, Austria.

Gentlemen :—I shall be as brief as possible in describing the method by which congenital dislocation of the hip may be reduced. For the success of the operation much depends upon the age of the patient. In young children there is generally but little difficulty. In older children and in adults reduction cannot be accomplished. The patients here to-day are from 2 to 9 years of age. In the case of the oldest we may expect to meet with much trouble, for it is near the age-limit, which in most subjects of double dislocation is from the sixth to the seventh year. In unilateral cases this period is extended to the ninth or tenth year. The oldest patient upon whom I have operated was 23 years of age and the result was a success.

In order to effect reduction all the soft parts, especially the long muscles, must be stretched. The adductors offer most resistance. These were formerly incised, but we were liable to divide too much or too little, and there was also the objection of leaving wound-cavities communicating with the air. For these reasons it is better to employ subcutaneous myotomy or to overstretch the structures. The muscles in particular are very refractory. Their opposition must be overcome by traction and, if necessary, by hyperextension. The resistance of the posterior muscles is opposed by flexing the thigh and extending the knee. The next step is to pull down the head of the femur to the acetabulum. Then begins the real process of reduction, the placing of the femur within the acetabulum. This may be done by pressing upon the trochanter, but I prefer to make abduction until I perceive signs of the head of the thigh bone slipping over the border of the acetabulum. There is, therefore, comparatively

* Delivered at Jefferson College Hospital, Philadelphia, December 11, 1902. Reported for The Medical Bulletin.

little trouble when that cavity is of normal shape and size, as in traumatic cases. In congenital dislocation, however, the acetabulum is too small, and the head of the femur will slip out of the socket. In order to return it to its proper position we must place the limb at a right angle by abduction and also make hyperextension. As regards rotation, it may be made either inward or outward.

It requires no special force to return the head, but the femur must be held in extreme extension. The anterior parts, above all, must be put on the stretch by rotating the thigh. When the reduction has been accomplished the contracted flexors of the leg bend the knee. The whole limb must then be stretched while the patient is under the influence of the anæsthetic. The limb is kept in a suitable position by being inclosed in a plaster of-Paris cast, the thigh in the abducted position and the knee flexed, both at right angles.

In unilateral dislocation the patient may be permitted to walk soon after replacement, but not in bilateral cases. In the latter class the child is kept in bed, and only passive movements are allowed. The cast should be retained rather too long than too short a time. Abundant time must be given. An important factor of success is to keep the head of the femur in place by means of nutritive shrinking of the pelvic muscles, compensated by extreme abduction. The process requires from four to six months. After the muscles have shrunk a less degree of abduction will suffice to maintain the head of the femur in its new position. Sometimes an additional rim of bone will form around the acetabulum. This possibility justifies us in leaving the dressings on for six months or even for a longer period.

Great care must be taken to retain the cast in good order and in a cleanly condition. It is applied over a stockinet which reaches from the lower ribs to below the knees, between which and the skin a number of muslin strips or bands extend in every direction. These bands have room enough to move freely beneath the dressing and can consequently be changed. By their means a napkin is held in place to receive the discharges. Both strips and napkin can be changed as often as is necessary, and in this way the cast is kept clean. Before the plaster has set a large opening is cut around the genitalia and rectum in order to leave plenty of room for the evacuations.

Case I.—We will begin to-day with the easiest case, that of a female child 2 years of age. * There is dislocation

upon both sides. The great trochanters move readily upward and downward. The head of the femur can be felt on both sides. Abduction is limited to a certain extent. The adductor muscles are put upon the stretch. I begin with rupturing their fibres by forced adduction and kneading. The ridge raised by the tendons presently disappears. This manipulation I perform first upon the right and then upon the left side. Next the posterior muscles are put upon the stretch by extreme extensions till the child's heel is brought close to the ear. The knee is then flexed and the head of the femur is forced into place. I insert a block under the buttocks, flex the hip, and at the same time make extreme abduction. The acetabulum is poorly developed and must be enlarged by stretching the anterior part of the capsule. The cavity is deeper upon the left side. The x-ray is not of much service in revealing the condition of development of the acetabulum, but this can be ascertained by using the head of the femur as a probe.

After reduction we will keep the thigh bandaged in a position of abduction for six months or more. This is not a difficult case. A second important feature of the after-treatment consists in gymnastic passive exercises for the purpose of obtaining mobility. These movements must be made in such a manner as to keep the head of the thigh bone in position. They must not be made in the vertical direction of flexion. The movements of flexion and extension must be combined with abduction. Endeavour to exercise the pelvic trochanteric muscles, because they aid in keeping the head of the femur in position. Movements of the knee must also be made in order to avoid contraction. About two years are required to bring the lower limb down to a normal. The child at first waddles in walking, with its thighs bent outward. Walking helps, by the weight of the body, to keep the femur in the acetabulum.

Case II.—This is a boy 6 years of age, and the case is one of the worst which I have encountered. Both hips are involved. The manipulations are the same which I have described and which you have seen me execute.

These children will often creep before attempting to walk. They may aid themselves in the effort to walk by holding in front of them a cane or umbrella.

Case III.—This girl is 9 years of age, and the dislocation is upon the left side. At this age a case is expected to be difficult. The left trochanter is very prominent: a fact

which indicates that it is in good condition, but I cannot be sure about the acetabulum. The adductor tendons rise up in hard bands when put upon the stretch, but they at length yield. I now make the usual movements and you can see the head of the bone slip into its socket. In this case I have met with less resistance than I anticipated.

Case IV.—This little girl, aged 4 years, has a dislocation upon the left side. Contrary to what one would expect, this case proves to be much more difficult than the preceding. It is, indeed, by far the worst of the series. I shall be exceedingly loath, however, to be foiled in my efforts. The capsule is, perhaps, too narrow to admit the head of the bone. In this exceptional case I may be compelled to incise the capsule, and if I am driven to that measure it will be the first time in the last 400 or 500 cases. In fact, I have only opened the capsule by the knife three times in more than 1,000. The difficulty here may be due to inflammatory thickening subsequent to tenotomy, which had been performed. Finally, after repeated efforts, I have succeeded in reducing the dislocation. A more complete success could not have been obtained by the open method. It has been necessary to employ extension and counter-extension. Notwithstanding the great force used, there has been no tearing of an artery or other injury to the soft parts. In such young children the tissues are very elastic.

I have entirely abandoned the cutting operation. As regards the results of the bloodless method, we must distinguish between anatomical and functional results. The former are not very good, because the acetabulum was already deformed prior to the operation. The functional result, however, is good. If the head cannot be held in the acetabulum, it glides to the surface below the anterior superior spinous process of the ilium, and in that position an up-and-down movement of the thigh is possible. Experience shows that the anatomical result of the open method is also poor in these cases, and much worse functionally, because a secondary contraction of the point ensues. In the first two of these cases there will be improvement, and this means much to the child. Even if the bloodless method unfortunately fails in certain instances, the condition is, at least, no worse than before the operation.—*The Medical Bulletin.*

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine
University of Bishop's College ; Physician Western Hospital.

HEMORRHAGE IN TYPHOID FEVER.

R. G. Curtin, Philadelphia. The associated conditions that seem to be the most serious in severe cases of hemorrhage are the following :—

1. Renal disease, which sometimes alters the blood, in some cases rendering it less coagulable, and thus favouring hemorrhage from all points.

2. Marked organic heart disease, in which the blood, being impoverished and lessened in quantity, is propelled slowly, causing the tissues to be only imperfectly supplied with blood. Under these circumstances a hemorrhage from the bowel becomes a most grave complication.

3. Hemophilia, in which the blood becomes so altered that there is little likelihood of the hemorrhage being staunched, and much liability to other hemorrhages.

4. A tympanitic distention of the abdomen with the continual discharge of black, clotted blood, which is a very serious condition, as the blood vessels are kept patulous by the distention of the intestines ; or the latter and the blood vessels have both lost their contractile power, thus favouring relaxation, not only of the bowel, but also of the mucous membrane of the blood vessels.

5. Obstinate diarrhoea and vomiting, which are decidedly unfavourable to the staunching of the blood.

Treatment—Curtin has found the usual remedies for hemorrhage from the bowels to be of more or less value. If the hemorrhage is caused by a leakage from the mucous membrane, ergot, both hypodermically and by the mouth, is efficacious.

He has great faith in turpentine, externally and inter-

nally. In cases in which the hemorrhage is associated with typanites it is especially good. In applying it externally he prefers to have it sprinkled upon a piece of flannel. This is better than the stupe, which, by producing warmth, favours bleeding.

Opium is of great importance when the bowels are inclined to be loose.

In cases in which the stomach will bear it, oil of erigeron, given in a capsule, does have a seemingly good influence. The vegetable and mineral astringents may do good in the same class of cases, but they also are liable to disorder the stomach and take away the appetite, especially after the hemorrhage has been stopped. Ice applied to the abdomen externally, or pieces of rounded ice slipped into the bowel, seem to have some efficacy in retarding the flow of blood; but it is essential that the impression made upon the blood vessels be continuous, and not intermittent. In applying the ice externally, an ice-water bag, or some other receptacle that will keep the patient from becoming wet, should be employed.

During the last two years advantage has been derived from the use of suprarenal extract in cases in which there is general hemorrhage.—*Medicine, St. Louis Review.*

COUNTER-IRRITANTS IN MIGRAINE.

J. R. Clemens, St. Louis, says that there is no more beautiful example of rational therapeutics than the treatment of apoplexy and no more pitiable one than is witnessed in the treatment of a paroxysm of migraine. Both these conditions of a paroxysm of migraine call for almost identical lines of treatment. In both, cerebral hyperemia and congestion call for derivation of the blood from the brain, but how is the indication answered? In apoplexy, the patient is placed in bed on the flat of his back, the head is raised with pillows, and ice bags are applied, a drop of croton oil on the back of the tongue and hot water bottles to the feet. In migraine the sufferer is given powders of the phenacetin group and is obliged to put up with the pain as best he can until the physiological effects of the drug have time to develop. There is a simple remedy that will outdistance phenacetin by hours and which is almost as speedy as chlo-

the nape of the neck and ice to the head. There is no form of migraine, be the cause what it may, that will not be permanently eradicated by the application of a continuous counter-irritant in the shape of a seton. Setons and blood-letting are two old-fashioned remedies which it is neither wise nor logical to discredit, seeing they have been handed to us with the "imprimatur" of the best of all clinical teachers—the experience of ages.—*Phila. Med. Jour.*

A CASE OF SCURVY, WITH UNUSUAL POVERTY OF THE BLOOD.

J. E. Talley, Philadelphia, narrates a case and concludes:

1. There is no condition of the blood characteristic to scurvy.

2. Gingivitis is not a constant symptom of scurvy.

3. In certain scurvy cases there is a condition of the blood similar to that existing in pernicious anemia, though any definite connection between the two diseases is not demonstrated.

4. The most important element in the causation of scurvy appears to be a diet lacking in vegetables or their ingredients. Tainted food may produce it, and an exclusive diet of perfectly fresh meat and blood may prevent it.

5. The infectious theory is gaining a strong foothold among the authorities, although no definite micro-organism is acknowledged.—*Jour. A. M. A.*

TUBERCULOSIS OF THE MYOCARDIUM.

J. M. Anders, Philadelphia, sums up:

1. Tuberculosis of the myocardium is more common than has been supposed.

2. At present writing not more than three pathologic varieties are justifiable.

3. It is practically always secondary to a lesion in some other situation, most commonly in the bronchial or mediastinal glands.

4. Transmission to the heart occurs most frequently by the lymph stream, less often by the blood current, and more rarely still as the result of extension by continuity.

5. Myocardial tuberculosis in a considerable proportion of cases is secondary to pericardial tuberculosis and the latter to disease of the bronchial glands.

6. The symptomatology is extremely variable and indefinite.

7. Diagnosis is excessively difficult, but is probably possible with great care and under favourable circumstances. In addition to the suspicious features that may be present the existence of generalized tuberculosis and pericardial tuberculosis, one or both, is essential to a diagnosis.

SOME PHYSIOLOGIC FACTORS INVOLVED IN THE ORIGIN OF SCURVY.

R. R. Rogers, San Francisco, gives this summary :

1. The direct cause for the appearance or continuance of an attack of scurvy does not depend upon the activity of micro-organisms, although the latter may establish conditions favourable to the onset of scurvy or aggravate a case already existing.

2. The direct cause for the appearance or continuance of an attack of scurvy lies in the establishment of the condition known as "lack of oxygen" in the tissues.

3. Those conditions which tend to prevent the formation of acid, *i. e.*, of hydrogen ions (and possibly other products also) in the tissues, and tend to increase the store of available alkalinity, *i. e.*, hydroxyl ions in the blood and lymph, are the conditions most antagonistic to the development of scurvy or its continuance, and those most favourable to its cure.—*Four. A. M. A.*

NOTES FROM EXPERIENCE.

A splendid treatment for an ordinary cold is three grains of Dover's powder combined with two grains of acetanilide in capsule; one such dose given every four hours. I sometimes double the dose at bedtime in addition to the regular dose.

The best remedy for pruritus to be used locally is menthol and olive oil, 20 grains to the ounce. This is a specific for the so-called "chigger" bite which is met with in many localities.

In cases of torpid liver with enlargement and jaundice use massage twice a day over enlarged organ and give tablet triturates of calomel, ipecac and soda every second day.

Nothing can be superior to salol in typhoid and malarial fevers for keeping down meteorism nor in the gaseous distension of stomach and bowels so often met with in children.

Codeine is unexcelled for headache, mild pain anywhere and for troublesome, useless cough. It may be given in doses of from $\frac{1}{8}$ to $\frac{1}{2}$ grain, repeated every half to two hours.

Use potassium permanganate 10 grains to the ounce for tonsillitis, used as a gargle every four hours.

For nocturnal incontinence of children use atropine sulphate 1 grain to 2 ounces of water. Give one drop for each year of the child's age at 4 o'clock p.m., and again at bedtime. If dilation of pupil is cause, lessen the dose.

Acetate lead 8 to 10 grains to the ounce of sweet spirits of niter applied locally is the best treatment I have ever found for ivy poisoning.

For muscular rheumatism and those undefinable pains often met with in the back and other muscles of the body I use :

Ry. Sodium salicylate, $\mathfrak{z}\text{iv}$.

Saturated solution acetanilide in alcohol, $\mathfrak{z}\text{ss}$.

Citrate caffeine, gr. x.

Codeine sulphate, gr. ij.

Aquae q. s., $\mathfrak{z}\text{iv}$.

M. Sig. : Teaspoonful every three hours till pain is relieved, then three or four times a day.

I have been treating a case of simple goitre in a girl 14 years of age with thyroids and electricity for nearly a year with only slight results.

Too many articles are written recommending proprietary remedies in nearly all medical journals. If one feels like it, it is all right to do so, but when every number of a journal "happens" to contain an article in favour of a certain remedy it looks very much as though the manufacturers had something to do with it.

Proprietary remedies were not introduced to fill a crying need or for intrinsic value, but to fill the coffers of the advertiser. Let him, and not the physician, bring his remedy before the public.—H. A. Giltner, M.D., in *Wisconsin Medical Recorder*.

SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

Lecturer on Surgery, University of Bishop's College; Assistant Surgeon,
Western Hospital;

AND

GEORGE FISK, M.D.,

Instructor in Surgery, University of Bishop's College; Assistant Surgeon,
Western Hospital.

CHRONIC JOINT DISEASE IN CHILDREN.

Henry Ling Taylor (*Med. News*, August 16, 1902) says that chronic joint disease in children, in nine cases out of ten, probably oftener, means tuberculosis. Statistics of over 13,000 cases show, as to the distribution of the disease, that rather more than two-fifths are vertebral, somewhat less than two-fifths are situated in the hip, and about one-fifth in all the other joints; of this remaining fifth the knee claims more than half. One of the most marked characteristics of tuberculous joint disease is its insidiousness. The symptoms vary, but the most characteristic one is stiffness or limitation of motion due to peculiar spasmodic contraction of the muscles. In vertebral disease the location of the pain varies; it is found in the neck, shoulders and back of the head in cervical disease; at the sides or front of the chest and in the abdomen in dorsal disease; in the loins, lower back, lower abdomen, through the hips or down the thighs, or even in knee, leg, ankle or foot, in lumbar disease. The medical student clings with as desperate tenacity to the knee pain of hip disease as a pathognomonic symptom as does the schoolboy to the date of the discovery of America as the key to all history. It is well to know that disease of the lumbar spine, knee disease, and other affections, may cause pain in the knee, and that it is frequently absent in hip disease. The endeavour to elicit pain in the suspected hip by forced movements, pounding on the heel, or otherwise, is perfectly useless and may prove injurious. One should, on the contrary, seek to

demonstrate and define the limitation of motion and the involuntary, spasmodic muscular contractions without pain to the patient. The limitation of hyperextension at the hip is the earliest and most delicate test. In knee disease the joint very rarely becomes flexed and causes limping, which may be intermittent. There seems to be an antagonism between rheumatism and gout and tuberculous joint disease; also between rickets and joint tuberculosis. There are probably few chronic diseases in which correct early treatment is so beneficial, and in which the results of delay are so serious, as the chronic joint diseases of children.—*Medical Sentinel.*

SOME OF THE CAUSES LEADING TO AND PRODUCING SUPPURATION.

Wound infection is a condition which has existed since the beginning of operative surgery. Previous to the days of antiseptics infection was almost a universal rule, but even to-day it occurs occasionally with all our improved technic. Since the time of Lister there has been a continuous volley fired at the microbe, and in our endeavour to completely eradicate this thorn from the side of surgery we have too frequently neglected other important measures. It is not my object to detract in any way from the importance of our present methods of asepsis, but, on the contrary, I would like to point out a few glaring evidences of defective technic which occasionally are causes of wound infection.

Regarding many of the points I make no claim for originality. While the attention of the surgical world has been called to these conditions on numerous occasions, yet their frequent occurrence seems to justify still further emphasis.

One of the first defects with which one is confronted is improper plumbing. The basins are so constructed that in order to bathe the hands with any degree of comfort one is compelled to wash in standing water, one of the most filthy habits. Running sterile water is the ideal arrangement for washing the hands, and consequently the plumbing should be so arranged that, first, the water is controlled by the foot; second, the hot and cold water should come through a common faucet; and, third, this faucet should be placed a sufficient distance from both the wall and basin that hands and arms need not come in contact with either.

Some surgeons seem to be imbued with a false sense of security in the use of antiseptics. It has been observed frequently that after the reinfection of hands during an operation, the surgeon will simply dip them in the antiseptic solution and his surgical conscience is immediately relieved, believing that he has destroyed any germs that may have been lodged on hands or arms. This method cannot be too severely condemned and I have no doubt if the antiseptic solutions were discarded from our operating-rooms we would have cleaner hands by having more effective mechanical cleansing.

Next, notice the soap and brushes. Here you meet with a condition that is frequently disgusting, and one feels that it would be better to leave the patient to the ravages of disease rather than subject him to an operation under such conditions. The soap is not sterile, and is placed in vessels so constructed that it is impossible to extract it without coming in contact with the dirty edge of its container. The brushes may have been placed in some antiseptic solution, but are seldom sterilized. Frequently they are of the poorest quality, and, as a rule, have been used so long that there are scarcely any bristles left with which to do effective scrubbing. Assuming that we should introduce the least possible amount of septic material into our operating room, I believe we should not wear our street clothing. Street shoes should be changed for those which can be easily cleansed, and the trousers for those that can be sterilized, both of which can be readily obtained. A sterile long-sleeved gown should be worn, changed when infected, or at least after each operation.

The assistants and nurses should be of the least possible number, as the fewer the hands that come in contact with an operation the better. Two sterile nurses are ample, and possibly one is sufficient if the surgeon has two assistants.

Catgut is a material that is very frequently misused. It should be placed in wide-mouth jars, removed with a clamp, and in no case should it be returned to the jar when once removed, as there is a great probability of its becoming infected. The technic of handling catgut I will not discuss, but will simply say that it should be handled as little as possible. Literature, domestic and foreign, has been prolific regarding the sterilization of catgut, but, in my opinion, less trouble would accrue from its use if greater care were taken in handling it after its sterilization. Regarding sterilization, other things being equal, the greater the degree of heat the better the method. Considered in this light, cumol seems to answer

the requirements better than any other method. Another good way to prepare catgut is by the formalin method. This method is simpler than the cumol, as the latter method requires a special sterilizer. I have seen a great deal of this preparation used with entire satisfaction.

Instruments that have become infected from any cause should be discarded immediately. This rule seems to be occasionally forgotten, especially when infected from the intestinal canal in such operations as intestinal anastomosis, appendectomies, and the like. Basins that are used in operations should be sterilized by heat. We are not sure of their being sterile when simply washed with a cloth dipped in bichloride solution, as is the custom in some institutions.

Wounds should be handled as little as possible. The self-retaining retractor is an instrument that should be used more frequently, especially in abdominal work. It prevents handling the wound, protects its edges and holds it open to greater advantage than can an assistant. The ungloved hand must be a prolific source of wound infection. To-day it is known that there is no method of rendering the hands sterile. The surgeon will take all manner of trouble to render his instruments, dressings and ligatures sterile, but will without hesitation use his uncovered hand in the wound. Acting according to our present knowledge, it must appeal to everyone that the only positive method of having hands noninfectious is to cover them with a pair of sterile rubber gloves.

The protection of the operating field by towels is unsatisfactory, and not frequently do we find them misplaced some distance from their original position, thereby exposing an infected surface. The better cover seems to me to be that by an apron with a small hole, which cannot be displaced. The hole can be easily enlarged to meet existing circumstances.

The part of my paper that I wish to emphasize more especially is the increasing of the resistance of the patient. Bouchard has told us that "physicians ought not to permit themselves to be occupied alone with the research after microbes, but that they ought to busy themselves as well with investigating the circumstances which disarm the organism against microbic invasion." Lawson Tait's method of operating has taught us that by conserving the natural resisting forces of the patient he could almost do away with antiseptic methods.

Autointoxication is of special importance to the surgeon.

because the infectious organisms find tissues depressed by the absorption of excrementitious principles, much more vulnerable than those of the healthy individuals. It is important that the bowels should be in a state of activity, in fact they should be as nearly empty as possible, since the loss of a moderate amount of blood and the frequent inability of the stomach to retain water make absorption of the fluids from the intestines likely to occur. Before undertaking surgical procedures the condition of the heart and lungs should be ascertained, for in certain organic diseases these organs, by the additional burdens of an operation, may cause an auto-intoxication which, if not dangerous in itself, may become so by favouring local or general infection.

The liver and skin should not be overlooked in preparing a patient. The subject of auto-intoxication has been too commonly left to the domain of general medicine, and one in which the surgeon, as such need take only a passing interest. Park has well said that :

“ The surgeon will prove himself the best master of the situation who is thoroughly conversant with all that the general topic of autoinfection comprises and implies, for he will find that his surgical patients will do well or badly just in proportion as he maintains the equilibrium between ingestion, and egestion, or as he realises that retained excrementitious products are among the most active predisposing causes of what may be a little later a distinct surgical sepsis.

For a moment let us digress and see what can be done toward increasing the patient's resistance to infection. Where time and circumstances permit, the patient ought to be under treatment at least four days, and in some cases even a longer period of time could be used to advantage. During this period the patient should not indulge in any dissipation ; he should have strychnine three or four times a day and sufficient cathartics to keep the bowels moving twice a day. About six hours before operation he should receive an enema and bowel wash. The quantity and quality of urine should be ascertained. He should drink two quarts of water every twenty-four hours and receive a sweat bath every second or third day, followed by a hot bath. The stomach should not receive any food for at least six hours previous to operation.

In preserving the patient's resisting power, I believe there are a few things that compare with rapid operating ; almost all patients are in a good condition no matter what the operation is, at the end of fifteen minutes, of anesthesia,

and almost no patient is in a good condition at the end of an hour and a half or two hours. Morris has said that "if work is done in fifteen minutes the operation is executed, but if in an hour and fifteen minutes, perhaps it is the patient that is executed."

The anesthetic and the manner of administration has an important bearing. The commencing of an anesthetic by nitrogen monoxide gas, followed by either ether or chloroform, has the advantage of getting the patient anesthetized quickly with a minimum of anesthetic. An anesthetist who does not know how to administer all anesthetics has no place in an operating-room, as a patient may be left in such a condition by the anesthetic, even if operation is skillfully performed, that the slightest amount of infection may prove serious. A carefully prepared patient, a rapid but careful operation, a competent anesthetist, and an exacting technic, make a happy combination in an operating-room, which will give almost absolute assurance against infection.—F. W. McGuire M. D., in *Buffalo Med. Jour.*

SHORTENING OF THE RADIUS IN COLLES' FRACTURE.

G. R. Fowler, New York, notes that upward displacement of the lower fragment leads, as a rule, to shortening of the radius and elevation of the radial styloid.

If, in the treatment of Colles' fracture, sufficient force can be brought to bear to overcome the deformity at once, and pains be taken to maintain the normal position of the ulna by a sufficiently hard and properly applied pad placed on the palmar side of the head of the ulna; and if, in addition, early massage and movements of the fingers, both active and passive, be employed, the very best results can be obtained in the great majority of cases. In the application of this pad it is Fowler's habit to use a tightly rolled portion of an ordinary muslin roller bandage. The pad is about the diameter and length of the little finger. To prevent it from slipping it is covered with a piece of adhesive plaster folded in such a manner before applying that it presents an adhesive surface to the skin as well as to the roll. An anesthetic should always be employed in the reduction, and the normal length of the radius restored when possible. The ulna is now

forced into place and the roll placed upon the palmar surface to retain the reduction. This is held in place by several turns of adhesive plaster, the width of which corresponds to the length of the roll. The edges of the adhesive plaster are nicked to prevent these from sinking into the skin should swelling occur subsequently. The arm is placed in a sling with the hand dependent, so as to maintain the latter in a position of ulnar flexion (abduction).

The dressing above described is essentially that of Moore of Rochester. Besides meeting all the indications, it presents the advantage of being always available and of permitting movements, both active and passive, as well as the use of early massage.

In spite of every effort, however, in a certain proportion of cases it will be found impossible to effect complete reduction either of the fracture itself or of the displaced ulna. Upon removal of the dressings the ulna will fall forward almost, if not quite, to the position which it occupied before its reduction. This usually occurs at once. If it is delayed this delay is due to incomplete repair of the posterior radio-ulnar ligament. Such cases, however, are rare. In the great majority of cases the essential feature of the displacement of the ulna is the shortening of the radius.

In the treatment of cases in which the deformity resulting from failure to reduce the displaced ulna is of sufficient importance, whether from the standpoint of impairment of function, the presence of pain, or for reasons pertaining to the presence of the deformity pure and simple, for several years past Fowler has practised removal of the head of the ulna through an incision made along its inner border. The operation is performed subperiosteally, the section of the bone being made by the Gigli wire-saw. The amount of bone to be removed will depend upon the amount of impaction of the fragments of the radius, and consequent shortening of the latter.

In cases in which the alignment of the radius is but slightly disturbed, the displacement of the lower fragment being entirely in an upward direction, and this at the expense of its cancellous tissue into which the upper fragment is crushed, this operation will be found to fulfil all the indications of improvement of function, relief of pain, and correction of deformity. In cases, however, in which the impaction is slight, the shortening being due to either an angular deformity or a bowing of the radius at the point of fracture,

it neither will nor can be expected to serve the same useful purpose. Here, nothing short of a refracture, with, perhaps, cuneiform osteotomy, will completely serve the purpose.—*Medical News.*

Therapeutic Notes.

TO CHECK HEMOPTYSIS.

A. Hecht has employed with success the following pill, in checking hemoptysis in tuberculosis :—

R_y. Extract ergot..... gr. xxx
 Pulv. digitalis fol..... gr. xx
 Extract hyoscyami..... gr. xxx

M. ft. pil No. xx.

Sig.—Three to five pills may be taken daily.

He believes that the real virtue of this combination, in checking hemostasis lies in the quinine, reinforced by the digitalis.—*A. M. A. Four.*

RHEUMATISM.

Salicin has been of service in rheumatism, given in combination as follows :—

R_y. Salicin..... ʒ j
 Potassium bicarb..... ʒ iss
 Sodium bicarb..... ʒ iss

M. et. ft. chart. No. x.

Sig.—One powder every three hours, dissolved in hot water or hot milk.

Aspirin, a more recent preparation, is a very valuable substitute for the salicylates, salol, or salophen, and, its action being similar, it may be classified in this group. It may be prescribed as follows :—

R_y. Aspirin..... ʒ iss
 Extract nucis vomica..... gr. v.

M. et. ft. capsule No. xij.

Sig.—One capsule every four hours.—*A. M. A. Four.*

CASTOR OIL FOR CHILDREN.

Dr. George F. Little, of Brooklyn, says in the Brooklyn "Medical Journal" that castor oil needs no recommendation as to its value in pædiatric work. Most children take it well; where they do not, the following formula is acceptable:—

R. Ol. ricini.....
 Glycerini, of each..... ʒj.
 Ol. gaultheriæ..... ℥x.

M. Sig:—A tablespoonful to a tablespoonful, according to age. Shake well.

The addition of the oil of wintergreen and the glycerin makes the mixture very palatable, and the latter assists the oil in its action.

EPILEPSY.

The following formula for the administration of the bromides in epilepsy is recommended by Dr. Gilles de la Tourette, and is used very commonly at Hôpital la Salpêtrière in Paris:—

R. Potassii bromidi..... ʒx.
 Sodii bromidi.....
 Ammonii bromidi.....
 Sodii benzoati, of each ʒij.
 Aq. destil..... Oij.

M. Sig:—As a beginning dose take one tablespoonful after breakfast and at bedtime.

The dose should be increased so as to control the seizures. If the epileptic attack recurs at a regular hour each day, two-thirds of the daily amount should be given an hour before the time of the expected attack.—*Gaillard's Medical Journal.*

TOOTHACHE.

When this condition arises from a diseased tooth in which there is a cavity, Mason recommends that a few drops of the following combination be placed upon a pellet of cotton and applied to the cavity:—

R. Linim. aconiti (B. P.).....
 Chloroform, of each..... 3 drachms.
 Tinct. capsici..... I drachm.
 Tinct. pyrethri.....
 Olei carophylli.....
 Pulv. camphoræ, of each..... ½ drachm.

—*Philadelphia Medical Journal.*

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Editorial.

CONVOCATION OF THE MEDICAL FACULTY OF THE UNIVERSITY OF BISHOP'S COL- LEGE.

The Thirty-Second Annual Convocation of this Faculty was held on the 24th of April. The day was beautiful, and the attendance very large, the Synod Hall, in which the Convocation was held, being crowded to its utmost capacity. In the absence of the Chancellor in Europe, the Principal and Vice-Chancellor, the Rev. Canon Whitney, presided. Convocation being declared open, Dr. F. W. Campbell, Dean of the Medical Faculty, read his report. The attendance of students had been very large, and a gratifying feature was the fact that the Freshman Class was the largest in its history, numbering thirty-two. Allusion was made to the fact that the present session was the first, under the new law, which demanded a nine-months' session, and in future the Convocations would be held at a later date. The following graduates were then presented to the Chancellor by the Dean and received their diploma, viz. : W. W. Kelly, James

Franckum, D. W. Morrison, W. H. White, F. Richards. Referring to the presence of Dr. Casey A. Wood, of Chicago, the Dean spoke of the pleasure which the Faculty felt in welcoming him. He remarked that Dr. Wood graduated from Bishop's in 1877, and, after practising medicine in Montreal and being with his *Alma Mater* in a professional capacity during his entire residence here, had removed to Chicago after preparing himself for special work on the eye. His success had been phenomenal, at which Bishop's was naturally proud, and to-day Dr. Wood was undoubtedly the best authority on that subject in the western portion of De United States. Dr. Wood was then presented by the Dean, and had the degree of D.C.L. conferred upon him by the Vice-Chancellor.

The various prizes were then distributed as follows, viz.: Dr. James Franckum, Wood Gold Medal; Dr. James Franckum, Nelson Gold Medal; G. G. Armitage, David Medal; Dr. W. W. Kelly, Chancellor's Prize; A. Airis, Senior Dissector's Prize; S. Ship and L. Lucas—both equal—Junior Dissector's Prize. Several gentlemen were then handed certificates of having served as internes at the Woman's Hospital.

The address on behalf of the Graduating Class was delivered by Dr. Franckum, and that to the Graduating Class, on behalf of the Faculty of Medicine, by Dr. W. G. Reilles.

Dr. Wood then addressed the audience, briefly referring to those things which made for success in a medical career, and alluded to the practical training, which it was well known Bishop's College gave its men, which fully prepared them to enter upon their life's work with every prospect of success.

The following gentlemen were (in the absence of the Dean of the Dental College) presented by the Dean of the Medical Faculty and received the degree of Doctor of Dental Surgery, viz: L. N. Trudeau, B. W. Brock, Massue Fortier, H. R. Matthews, L. Tremblay, G. A. Vallee, Miss Georgiana McBain. Miss McBain is the first lady who has received the degree of D.D.S. in the Province of Quebec.

Dr. Matthews gave the address on behalf of the Dental Graduating Class.

AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The Thirteenth Annual Meeting of this Association will be held at the Hotel Windsor, Atlantic City, N.J., September 22, 23 and 24, 1903.

Messrs. Lea Brothers & Co. announce that, conforming to many requests, they have issued the superb work on the "Eye, Nose, Throat and Ear," edited by Drs. Posey and Wright, in two volumes, as well as in a single volume.

Volume I. will be known as "Posey on the Eye," and covers completely the subject of Ophthalmology. It contains 690 pages, 358 engravings and 19 plates in colours and monochrome. Price, cloth, \$4, net.

Volume II. will be known as "Wright on the Nose, Throat and Ear," and contains 570 pages, 292 engravings and 16 coloured plates. Price, cloth, \$3.50, net. The convenience of this plan, especially for text-book purposes, is obvious.

The work will continue to be published in a single volume. Price, cloth, \$7; leather, \$8, net.

HYPERCHLORHYDIA—A SYMPOSIUM.

The June issue of the *International Medical Magazine* will be devoted to a symposium on this most important gastric subject, than which none more important has ever been published in any American journal. More than half a dozen of the leading European specialists will contribute, among whom are: Prof. C. A. Ewald, Berlin; Prof. George Hayem, of Paris; Prof. Carl von Noorden, of Frankford; Dr. L. Kuttner, of Berlin; Prof. Rosenheim, of Berlin.

The selection of contributors from this side of the

Atlantic has been equally happy, and the following will take part: Prof. John C. Hemmeter, of Philadelphia, on "An Experimental and Clinical Study of the Etiology of Hyperchlorhydria;" Dr. Allen A. Jones, of Buffalo, on "The Effervescence Test for Gastric Acidity;" Dr. Boardman Reed, of Philadelphia, on "A Further Development of the Benedict Effervescent Test of Gastric Acidity;" Dr. John A. Lichty, of Pittsburg, on "The Relation between Hyperchlorhydria and Neurasthenia;" Prof. Fenton B. Turck, of Chicago, on "The Treatment of Hyperchlorhydria;" Dr. A. Robin, of Newark, Delaware, on "The Etiology of Hyperchlorhydria," Dr. Max Einhorn and others.

Personal.

The degree of D.C.L. *honoris causa* was conferred upon Dr. Casey A. Wood, of Chicago, at the Medical Convocation of the University of Bishop's College, held in Montreal on the 24th of April last. Dr. Wood graduated C. M., M. D., from Bishop's College in 1877, and almost immediately after joined its Faculty of Medicine, as professor of Chemistry. He subsequently occupied one or two other chairs, and continued an active participant in its work during a residence of about ten years in Montreal. He then went to Europe, where he passed some two years in studying ophthalmology. On his return he settled in Chicago where he has remained, ever since, and where he occupies a very distinguished position in his specialty. Indeed, we believe that he occupies the foremost position in his special department in the western portion of the Western States. In honouring Dr. Wood the University of Bishop's College was honouring itself, for he is to-day its most distinguished Medical graduate.

Dr. Joseph E Lanouette (C.M., M.D., Bishop's, 1872), of Manchester, N.H., has recently been appointed a member of the Board of Health of that city.

Dr. W. J. Kelly (C.M., M.D., Bishop's, 1903), of Montreal, has left to take up practice in Wisconsin. Dr. Fairfield

C.M., M.D.), Bishop's 1887), of Green Bay, Wisconsin, secured the location for him.

Dr. Richardson (C.M., M.D., Bishop's, 1903) has gone to Great Britain to secure an imperial qualification, after which he has an appointment awaiting him as resident Medical officer of a large Sanitarium in the South of England.

Dr. Addison (C.M., M.D., Bishop's, 1896), is still in Edinburgh, devoting himself to ophthalmology. He will shortly return to his home in New Zealand, and limit his work to that specialty.

The Executive of the Medical Graduates' Society of Bishop's College entertained the 1893 Medical Graduates at supper at the Savoy Hotel on the 25th April.

Dr. J. W. Davis (C.M., M.D., Bishop's, 1900), is a medical officer in the Baden-Powell Constabulary, South Africa.

Dr. W. E. Deeks (M.D., McGill, 1893), has for the present given up practice, and removed from Montreal. We understand that he enters the mining brokers' firm of Munro Brothers, of New York and Montreal, as an expert. Dr. Deeks has a first-class reputation as a geologist.

Dr. J. H. Richardson, of Toronto, was this month entertained to a public dinner by his old pupils and admirers. Dr. Richardson was for many years a distinguished Medical teacher in Toronto. Fifty-three years ago he was appointed Professor of Anatomy in the University of Toronto, and held the position till the Faculty was abolished. A few years later he accepted the same position in the Toronto School of Medicine, and in 1887 he joined in the same capacity in the University of Toronto Medical Faculty. Although now in his eightieth year he is hale and hearty, and a lover of outdoor sports. In summer he actively enjoys fishing and bowling. In winter he is an enthusiastic curler.

Dr. Uzziel Ogden, of Toronto, completed his fiftieth year as a lecturer in Medicine at the end of 1892, when he tendered his resignation to the Medical Faculty of Toronto University, of which he has long been a member. He still actively follows his professional work.

Sir William Hingston, M.D., has left for a brief visit to Europe. He will be back early in May.

Dr. E. G. Edwards (M.D., McGill, 1854) is still in the active practice of his profession at Grand Rapids, Michigan

There are but few survivors of the class of 1854, but among them are Dr. Robert Craik and Dr. Thomas Simpson, of Montreal, and Sir James A. Grant, of Ottawa. Of the professional staff of McGill Medical Faculty in 1854, there are but two now living viz., Dr. Duncan C. McCallum and Dr. William Wright, the latter now a clergyman, and for many years out of Medical practice.

Dr. W. W. Kelly (C.M., M.D., Bishop's, 1903), has settled at Flintville, Wisconsin, U. S., 15 miles from Green Bay, where, under the auspices of Dr. W. E. Fairfield (C.M., M.D., Bishop's, 1887), of Green Bay, Wisconsin, his success is assured. Dr. Fairfield, a native of Clarenceville, Que., is ever on the lookout for good positions for Bishop's men. He is another Bishop's man who has achieved marked success.

Book Reviews.

Surgical Emergencies—The Surgery of the Head, by Bayard Holmes, B.S., M.D., Professor of Surgery in the University of Illinois, Professor of Clinical Surgery in the American Medical Missionary College, Chicago. Attending Surgeon, the Chicago Baptist Hospital, New York. D. Appleton & Co., 1893.

This is the first of the series of books on the everyday surgery of the human body, which has been in preparation for some time. It omits the surgery of the eye, ear, nose and throat and other well-established specialties. The author places before the reader at the beginning of each chapter, the motive for the study of the chapter, and some concrete examples of the more important conditions requiring surgical attention. Three distinct kinds of subjects have secured attention; those conditions which are most frequently met with are thoroughly discussed, those that are less frequently met with, but require instant relief, receive the next share of attention; and last of all those that are of great theoretical importance, though of less frequency, are also fully considered. Every possible device is used to secure in the mind of the reader the most intense and lasting impression, and one which insures for the subject an individuality and integrity which is inconsistent with a dissected and chopped-up discussion. The author says, "Probably nine-tenths or all the surgical work which the general practitioner is called upon to perform is confined to one-ninth of the subjects found in our Encyclopedia of Surgery, and it is therefore unreasonable that the discussion of surgical

varieties should overshadow that of the everyday emergencies of the average practitioner and confuse him by their bulk. The work is profusely illustrated and contains excellent colored plates, photo-engravings and wood cuts. It is printed on good white paper, and it is easy and comfortable reading.

F. W. C.

International Clinics.—A quarterly of Illustrated Clinical Lectures and especially prepared articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Peridiatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose and Throat, and other topics of interest to Students and Practitioners. By leading members of the Medical Profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of John B. Murphy, M.D., Chicago; Alexander D. Blackader, M.D., Montreal; H. C. Wood, M.D., Philadelphia; T. M. Rotch, M.D., Boston; E. Landott, M.D., Paris; Thomas G. Morton, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh, and John Harold, M.D., London, Eng., with regular correspondents in Montreal, London, Paris, Leipsic and Vienna. Vol. IV., 12th series, 1902, Vol. I., 13th series, 1903. J. B. Lippincott Company, Philadelphia. Dominion agent, Charles Roberts, 1524 Ontario Street, Montreal.

Vol. IV., 12th series, contains twenty-five articles, with some sixty-eight illustrations. There are six articles on therapeutics. Dr. Charles Fox Gardner describes a sanitary tent and its use in the treatment of pulmonary tuberculosis. Dr. E. Lancereaux, Paris, who in 1897 wrote a paper on the treatment of aneurisms by gelatin in hypodermic injection, gives a further contribution on the subject, pointing out the reasons for the failures recorded and claiming that in the majority of cases, where properly treated, the results are satisfactory. There are seven articles under the head of Medicine. Dr. Lawrence A. Flick writes on the differential diagnosis between tuberculosis of the lungs and diseases which resemble it. E. Stanmore Bishop, F.R.C.S., Eng., gives an instructive paper on abdominal diagnosis, illustrated by several coloured plates. Aloysius A. J. Kelly writes on some clinical aspects of aneurism of the aorta. In neurology there are four papers, and in surgery five. Among the latter is a very instructive article on the anatomy of the inguinal region and the radical cure of inguinal hernia, by M. F. Fallon, M.D. Illustrations and descriptions of the parts and methods of operating convey detailed information in regard to the technique of the operation. Articles on dermatology and ophthalmology are contributed by Drs. Arthur Von Harlingen and Wm. T. Shoemaker. Horatio C. Wood, M.D., LL.D. and Wm. W. Kern, M.D., LL.D., are the subjects of Dr. Guy Hinsdale's continued paper, Biographical Sketches of Eminent Living Physicians.

The last ninety-five pages of the volume contain a *monograph* on the blood in health and disease, with a review of the recent important work on this subject, by Thomas R. Brown, M.D., instructor in Medicine, Johns Hopkins Medical School, Baltimore. This is a very comprehensive article, giving the recent advances in hæmatology, in all its departments, including serum, diagnosis and therapy.

Vol. I., thirteenth series, 1903, contains sixteen articles and a lengthy review of the progress of medicine during the year 1902. While not so numerous as in preceding volumes, the articles are of exceptional interest and by leading writers. The first article is by Dr. Wm. Osler, of Johns Hopkins University and Hospital, on aneurism of the descending thoracic aorta. He discusses the general features of fourteen cases which were treated in the wards of the hospital since its opening. The thorough manner in which the clinical features of the group of cases are discussed makes interesting and instructive reading. Special characteristics receive further illustration by reference to other interesting cases which had come under his observation. A medical treatise is the perusal of the clinical lecture by Dr. Reynold Webb Wilcox, professor of medicine and therapeutics in the New York Post-Graduate Medical School and Hospital, on the treatment of cardiac and vascular fibrosis, Hodgson's disease, the treatment of anæmia, anæmic and vascular murmurs. Dr. Thomas E. Satterthwaite, consulting physician to the Post-Graduate Medical School and Hospital, New York, gives an interesting paper on Nanheim methods in chronic heart disease with American adaptations. The resistance exercises are described in detail and photogravures of each movement are given and a perfect scheme for the ordinary six months' course of baths is given, and the method of administering them.

The treatment of chronic urethritis is discussed by Dr. Ernest Finger and diphtheria by M. Howard Fussel, M.D.

In Medicine there are two papers: Primary Intestinal Tuberculosis, by Frank Billings, M.D., and Pyloric Obstruction, Gastric Dilatation and Gastric Stagnation, by Max Einhorn, M.D.

In Surgery there are clinical lectures given by Dr. W. W. Kern, of Philadelphia, and Dr. Nicholas Senn, Chicago, on a variety of topics.

Of very great interest is the clinical lecture by Thomas Jonnesco, M.D., delivered in the surgical clinic of the University of Bucharest on the enduring results of total bilateral reflection of the cervical sympathetic in Baredow's disease. He considers it the only rational operation, if it is conceded that the disease is due to functional rather than organic changes, and it is the only operation which relieves the main symptoms of the disease and lessens or removes the accessory conditions, and the relief given is lasting.

Other valuable papers are by Thos. H. Manley, M.D., on the great importance of the organs in the right as compared with those in the left lateral half of the abdomen. The Causation

Treatment and Prognosis of Convulsions in Young Children, by John Thomson, M.D., F.R.C.P., Edin.

Functional Reversion and its import in Medical Practice, by A. F. A. King, A.M., M.D., and the General Principles of Embryology, by J. W. Ballantyne, M.D., F.R.S., Edin.

The Review of the Progress of Medicine, during the year covers 70 pages, and is written by Drs. Edward Willard Watson, M.D., and Henry W. Cattell, M.D.

There are an unusually large number of illustrations in the volume, which add to its value.

Readers of the Clinics are kept fully posted on the progress being made in all branches of medicine.

Progressive Medicine. Fifth Annual Series. Volume 1, March, 1903. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 450 pages, illustrated. Per volume, \$2.50., by express pre-paid. Per annum, in four cloth-bound volumes, \$10.00. Lea Brothers & Co., Publishers, Philadelphia and New York.

This invaluable periodical publication differs very materially in its scope from the ordinary year-books and epitomes of Medicine and Surgery. As the title of Progressive Medicine indicates, its pages are devoted to the real advances of medical science. The editors of its different departments are all scientific men and teachers of experience, and its contents are not mere abstracts of articles appearing in current medical literature. It may be compared to an advanced text-book of medicine and surgery, kept abreast of the times by continual revision and addition. Its sections are so arranged as to cover every branch of professional work without interference or repetition. It is only possible here to direct attention to the more important features in the present issue, although a vast amount of other valuable matter is included.

In the present volume, Frazier, in the section on the Surgery of the Head, Neck and Chest, describes particularly the wonderful progress which has been made in the surgery of the skull and brain, especially in the diagnosis of brain tumours and abscesses; he also particularizes the latest researches into the surgery of the thyroid gland, and some of the remarkable results achieved in recent operations upon the heart. Among other topics, he also discusses the surgical treatment of diseases of the œsophagus and stomach.

Herrick writes the section on the Infectious Diseases, devoting especial attention to the importance of serum therapy in the light of recent discoveries. His description of the methods in vogue in the management of typhoid fever and pneumonia is remarkably full and of great value.

Crandall, in considering diseases of children, describes in

detail the methods of feeding and of milk modification, which are of such immense practical value in the treatment of diseases of infancy and childhood.

In the section on Pathology, Dr. Hektoen devotes particular attention to the late studies into the specific properties of the various tissues and fluids of the body. The study of cytotoxins, agglutinins and precipitins is of such importance and of such intricacy that a lucid explanation will prove of inestimable value to the great body of the profession, who otherwise would be unable to acquaint themselves with the recent strides achieved by workers in chemical pathology.

A. Logan Turner, in the section on Laryngology and Rhinology, presents a summary of recent achievements in the correction of nasal deformities by means of paraffin injections.

Randolph's article on Otology is devoted largely to a discussion of the methods employed in the treatment of various chronic aural conditions, heretofore considered as almost hopeless from a therapeutic standpoint.

The volume is profusely illustrated and completed with an index which is so arranged as very greatly to enhance its value to the busy practitioner as a work of reference.

F. W. C.

PUBLISHERS DEPARTMENT

Conclusions so startling as those reached by Dr. Wallace's *Fortnightly* article on "Man's Place in the Universe" could not go long unchallenged, and the April number of the *Fortnightly* brings a prompt reply from no less an authority than the Savilian Professor of Astronomy at Oxford. Professor Turner's article will be reprinted in *The Living Age* for May 9.

The intense interest felt in the ecclesiastical situation in England at the present time is reflected in the April magazines. Two notable articles from "The Nineteenth Century and After" will be reprinted in *The Living Age*, Viscount Halifax's strenuous appeal to the High Church party, entitled "The Crisis in the Church," will appear in the number for May 9, and Lady Wimbborne's earnest presentation of the opposite view, "The Church's Last Chance," in that for May 16.

Some very clever parodies on fashionable forms of fiction—the romantic novel, the kailyard novel, and the rest—will be found in the "Letters to a Literary Aspirant" which *The Living Age* for April 25 reprints from *Blackwood's Magazine*.

Human nature does not change much, and readers of the diverting article on "Servants and Service in the Eighteenth Century," which *The Living Age* for April 25 reprints from *The Cornhill Magazine*, will be astonished to find so many of their own domestic grievances at least a hundred years old. The picture of the departing guest, "tipping" his way out, between rows of expectant servants, is particularly realistic.