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Original Articles

No paper published, or to be published elsewhere as original, will be accepted in this department.

FRACTURES.*

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In fractures we have a common ground where the physician and the surgeon meet upon a level, and where common usage allows the physician as well as the surgeon to treat the case. Fractures constitute about one-seventh of all accidents and are ten times more frequent than dislocations. The knowledge requisite for treating fractures of all kinds has no limitation. I feel that if we together review the subject and refresh our minds on some of its salient points, we will have a clearer conception of the whole subject. I trust, then, you will pardon me for bringing such a common theme before your scientific body.

Etiology of Fractures.—Violence is the leading factor in fractures; it may be direct or indirect. We should not, however, forget that muscular action is often a cause of fracture. The fractures of the olecranon and patella are examples of this kind. In fractures by indirect violence the long bones suffer most often. Males, on account of their occupations, are more prone to meet with fractures, the time being that period of activity and exposure between twenty and thirty years of age. Old age comes next as a predisposing factor because the medullary canal of the bone

* Read by invitation at the Lambton County Medical Society, May 10th, 1899.

becomes enlarged and the cortex becomes thinner as age advances. Constitutional trouble, as syphilis, rickets, scurvy, struma and trophic lesions, due to diseases of the nervous system, are factors; also caries and local inflammation, as osteitis, and atrophic changes in the aged. The nature of the force, the weak points and the contour of the bones will help determine the diagnosis and the seat of fracture; for instance, in fracture of radius, clavical and neck of femur, etc. The complications of fractures, like other injuries, may be immediate or remote. The immediate complications are shock, followed by delirium, injury to soft tissue, arteries (causing free hemorrhage), veins and nerves. Secondary complications may be delayed union, false joint or an ankylosed joint, sepsis, thrombosis, embolism, tetanus and trophic changes due to pressure or involvement of nerve in callus.

Diagnosis.—Differential diagnosis ranges from the cases that can be made out by the eye alone, to those cases where every point in the history, subjective and objective symptoms, pain, deformity, redisplacement, loss of function, mobility, crepitus, ecchymosis, shortening and other means have been reviewed without positive results. The comparison of the two sides is the means that few of us use to the advantage we should. The landmarks of the two sides should be almost identical, as well as the symmetry and measurements. Ecchymosis over or near superficial bones, and at the nape of neck will point to fractures near the side of the ecchymosis and at the base of the skull respectively. In distinguishing fractures from dislocations we should remember that when a dislocation is once reduced the function of the limb is normal. This is not so of a fracture. The fracture once set, and the parts allowed to take rest the deformity is re-established. There are fractures which, under certain conditions, it is impossible to diagnose. Some of these are: fractures at the base of brain, impacted fractures (especially near joints), greenstick fractures, epiphyseal separations, intracapsular fractures, fractures of the malar bone, fractures of the vertebra and of the carpa, metacarpal, tarsal and metatarsal bones.

Treatment.—In compound comminuted fracture of an extremity it is always good surgery to make an attempt to save the limb, especially if the arterial circulation appears to warrant it. These cases of compound fracture should first be put locally in good surgical condition, the patient, if necessary, being placed under general anesthesia to carry out the details of making a complete diagnosis. These cases need the gentlest of traction, and the least amount of lateral support requisite to keep the parts in place to prevent muscular spasm, etc. To prevent absorption of septic material, drainage must be allowed with an abundance of gauze protection. The swelling may be kept in check by the judicious

use of cold compresses or ice bag. Here the surgeon needs the most careful judgment so as not to devitalize the parts. When there is much contusion, and the circulation poor, moist heat is the best treatment. Support of the most gentle kind is all that is required in this case. Slight motion of the fractured parts does not prevent union. The bowels should move once in twenty-four hours. Tonics should be given the patient, and the heart and lungs should be examined, and treated when required. The skin should receive attention, and where pressure exists care to prevent bedsores should be taken. The urine should always be examined, and the kidneys put in the best possible condition. In all compound and in severe fractures, I examine the urine, especially if the patient is past middle age or gives a history of any former trouble, or if his mode of life shows any disposition to kidney changes. In simple fractures, prolonged manipulation is uncalled for, the diagnosis can often be made without touching the parts. The main principle upon which I treat fractures is to place the entire limb at rest. If the fracture is in the leg I splint and bandage foot, leg and thigh; if in forearm, I do the same with forearm, arm and hand; if the foot is the seat of fracture, the foot and leg are to be put at rest, and if the hand, hand and forearm.

Fracture of the nasal bones can be made out by the contour, mobility, crepitus and the history. It is not a dangerous condition unless complicated by fracture of the cribriform plates of the ethmoid bone; then shock will be most pronounced and cerebral complications will be manifest. In the treatment of this fracture a miniature roller of gauze is placed in position on a glass rod, adjusted within the nose, and the rod withdrawn. Fractures of the superior maxillary bone repair quickly and firmly on account of the liberal blood supply. This is the reason that the parts should be kept in apposition and that all fragments should be left in place if possible. On account of the liberal supply of blood to this bone we may have different forms of inflammation, which may extend to the antrum. This is a severe complication. Fractures of the alveolar process can best and most easily be kept in place by wiring the teeth, taking the precaution to skip the tooth next to the line of fracture. When wire is not handy, waxed linen thread does very nicely. If the wire does not accomplish the purpose the inter-dental splint of wire must be used. I have not yet found it necessary to resort to ivory pegs in the fractures of either of the maxillary bones. Where the alveolar process of the upper or lower maxillary bone shows a comminuted fracture, it is good practice to wire the teeth of both bones together and keep them so for at least eight or ten days. Fractures of the malar bone can usually be reduced by manipulation. When the body or ramus of inferior maxillary is fractured, a four-tailed bandage, with or with-

out splint, is a very good dressing ; but what I like better is a double splint.

In fractures of the hyoid bone the fragments, if possible, should be manipulated into place and supported with adhesive plaster. Should edema occur, and respiration and deglutition be interfered with, an incision should be made and the irritating fragments be removed. Fractures of the ribs generally occur in the fourth, fifth, sixth, seventh or eighth, and when only one is involved a simple bandage of adhesive plaster encircling the chest is quite sufficient for dressing. The complications are those which involve the plural cavity, lung, diaphragm or pericardium. Hemorrhage into the plural cavity adds to the gravity, while emphysema may extend over the entire body. In the treatment we may be obliged to make an external opening, suture the ends and carry a strip of sterilized gauze well into the bleeding cavity, secure it by pressure from within out, enforced by pressure from the outside inward. This will generally control all hemorrhage. Adhesive plasters encircling the chest to limit movements make treatment complete. The sternum can generally be kept in place, when fractured, by adhesive straps, excepting that of the xiphoid cartilage, which may be either sutured or removed through incision. The clavicle is fractured more often than any other bone. There is displacement of the internal fragment, which is pulled upward by the sterno-oleido-mastoid muscle, and the outer fragment downward by the subclavian muscle. The fragments also are carried inward by the weight of the shoulder. These facts afford a key to the treatment, which is to carry the humerus and the shoulder of the injured side well back, crossing the arm across the opposite breast. I do not think it advisable to keep up manipulation of fragments. Where the patient is a young female it would be easy and good treatment to place patient in bed, the hand and arm by the side, and a small pad strapped over the scapula of the affected side. Fractures of the scapula should be treated by immobilizing the arm. The head of the humerus should be well in place, a pad in the axilla, and the arm supported by a bandage passing under the elbow, crossing the chest and back to the sound shoulder and under its axilla, where it is made fast to the anterior or posterior portion. Then the hand should be carried in a sling.

The Humerus.—There are two classes of fractures of this bone which need particular attention : those of the upper, and those of the lower extremity. Fractures of the upper extremity of the humerus involving the anatomical or surgical neck, tuberosities or head can be treated on similar lines, though the lesions and symptoms of each may differ from the others. Fractures of the upper part of humerus, the surgical neck, and anatomical neck, through the tuberosities may all be treated in the same way. A cap splint,

well padded, reaching well over the shoulder and down to the elbow, and an anterior splint from the axilla to the elbow on the outside should be applied, the forearm flexed at right angle, and a bandage applied from it to the shoulder. Extension should be kept up while splint and bandage are applied. Where there is dislocation of head of the humerus with fracture, reduction should be made even if we have to resort to McBurney's method. Delayed and non-union are more frequent in this bone than in any other. Some years ago, before the American Medical Association, I recommended letting the arm hang with the bandage on. I still think that is good treatment. To the young physicians fracture at the elbow is a bugbear. Always keep in mind that if a line is drawn from one epicondyle to the other in a horizontal direction, the top of the olecranon will be below it, so if either condyle or olecranon is fractured it may by this means be made out. We may also have the "T" fracture here, and in this or any other fracture involving the joint it is not positive that we should have undesirable results, if we remember in splinting for this fracture that the arm is used for carrying, and that the forearm and the arm form an obtuse angle when the arm is at the side and is in the normal supine position, the hand being away from the body. The right-angled splint, or when the condyles are involved, a slight flexion, is the best dressing—bandaging from hand to shoulder. It is better to have the patient keep still for a number of days and not think of moving the parts until the fractures are united.

Fractures of the olecranon process and coronoid process of the ulna, and fractures of the neck of radius, may be treated alike. First, dressing with the arm and forearm at a slight angle; second, dressing nearly at a right angle, but put on with plaster-of-Paris. If there is considerable displacement of fracture of olecranon, or if the fracture is compound, a large fenestrum may be cut out of the site, over the joint. The wound can be dressed, if compound, and if the fractured parts tilt to one side or the other, or remain apart, an adhesive plaster may be applied over the upper and posterior part, carrying one end to the right and the other to the left, around over the anterior surface of the forearm. Fractures of the shaft of the ulna and radius can be treated with the anterior and posterior splints; that the arm should be semi-pronated and the padded splints wider than the arm, are the only special things to be kept in mind. The radius comes next in frequency to the clavicle in the list of fractures. A good way to diagnose fractures of the shaft of the radius is to find out whether the head rotates with the shaft of the bone. The so-called Colles' fracture and fractures of the lower end of the radius and about one inch, or less, from the articular surface are the ones that cause us more or less trouble. First in importance is the reduction of this fracture, which can be

made by fixing the arm, grasping the prone hand, palm to palm, and making firm extension, then manipulate upon the palmar and dorsal surface until fragments are in position. A well-padded splint from the elbow to the end of fingers, the fingers and hand slightly flexed, cotton for a posterior splint, the arm in a semi-prone position and bandaged—that is the treatment. There are cases of transverse or slightly oblique fracture where Dr. Moore's dressing will do. At the end of the first week's dressing the distal joints of the fingers may be freed; at the end of the second week the next joint; at the end of the third week the next joint, etc., about five weeks being required to get firm union. We should not forget greenstick fractures of the radius and ulna, which are frequent with children. I would advise, when having a history as of injury of the forearm in a child, to apply splint. In fractures of the carpal bones any splint that gives rest will do; the metacarpal bones can be treated with a ball in palm of hand, the hand and fingers bandaged over that. Fractures of the phalanges—extend fingers on a padded splint and bandage.

Pelvis.—Fractures of the pelvis are divided into those of the so-called extremities or prominences, crest of the ilium, ischium and coccyx, all of which, except the latter, may be treated with circular bandage. The coccyx may be replaced by finger in rectum and retained by gauze packed around a tube in rectum. Where we have fractures involving the ring of the pelvis it is a serious condition, as the urethra, bladder, blood vessels, and even intestines may be involved in the injury and should receive first attention. Outside of the complications the fractures of the ring of pelvis or acetabulum require extension applied to leg, fixation of pelvis by circular bandage and rest in bed. The femur is implicated in about one-eighth of the fractures of the lower extremity. Intracapsular, extracapsular and fracture of the neck of the femur are frequent in the aged, and we wonder at times how slight violence could produce this fracture. In making the diagnosis we should not forget that in the intracapsular fracture the patient may be able to walk a little at a time without a great deal of discomfort. In the extra capsular variety this is hardly possible. In fractures of the neck of femur the pain and displacement is so great that the patient is unable to walk, and this is a diagnostic point. In intracapsular and extracapsular fractures there may not be any suggestive position of the limb, but in fracture of the neck of femur the picture is typical; the limb lies helpless, is everted, the muscles and fascia being quite relaxed yet the limb may be flexed and raised. So I would say that pain, crepitus, eversion, shortening and spasm of the muscles, all being in the affirmative, the crepitus would make the diagnosis of fracture of neck of femur quite easy and positive. Personally I have come across more undiagnosed cases involving the head of

femur than any other fracture. In the aged the prognosis should be guarded, not only as to the usefulness of the limb, but also to the danger of life. In fractures of the middle and upper part of the shaft, the surgical neck, intracapsular and extracapsular fracture of the femur, the plaster-of-Paris, or long external splint may be used. These two and all other treatments hinge on extension with what other merit they may possess. For the aged, extension upon the leg with adhesive plaster, with weights attached by pulley, with splints around thigh and abdomen to the extent that the patient can bear. In the very old and weak patients I simply use sand bags, having several, so that cleanliness can be maintained by frequent changing. On strong and younger patients we can use plaster-of-Paris bandages, well applied, under anesthesia, to the leg, thigh and abdomen, while strong extension is being made. The Hodgen splint is the most perfect splint that I know of when applied with care and skill and can be used in any fracture of the femur from the intracapsular to the condyles inclusive. Sometimes a lateral splint, reaching well up to the axilla, is required to prevent inversion. Fracture of the lower extremity of femur may be complicated with injury to the blood vessels on account of the connection of the hamstring muscles acting on the lower fragments or pulling the lower fragments upward. Intercondyloid fracture is serious on account of joint involvement, and the epiphyseal separation may require an amputation. Fractures of the patella are easily made out excepting when there is extensive effusion of serum and blood. In compound fractures the greatest of care must be given to the parts at seat of fracture. The fragments may be sutured and wired together and the joint protected in the best way possible. It may then be treated the same as simple and comminuted fractures; that is, a posterior splint extending from buttocks to foot. The anterior splint may be applied one upon leg and the other upon thigh, or, what is better, a plaster-of-Paris splint covering the same area. A fenestrum in either case can be made over the patella, and an adhesive strap applied to patella and pulled down the same as that recommended in fractures of olecranon. Where there is separation of even an inch we may get good union, and I hardly think it advisable to attempt to wire or in any way suture the fragments. A fracture of this bone requires that the patient should lie in bed for at least five weeks. He should walk with the aid of crutches about the same length of time, after which you may begin your massage. This, you see, carries your patient along four or five months. Fractures of the shaft of tibia and fibula can be treated with the fracture box—a posterior splint and two lateral splints. These should extend a few inches above the knee. This can be left on a week before the plaster-of-Paris is applied. The first few days I bandage, and

splint the thigh. The fracture-box is the ideal first dressing in all compound fractures of foot or leg. Fracture of head of tibia or fibula may have Hodgen's splint. We should not forget that fractures of the upper end of tibia, even when the joint is not involved, require twice the length of time that the lower end needs. This bone is quite often fractured in wrestling where torsion is the force applied. A complication may occur in fractures of tibia; the complication is the trauma to the vessels. Where the lower end of fragment is displaced downward and backwards, etc., we may resort to tenotomy of the tendo Achilles. Pott's fracture, produced by eversion and outward rotation of the foot, is the triple fracture. The lines of fracture may be at internal malleolus, the fibula two inches above its lower end or through a part of the articular surface of the tibia. The diagnosis is made out by the prominence of the internal malleolus and the extreme eversion of the foot. For treatment, extension of foot, and it may be, the placing of the limb and foot in a fracture-box until swelling has been reduced, then apply plaster-of-Paris splint from toes to the knee joints. Fractures of all parts of fibula—apply plaster-of-Paris. Nature puts the other splint on in the form of the tibia. In fractures of the bones of the foot, when compound, if they cannot be replaced, remove fragments. Place the foot at right angle to the leg and apply plaster-of-Paris. The results are generally good. When the fracture is through the neck of the astragalus, the foot is placed so as to make an obtuse angle of foot and leg and retained. When the other bones of foot are fractured manipulate the parts into position and retain them with plaster-of-Paris dressing. Have not taken up all methods of treatment, among the most important left out being the ambulatory treatment.

THE SURGICAL TREATMENT OF THE INSANE IN PRIVATE PRACTICE.—NO. 2.

BY ERNEST HALL, M.D., L.R.C.P. (EDIN.), VICTORIA, B.C.
Fellow of British Gynecological Society.

In the DOMINION MEDICAL MONTHLY of January, of this year, I reported the pelvic examination of twenty-three female patients, with a statement of the conditions found in each examination. I also reported the operative treatment of twelve of these that were submitted to surgical measures, with the result of three being cured, four improved, and five unimproved. I herewith

submit the report of the examination of thirty-nine additional cases, and the treatment of another series of twelve.

The finding of the preliminary pelvic examination, the additional minor conditions discovered upon opening the abdomen and the subsequent history of these cases, is such as to support and confirm all theories advanced and deductions contained in the previous article, and to give greater stimulation and encouragement to a more thorough investigation of this most neglected department. What was once supposition and hope has now become fact and reality. We do not pretend to understand the mystery of the relation between the physical and the psychical. We do not pretend to state definitely that the presence of adherent appendages or uterine fibroids cause that disturbance of the psychical called insanity; nor are we able, after the removal of such pathological conditions, to explain why normal mentality is resumed; but this we do know, that disease of the pelvic organs is present to an exaggerated degree in those manifesting psychical disturbance, and that in a large proportion of cases the removal of the pelvic disease is followed by the restoration of the mental functions? More knowledge of the nervous connection, the sensory tracts, and of the sympathetic system, more especially that of the interpelvic plexuses, with probably a newer conception of the science of psychology, based upon knowledge gained in the laboratory rather than that developed from a metaphysical basis, is needed before we can speak with any desired degree of definiteness on this matter.

It is not the removal of any individual organ or organs, upon which depends the recovery in these cases—the ovaries appear to have no greater influence than various other parts, as recovery has taken place in one case where it was impossible, on account of the dense adhesions, to find but one ovary, and in another case where both ovaries were untouched. Although in earlier operations, organs and parts of organs were sacrificed, the present method is to remove no organ or part of organ which does not present distinct evidence of disease. Even after the removal of a hopelessly diseased ovary the tube is frequently preserved, with this exception, which may be a point upon which some readers would take issue, that in these cases all possibility of future pregnancy should be put at rest.

As an illustration of the deplorable condition of our asylum population, and the correspondingly great credit that is due to such superintendents as Dr. Buck, of London, with his able staff of assistants, Dr. Burgess, of Montreal, and Dr. Gillis, of Brandon, in their noble and energetic efforts on behalf of those committed to their care, I will briefly state the result of an examination in a Canadian asylum of thirty-three cases, selected from some seventy

female inmates as being the more intelligent and more favorable cases, presenting no indications of hereditary disease or physical degeneration. Out of these thirty-two examined distinct pelvic disease was found in thirty, conditions which, in the opinions of the best gynecologists would justify operative treatment. Out of this number seven were submitted to operative treatment with the result of three being discharged from the asylum and sent to their homes, two improved but still in the asylum, and one death; this last case was one of curretting, amputation of the cervix, vaginal section, double ovariectomy (cystic and adherent ovaries), and anterior vaginal fixation; progress favorable until the fourteenth day, when she had a chill, rise of temperature, development of abdominal tenderness and tympanites. She continued in this condition for some two weeks, when she experienced pain, sudden elevation of temperature, and death followed, the history pointing somewhat directly towards pelvic sepsis, which condition would have justified the re-opening of the abdomen; post-mortem was not granted.

As an indication of the various attitudes of asylum authorities I may state that the day upon which I made sixteen examinations, recommending fifteen for hospital treatment, I received a telegram from the superintendent of an adjoining asylum stating that no cases under his care needed examination, and none could be benefited by an operation.

A glance at the table shows that in but three cases could any history of pelvic disease be obtained from either the patient or her friends, and that in but two cases was there knowledge of the presence of pelvic disease. Although but five months have elapsed since the operation upon case twenty-one, the first of this second series, three can be reported cured, and four improved, giving a total of six cured and eight improved.

Although but seventeen months have elapsed since the treatment of the first case, yet the results are sufficiently interesting, if not startling, to demand the attention, not only of the physician but of the politician. If 90 per cent. of our female asylum population are fit subjects for the hospital, and if from the hospital from 30 to 40 per cent. can be returned to their homes, is it reasonable that a profession, many of whom ridicule, if not oppose, the methods and depreciate the results, can continue to retain the confidence and respect which their self-sacrificing services in other departments entitles them? Nor can any government which prides itself on its humanitarian principles and economic practices be awake to its opportunities and obligations, who would refuse to co-operate in a work, by means of which thousands of its subjects can be restored from worse than death, and the government be released from no small amount of financial obligation.

TABLE OF CASES SUBMITTED TO SURGICAL TREATMENT.—SECOND SERIES OF TWELVE.

Case	Age	Children	Miscarriages	History of Pelvic Disease		Knowledge of Pelvic Disease by Patient or Friends		Variety of Pelvic Disease	Variety of Insanity	Duration of Insanity		Treatment	Results		
				Pelvic Disease	History of Pelvic Disease	Knowledge of Pelvic Disease by Patient or Friends	Knowledge of Pelvic Disease by Patient or Friends			Insanity	Insanity		Physical	Mental	
21	32	1	..	Salpingitis specific	Yes	Adhesions of clitoris. Prolapsed urethra. Right ovary cystic and adherent. Left uterine and adherent. Retroversion	Yes	Adhesions of clitoris. Prolapsed urethra. Right ovary cystic and adherent. Left uterine and adherent. Retroversion	Melancholia and Sarcinal	Ten years	Two years, six months	Nine years	Freezing of clitoris. Removal of papilloma and urethra, dilatation and curetting, double salpingo-oophorectomy.	Cured	Cured
24	42	0	3	.....	.....	Uterus adherent. Small parovarian cyst. Tubes and ovaries encased and adherent. Appendix enlarged and full of fecal matter	.....	Uterus adherent. Small parovarian cyst. Tubes and ovaries encased and adherent. Appendix enlarged and full of fecal matter	Melancholia and Sarcinal	Three weeks	.....	.....	Dilatation and curetting. Left appendage removed. Right tube and part of right ovary	Cured	Cured
26	18	..	..	Appendicitis and Typhoid Fever	.....	Bilateral incarceration of cervix. Left ovary enlarged. Right cystic and cirrhotic. Fungosities	.....	Bilateral incarceration of cervix. Left ovary enlarged. Right cystic and cirrhotic. Fungosities	Sarcinal and Exealable	Two years	.....	.....	Curetting. Amp. of cervix. Left appendage removed. Right ovary resected and tube removed.	Cured	Improved
29	28	4	..	.....	.....	Intra-uterine fibroid, with interligamentous fibroid, filling pelvis, attached to cervix.	Yes	Intra-uterine fibroid, with interligamentous fibroid, filling pelvis, attached to cervix.	Delusions with Religious Mania	One year, three months	One year, three months	.....	Super-vaginal hysterectomy leaving ovaries and tubes.	Cured	Cured
30	50	2	..	Fibroid Tumor	.....	Cervical incarceration. Uterine fungosities. Cystic ovaries.	.....	Cervical incarceration. Uterine fungosities. Cystic ovaries.	Delusions	Four years	Three years	.....	Amp. cervix. Curetting. Resection of ovaries.	Cured	Improved
31	36	4	?	.....	.....	Retroversion with adhesions. Fluorine fungosities. Cysts ovaries.	.....	Retroversion with adhesions. Fluorine fungosities. Cysts ovaries.	Demencia	Four years	Four years	.....	Curetting. Right ovary removed. Left resected.	Cured	No change
32	28	..	..	.....	.....	Incarcation of cervix. Varicocele. Cystic ovaries. Retroversion.	.....	Incarcation of cervix. Varicocele. Cystic ovaries. Retroversion.	Idiosyncratic Delusions	Four years	Three years	.....	Curetting. Amp. cervix. Anterior section. Removal of left ovary, resection of right.	Died four weeks afterwards	.....
33	27	3	?	.....	.....	Lacerated perineum and cervix. Varicocele and cystic ovaries.	.....	Lacerated perineum and cervix. Varicocele and cystic ovaries.	Delusions	Three years	Three years	.....	Curetting. Amp. cervix. Right appendage removed. Left ovary resected.	Cured	Improved
34	27	3	?	.....	.....	Lacerated perineum and cervix. Enlarged uterus. Adhesion of clitoris.	.....	Lacerated perineum and cervix. Enlarged uterus. Adhesion of clitoris.	Religious Mania	Five years	Five years	.....	Curetting. Amp. cervix and ventro-suspension. Freezing of clitoris.	Cured	No change
41	27	..	..	.....	.....	Adhesions of clitoris. Retroversion.	.....	Adhesions of clitoris. Retroversion.	Melancholia	One year	Three months	.....	Freezing of clitoris. Curetting. Ventrofixation.	Cured	Improved
43	51	11	2	.....	.....	Varicocele of both broad ligaments. Lacerated cervix. Piles	.....	Varicocele of both broad ligaments. Lacerated cervix. Piles	Melancholia, Delusions	.....	Four years	.....	Ventrofixation. Amp. cervix. Removal of Piles.	Too early to report	.....

All reforms have a somewhat similar history ; vested prejudices and conventionalities must be disturbed, and such disturbance necessarily means opposition ; but in view of this contest between the unalienable rights of incarcerated invalids, and the inexcusable attitude of officials, it is high time that this first period of opposition should pass into that of calm discussion or co-operation. It is too late in the history of civilization for human rights to be ruthlessly neglected, even by official decree. From a thousand invalids, from a thousand homes, comes forth the prayer breathed so often in history, " Liberty or Death." We have entered upon this crusade and shall cease only when every asylum patient in our Dominion has extended to her and to him the privileges and blessings which are at the disposal of modern medical science, even if the chariot wheels of progress be dyed red with the political and official life-blood of those who affirm that the present methods are adequate.

The importance of this subject cannot be overestimated. It lies too closely to many of us to be thoughtlessly put aside, and appeals to our sympathies as perhaps few others can. We, as practitioners, cannot afford longer to view this matter in the light of our class-room knowledge, while patients are being committed to the asylum with little examination and less treatment. The rôle of such farcical performances must cease, and in their place appear a measure of reasonable effort and the same principles of diagnosis and treatment obtain which are recognized in other departments.

Some allowance can be made for the apparent incredulity or indifference in regard to the results of different workers in this department ; upon the part of those who, overworked in their daily round of self-denying services, their lives already too full, have given no thought to this matter ; but we are far from supposing that any reasonable number of our profession, after having weighed the evidence submitted and considered the subject in detail, could fail to appreciate the main points at issue, or to co-operate in this effort on behalf of more reasonable treatment of this neglected class.

Reports of Societies

ONTARIO MEDICAL ASSOCIATION.

The nineteenth annual meeting of the Ontario Medical Association was held in the Normal School Building, Toronto, June 13th and 14th, Dr. W. J. Gibson, Belleville, presiding.

The following gentlemen were introduced to the Association: Dr. Wilding, delegate from the New York State Medical Society; Dr. Christian Fenger, Chicago; Dr. V. Y. Bowditch, Boston; Dr. J. C. Wilson, Philadelphia, and Dr. D. W. Montgomery, Los Angeles, Cal.

Dr. J. F. W. Ross presented the report of the Committee on Papers and Business, which was approved.

In the absence of Dr. J. A. Temple, Dr. William Oldright presented the report of the Committee on Arrangements; also approved.

A CASE OF MUSCULAR DYSTROPHY.

Dr. INGERSOLL OLMSTED (Hamilton, Ont).—The subject of this case was a young married man 25 years of age, who had come to the doctor complaining of wasting of muscles and inability to work. His family history showed that other members thereof (though not in either parent) had been afflicted with the same trouble. The patient was presented to and examined by the members of the association, the peculiarity of his gait and movements noted, especially interesting being his manner of assuming the erect posture from a prone position. Wasting was most marked in the region of the scapulæ, deltoids, biceps, fore-arm and thigh muscles, whilst those of the calves and hands were moderately well developed. Winging of the scapulæ was especially well marked.

Dr. MCPHEDRAN stated he had examined the case with very much interest. It was an orthodox case of this kind, but presented one or two phases of unusual character, especially the preservation of the trunk muscles. He thought there must be some degeneration of nerve fibres present in these cases.

Dr. GEIKIE thinks that as we come to know more and more of this disease that destructive changes will be found existing in the nerve centres.

Dr. OLMSTED.—With regard to what Dr. Geikie has said, he thought there was no question that extensive atrophy takes place without any involvement of the central nervous system.

RELAPSE IN TYPHOID FEVER.

Dr. J. C. WILSON (Philadelphia), read a very interesting and able paper on this subject. He exhibited a number of temperature charts and said that special attention should be paid to the condition of the gall bladder as a causative factor in producing these relapses. He took this as his "working hypothesis," and proceeded to demonstrate the concomitant occurrence of a relapse with the renewed physical movements of the patient, the beginning of the administration of the more solid forms of food, the consequent peristalsis thus produced in the gall bladder, and the subsequent discharge of the accumulated contents of this cyst, containing large quantities of the bacillus typhosis into the intestine, thus producing the reinfection and the relapse. This, he thought, must be due to intrinsic and not to extrinsic infection. Dr. Wilson then spoke for some time on immunity, and concluded in this way: "Thus we have a 'working hypothesis' to explain relapse, which may be set forth in these terms: intrinsic re-infection from the gall bladder at a time when the intestines are stimulated by larger meals of a different character, an immunity not yet complete, and re-infection at once without a period of incubation." He perfectly understands that the change in blood serum which underlies the Widal test is not a process of immunity, but a process due to the infection. He closed his admirable paper as follows: "That the histological changes taking place in the solids and fluids of the body bringing about immunity are also gradual, and if the 'working hypothesis' stands at all, it demands that complete immunity shall be established in the primary attack, otherwise intrinsic reinfection, which gives rise to the relapse, could not possibly occur."

Dr. MCPHEDRAN thought Dr. Wilson's definition of relapse a good one, and that he drew a very clear picture of it. We know that some of the cases of typhoid may be an abortive attack, and he saw no reason why relapses also should not be abortive. The question of the gall bladder as being the source of the infection of these relapses, is a very important one, because of the suddenness of the outbreaks of symptoms. He thought it might be due more directly to the toxins in the bile.

Dr. J. L. DAVISON quoted Fagge, who refers to cases in Guy's Hospital that had died from the sequelæ of typhoid weeks and weeks after convalescence had been established, and on *post-mortem* examination Peyer's patches were found still infected, or still in a condition which showed evidences of the bacillus. In many cases the disease smoulders along for weeks, and while Dr. Wilson's hypothesis of the gall bladder is a reasonable one, it hardly explains why we should have cases of relapse after thirty days and later, and, therefore, Dr. Davison thinks there must be other storehouses for the retention of the specific germs than that.

The question of the number of relapses is a very interesting one. While Dr. Wilson stated he had seen as many as seven in a six months' illness, the largest number he had seen in any one case was three. He instanced a case of recovery after perforation. The question of immunity was an interesting one in typhoid fever. From recent researches it appears that there are two immunity substances, one which produces an anti-toxin and destroys the action of the toxin in the body and thus serves to keep the patient alive, and the other which is bactericidal in its action. It appears that we must have both of these in order that a patient may recover from the disease. It is this bactericidal element which has a large part to play in the destruction of the germ itself.

Dr. THISTLE asked why go to the gall bladder when the bacilli are in the intestinal contents.

Dr. WILSON, in reply, stated, the infective comes from the gall bladder because the toxin is accumulated in a great mass in a hollow viscus, which, under physiological conditions of low diet may remain there; but when you begin to feed the patient at longer intervals with solid foods, the gall bladder is suddenly stimulated to empty itself. Dr. Wilson did not exclude the intestine if the gall bladder is quiescent. Under the condition of feeding small amounts of fluid alone, the gall bladder is not stimulated to push out its contents.

TUESDAY, 3.30 P.M.

The HON. G. W. ROSS delivered an address of welcome to the association. He expressed his pleasure at meeting the medical gentlemen of Ontario. We look on the medical men of the province as belonging to a class of progressive educationists which are of assistance to the Department of Education in maintaining the proper scientific spirit in the country. He spoke on the subject of tuberculosis, and said if the Medical Association of this province can throw out some hints whereby that disease can be banished, they will have conferred a great boon upon the people of this country. There is no profession to which the province owes more than it does to the medical profession. In this instance he referred to the extent in which that profession had guarded all of us from contagious diseases, had improved sanitary conditions everywhere and made hospitals habitable. Speaking of the standards of education, he was in favor of keeping these up and emphasized having a good general English education before entering upon professional studies, and after four or five years of professional study no one could say that the medical profession is not an educated body. The doctor is one of the most influential members of the community. Health in the public schools next engaged his attention, and he exhorted the profession all over the province to interest themselves in this most important object. Physical training and

exercise should go hand-in-hand with mental development. He referred to the unhygienic conditions of public schools in regard to fresh-air space per pupil, lighting, heating, ventilation, etc. Improvements all along this line would tend to develop a good strong sturdy, Canadian stock. Home lessons should not be imposed upon the children so far as the Department of Education is concerned. Examinations at too early an age were injurious and harmful. The country must produce men, strong in mind and body, men with nerves that will endure the strain of public life.

PRESIDENT'S ADDRESS.

Dr. W. J. GIBSON (Belleville, Ont.) expressed his thanks at the honor conferred on him at having been made president of the association. In regard to serum-therapy, it was a matter of congratulation to the profession to know that so many able workers are in the field. He instanced tuberculosis and stated that the whole world was on the alert to discover a cure for this disease. More attention should be given to personal hygiene and cleanliness. It would be difficult to estimate what good purpose it would be to report all the cases of tuberculosis to the health officers. It would be a difficult matter however, to make isolation in all cases compulsory. He spoke of the number of diseases now treated with anti-toxins. No doubt investigators were on the threshold of important discoveries. Every member of the profession should investigate the causes of disease more carefully. Dominion registration under Dr. Roddick bids fair to become an accomplished fact. It is to be hoped some feasible plan could be adopted whereby the student may be spared the examinations and the expense of being licensed in another province. In regard to over-pressure in the schools he was glad to know that the Toronto School Board had done away with final examinations. The combining of mental and manual work, or technical schools, is desirable. He spoke of the improvement in medical teaching, in regard to there being more clinical instruction than didactic lectures, and the importance of laboratory work was emphasized. The public is indebted to the medical profession for the lives saved, suffering reduced, and calamities averted in civilized countries. Physicians stand in the front rank of the benefactors of mankind.

Dr. BRUCE SMITH moved, seconded by Dr. Harrison, that the president be tendered a hearty vote of thanks for his admirable address. Carried.

SYMPOSIUM ON TUBERCULOSIS: SANITARIUM TREATMENT OF PULMONARY TUBERCULOSIS.

Dr. VINCENT Y. BOWDITCH (Sharon Sanitarium, Boston) stated it was gratifying to notice the marked change of opinion in regard to the treatment of tuberculosis in institutions devoted to that

work. Massachusetts had been the first state in America to establish sanatoria. He gave a short history of the Rutland and Sharon sanatoria. It was important to keep this class of hospitals for the incipient disease. He spoke of the educational influence of the hygienic methods employed in these sanatoria. Open windows, even in cold weather, was to be insisted on as a special treatment of the disease. Patients have returned to these sanatoria, begging to be taken back because they could not breathe in their own houses. He thought much more could be done for the patients by having them treated nearer home. Much more can be accomplished by treating consumptives in these sanatoria than by treating them in their own homes. Thirty per cent. have been discharged at Sharon as arrested cases. Dr. Bowditch has never used the term "cure," believing that the term is unjustifiable until after a lapse of years and no symptoms returned. The causes of death in these cases: (a) Advanced condition of the disease on entrance; (b) intercurrent of some other disease; (c) too early departure from the sanitarium and return home to the unhygienic conditions. As to treatment, experiments were made with the so-called specifics. Oil of peppermint proved at times beneficial. Creosote was found to be beneficial as an aid to digestion. Anti-phthisin proved negative. Had refrained from the use of the serum treatment. Abundance of fresh air, judicious exercise, pulmonary gymnastics and calisthenics form the base of all treatment. Results at Sharon mean that sanatoria should be near all the large cities and towns. He congratulated the profession in Ontario upon the establishment of the sanitarium at Gravenhurst and spoke also of the necessity of having hospitals for the hopelessly sick. We take away the principal source of infection when we remove these from their homes.

PATHOLOGY OF TUBERCULOSIS.

Dr. W. T. CONNELL (Kingston), who was to read this paper, was unavoidably absent.

EARLIEST DIAGNOSIS AND SELECTION OF CASES FOR SANITARIUM TREATMENT.

Dr. N. A. POWELL stated that for ten years he had practised in a part of the province where phthisis is practically unknown. The diagnosis of early phthisis calls for what we understand by incipient or early phthisis—the pre-tuberculous stage. In this regard our views have changed materially within recent years. Up to the time of the demonstration of the bacillus a case was considered early unless there were large growths within the lung, and until gross constitutional symptoms had shown. There is an inherent tendency towards recovery in phthisis when recognized early. This leads to the question, How often is phthisis recognized in an early stage, in a stage before physical signs are manifest in

the chest, and before expectoration has commenced? A very slight proportion of such cases are recognized. Why? The teaching of the students in diagnosis is exceedingly efficient. Why are mistakes made outside, and disease of the lungs not recognized until serious inroad has been made into the health of the patient. A part of it comes from the earnest belief that the physician's education has been complete, though crowded. Medical students crowd the course in surgery and gynecology, but neglect physical diagnosis. He believes early diagnosis will depend upon close study and family and personal history. There are certain aids to the examination, such as the use of the fluoroscope and the tuberculin test. In regard to the state of the family history and the personal make-up of the patient, in the careful examination it is important to estimate weight and height together before you can arrive at anything of importance. The symptoms of early phthisis are uncertain. None of them upon which you can rely. A man who is in apparently excellent health may have serious pulmonary disease. It is sometimes important to notice any scars of the neck. As to cough and early hemorrhage, distinct hemorrhage which comes with comparative earliness, are two symptoms of importance. The patient should be made to cough in the presence of the physician, and any sputum thus gained should be examined. In regard to physical diagnosis, if you wish to estimate the value of a stethoscope take a watch and place it on the table, then with the back of the hand on the watch place the bell of the stethoscope in the palm of the hand and listen to the tick of the watch in this way. In examining a patient, the stethoscope should always be used whose accuracy is above suspicion. The evening temperature running up two-fifths, three-fifths, or one degree, associated with morning pallor, is one of the most important elements in early diagnosis. Dr. Powell spoke of the physical examination, and said the patient should always be stripped to the skin and examined in a quiet room. If you can get association of relative dullness in the spinous fossæ with the slightest accentuation and conveyance of the whispered voice, or any prolonged expiration, it is safer to treat such a patient as being probably tubercular. In a case presenting progressive loss of weight and loss of physical energy, if one can get a little wavy or cog-wheeled respiration near the lung, it is safest to treat such a patient as being probably tubercular. Personally, without having much basis to go on, he said that he was afraid to use tuberculin as a test for the fear of lighting up tuberculosis. In a case of prolonged expiration and evening fever, he was very unwilling to try the tuberculin test. As to the fluoroscope, Dr. Williams, of Boston, has done perhaps the best work upon this subject. With this instrument it is perfectly easy to recognize excursions upwards

and downwards of the diaphragm during respiration—the average excursion of the adult male being about two and one-half inches. If it is notably lessened on one side it would raise strong suspicion of the presence of tubercle. Dr. J. E. Graham took the position some years ago that there might be considerable advance in the condition without being recognized by even a trained observer. The apparatus of Roentgen is of positive value when a trained observer recognizes the movements of the diaphragm, and a man of expertness may recognize degrees of shading which will be of benefit in diagnosis.

HOME TREATMENT AND PREVENTION OF TUBERCULOSIS.

Dr. T. F. MACMAHON (Toronto) read this paper, and first spoke of how we should treat the patient in his own home, and what means we shall take to cure the disease and stay its ravages. Without a specific germ there could be no tuberculosis. The main source of infection is the sputum and then infected food. Prompt destruction of the sputum would go far towards the removal of the disease. The public generally and the patients must be educated to this fact. Instruct your patient never to spit on the floor or into a handkerchief. Sputum should be received into proper spit-cups. That the danger from handkerchiefs is a real one is borne out by the facts that washerwomen in health resorts have contracted the disease through washing these handkerchiefs. Very fine drops of saliva may be a source of infection. Intimate association with coughing consumptives is dangerous to nurses in the rooms. Another important instruction is that rooms should be dusted with damp cloths, using a disinfectant solution. Government and Health Boards must take the question up in earnest. Without education of the public all our efforts will be in vain. Of course, newspaper propaganda should be carried on. Premises occupied by consumptives and vacated should be made fit for occupation by the Health Board. Bacteriological examination is quite as important. Association of consumptives with other patients in public hospitals is injurious and scandalous. Consumptives should not be treated in the ordinary hospitals. There should be systematic inspection of dairies and food supplies. There is also danger of infection from domestic pets—cats, dogs, birds, etc. The germ of tuberculosis is always with us. Patients should have as much open-air exercise as it is possible to acquire. Individuals especially predisposed should receive special attention. If the family physician would make it his duty to watch out for badly-formed chests, he could do much. Prompt attention should be paid to anemic and dyspeptic young women. Every precaution should be taken against “cold-catching.” The patient should not choose a sedentary occupation. Much out-door life is especially

desirable. Cure is altogether a question of instruction. There should be no cough mixtures. The nearer we approach the methods of the sanatoria the better our results will be. The only method is the open-air treatment. The patient should occupy the room, when in the house, with the most sunshine. Nothing should be allowed to interfere with the fresh air treatment. Rest in the open air will improve the digestion. Excellent results have been obtained from this treatment in the sanatoria. Cod liver oil, where it agrees, is undoubtedly useful. The best results follow the administration of creosote—not too large doses.

CARE AND PREVENTION.

Dr. CHARLES SHEARD spoke of the open-air treatment as the ideal treatment from the tubercular standpoint. In every case where we find the bacillus present, we have a case of tuberculosis to deal with. If several examinations at various times fail to show any evidences, he thinks we have not got a case of tuberculosis to deal with. This is not the only disease which fresh air benefits. Many cases of bronchitis and bronchiectasis are also benefited thereby. The sanitarium is anxious to effect cures in tuberculosis. There are a great many cases with cavities in the lungs, and we have to care for those cases as well. We have all seen those cases very recently put side by side in the same ward with a patient with chronic bronchitis, with another with pleurisy and with another case with obscure chest trouble; yet there ought to be better places for the care of these cases. There ought to be separate buildings in connection with our hospitals for those cases which the sanatoria will not admit. The profession ought to stand united for the attainment of this object. He spoke of the benefit of the open-air treatment, and thought there should be glass houses and glass sheds so as to protect them from the changes in the weather. Much can be hoped for if patients are kept constantly in the open air. As regards the danger of getting tuberculosis from animals, Dr. Sheard quoted Clifford Allbutt, who fed his own family with the meat of tuberculous cattle, yet none of them contracted the disease. The tuberculin test applied to cattle is a very crucial one. In one cow which responded to the tuberculin test, tuberculosis was limited to one gland alone. Generally we agree that tuberculous milk is dangerous according to the stage of the tuberculosis in the animal. How far are we prepared to go in enforcing laws *re* infection of this disease in animals and in man? He thinks the practitioners should report this to the Health Board. We must understand that we have got a vastly different disease to deal with than the acute infectious diseases which run their course in a few weeks. How much separation from the general public are we prepared to enforce on a

consumptive, or whether we are right in doing even this. It is very questionable if we are prepared to enforce segregation in these cases, and it is doubtful if the public is ready for this just now. In the meantime steps should be taken to notify hotels and lodging houses of cleansing rooms occupied by consumptives.

Dr. BEEMAN (Newburgh, Ont.) spoke of the bacteriological work done in the laboratory and thought that more should be done by the general practitioner. He thought he better secured the confidence of the patient by having this apparatus in his own office to give this gross diagnosis.

Dr. P. H. BRYCE dealt with the establishment of sanatoria from the governmental standpoint and quoted statistics showing the widespread prevalence of tuberculosis in this province.

Dr. MCCONNELL (New Mexico) told of three years' experience in the far South-west. He stated that more patients were now sent out there in whom as yet the bacillus has not been demonstrated, *i.e.*, in the pre-tuberculous stage.

Dr. JOHN HUNTER said every physician should examine the chest of every one of his patients, no matter what disease he came to be treated for.

Dr. WM. OLDRIGHT.—Notification of the disease should be given in all cases. Disinfection after habitation by a consumptive should be carried out; also sleeping-cars after carrying a patient to a health resort. He thought we ought to have sanatoria near the city.

Dr. PLAYTER spoke of the use of ozonised air in the treatment.

Dr. COVENTRY (Windsor, Ont.) thought la grippe was responsible for laying the foundation for many of these cases.

Dr. PRICE BROWN (Toronto).—The lungs are only part of the respiratory apparatus. Every medical man should be able to use the laryngoscope and the rhinoscope. By treating the nose and throat, you can sometimes prevent the disease; and do not forget that you may have tuberculosis without cough or expectoration.

The annual banquet of the association was held in the evening at McConkey's restaurant, Dr. W. J. Gibson presiding. A very enjoyable evening was spent by all present.

WEDNESDAY, JUNE 14th.

SURGICAL SECTION.

Dr. WISHART (London, Ont.) was elected chairman of this section.

INGUINAL HERNIA.

Dr. WM. OLDRIGHT presented four patients, in all of whom he had performed the radical cure very recently. He quoted the indications for and against operating in these cases as set forth by

Dr. W. B. Coley in *Sajous' Annual*. He thought Halsted's modification of the Bassini method was not an improvement.

TREATMENT OF HERNIA.

Dr. A. MCKAY (Ingersoll, Ont.) estimated that something like 20 per cent. of the population was ruptured. He exhibited a new truss which he had contrived after a year's experimenting, and stated that in making trials of its efficiency he had selected men who were lifting all sorts of heavy loads and found that it would give the greatest satisfaction. The idea of the truss is to allow of the body motion, a constant wavering of the pad over the ring.

Dr. W. J. GIBSON spoke of the difficulty of supplying patients with proper trusses. Dr. McKay's truss is devised to prevent the excoriation of the skin.

A PECULIAR GYNECOLOGICAL CASE.

Dr. HARRISON (Selkirk, Ont.)—The subject of this case was a woman with a considerable family. Having become pregnant again—two and one-half months—she was advised by a neighbor to produce an abortion, as it was a very easy thing to do and no trouble arose other than an ordinary monthly sickness. A glass stylet penholder was passed, blunt end foremost, which slipped from the woman's grasp and was lost to her touch. On examination the doctor could find no rent or tear of any kind either in the vaginal walls or in the walls of the uterus. Even after putting the woman under chloroform, the stylet could not be found. The woman was most positive that it was there and that it had been passed blunt end foremost. An exploratory abdominal operation was performed and the stylet was found in the region of the spleen with the point almost impinging upon the diaphragm where the heart lies on that muscle. The woman recovered with nothing worse than a stitch abscess.

Dr. POWELL cited a similar case where a knucle of intestine was found protruding through a rent in the anterior wall of the uterus. The woman died, however, in this case.

Dr. ROE (Georgetown, Ont.) asked if the woman had aborted.

Dr. HARRISON thought so.

Dr. J. F. W. ROSS spoke regarding perforations of the uterus that give rise to practically no symptoms. He instanced three cases seen recently in practice in which, with well marked rupture of the uterus, there were no symptoms of collapse.

Dr. E. E. KING thought that the stylet in Dr. Harrison's case had never gone into the uterus at all.

Dr. HARRISON thought that the pen had passed through the fornix, but he could see no rent whatever in the vaginal wall.

THE SENINAL VESICLES IN HEALTH AND DISEASE.

Dr. E. E. KING (Toronto) described this condition as a pyosalpinx masculinus. He exhibited a number of sections and specimens and said that this was a store-house as well as a secreting organ. He further described the normal condition and relations of the organs, and also their condition in enlarged prostate and in a previous gonorrhoea. He stated he had examined during the last week in the Asylum, ten cases of chronic masturbators and in only one of these were the vesicles found exceedingly enlarged. The prostate was only found enlarged perceptibly in one case.

Dr. PRIMROSE and Dr. MCCONNELL discussed the paper.

A NOTE ON KOCHER'S METHOD OF RADICAL CURE OF HERNIA—
FEMORAL AND INGUINAL.

Dr. PRIMROSE gave a very lucid black-board description of this operation and showed clearly how the inguinal pouches in the peritoneum were obliterated. As a guide in performing this operation, it was best to introduce a finger into the canal and cut upon the finger. Kocher recommends the silk suture in both operations.

Dr. FERGUSON (London, Ont.) discussed this paper.

FIBRINUS RHINITIS.

Dr. D. J. GIBB WISHART stated that several cases of this had occurred last summer in his own practice. In the text-books published this year Lennox Brown and Walsham both state that it is a distinct disease from diphtheria and that these cases need not be isolated.

Drs. PRICE BROWN, L. L. PALMER and INGERSOLL OLMSTED discussed at some length Dr. Wishart's interesting paper, Dr. Palmer instancing an outbreak of diphtheria following one of these cases, in a public institution.

ELECTROLYSIS AND CATAPHORESIS IN THE TREATMENT OF INOPERABLE
AND RECURRENT MALIGNANT DISEASE.

Dr. R. N. FRASER (Thamesville, Ont.) read a highly interesting report of a case and its treatment. He said in this connection that he wished to report the history of a case in which apparently a favorable result has been secured after repeated failures. He was not aware that any case had heretofore been reported in Canada in which a similar plan of treatment had been adopted, and went on to give the detailed history of the case and its treatment. It was a case of malignant disease of the right testicle occurring in a married man, aged 40 years, with the history of a previous orchitis following ordinary mumps. After a prolonged bicycle ride, the testicle had become very much enlarged and the pain almost constant though not very severe. Aspiration had been

performed several times and septic inflammation followed. A section of the tumor was sent to Dr. Caven, Toronto, who pronounced the case one of cystic sarcoma. The growth was removed. It was about the size of a walnut. Dr. Anderson, Toronto, said it was a carcino-sarcoma. Dr. Frazer described at some length the manner of the treatment of the case.

ON SOME POINTS IN THE DIAGNOSIS OF EYE AFFECTIIONS.

Dr. R. A. REEVE read a very interesting paper with this title—He said this was important for the general practitioner, as patients were continually consulting them with regard to defective sight, or stenopia or for actual disease of the eye. It was necessary, in the first place, for the general practitioner to know whether there was any disease present. As to trauma, whether any existed and to what extent was the eye-ball damaged. Was it in the fundus or in the orbit itself? If a large magnet be brought close to the eye, pain is experienced owing to the fact that the foreign body is attracted to the magnet and injures the tissues. Then in some cases we have to determine whether there is rupture of the eye-ball itself posteriorly. He spoke of rupture by *contre coup* and also of luxation. For foreign objects, we should carefully scrutinize the anterior eye and the conjunctiva. He thought the time had come when the general practitioner should have a fair knowledge of the eye and be able to apply it. He should be able to fit the eyes with proper glasses when required. Patients who can read 20/20 will bring ordinary print close to the eye. Here we should suspect astigmatism. Then there is a clue to be got by testing the tension of the eye. This will give you a clue to the presence of glaucoma. Another point that should be attended to is the testing of the field of vision by closing one eye with the hand or using a watch glass. Diseases of the cornea and conjunctiva are to a large extent now capable of division bacteriologically. Be on the *qui vive* for tobacco amblyopia in cases of cataract; and it is important to urge gentlemen over fifty to reduce the quantity of their tobacco.

MEDICAL SECTION.

Dr. J. RUSSELL (Hamilton, Ont.), was elected chairman of this section.

OPHTHALMOLOGY AND THE GENERAL PROFESSION.

Dr. G. H. BURNHAM read this paper, the object of which was to bring forward some of the diseases of the eye, and also some disturbances associated therewith, which required early recognition in order to be successfully treated. He instanced acute glaucoma, chronic glaucoma, tobacco poisoning causing dimness of sight. In regard to the subsequent changes produced by an attack of iritis, he did not for these perform iridectomy; but instead of an oper-

ation gave his combined form of treatment, viz., mercury and the iodide of potassium internally, and pilocarpine hypodermically. He said his results were in this way much better than by an operation. In regard to diseases of the tear passage, he strongly recommended early treatment. He does not favor the employment of the largest probes, and does not probe frequently, as good, if not better, results can be obtained without the additional suffering which frequent probing is always associated with. He also spoke of eye strain causing so many nervous disorders, as headache, neuralgia, constipation and St. Vitus dance, and of the great importance of having the sight tested by an oculist, and not by those so-called "doctors of refraction."

Dr. G. S. RYERSON thought that the paper fully met the requirements of the subject. Ophthalmia neonatorum was, however, omitted. A large per cent. of eyes were lost from this cause. Medical men should take great care in cleansing the maternal parts before delivery, and the eyes of infants later. Credé's methods greatly reduce the per centage of this disease. One or two drops of a one per cent. solution of nitrate of silver should be dropped into the eyes. This is not too strong. In regard to the question of refraction, doctors of refraction or doctors of ophthalmology was very misleading. He had tried to legislate against these when in the legislature, and had approached the government *re* these titles being used unlawfully. The giving of glasses by laymen to the public has been long done; but these titles are very misleading to the public. The question of refraction was a most difficult and complex one, and how can these men on a few month's training undertake such work and treat such cases?

Dr. R. A. REEVE said that in the preventive treatment of ophthalmia neonatorum, bacteriological examination of any natural discharge is of great help. He also upheld the application of nitrate of silver or perchloride of mercury to eyes after birth. He also recommended protargol, 2 per cent. to 4 per cent., as being painless and effective. The Provincial Board of Health should give instructions to doctors and maternities that Credé's or some method be used regularly. He referred to the question of refraction and the difficulty in dealing with it.

Dr. BURNHAM.—Only some points can be referred to in a short paper. He agreed with Dr. Ryerson and Dr. Reeve in regard to refraction and thought the general profession negligent in the majority of cases.

THE INSANITY PLEA IN MEDICAL JURISPRUDENCE.

Dr. J. RUSSELL (Hamilton, Ont.), read a carefully prepared paper on this subject. He thought the public were beginning to doubt that the law was being properly administered in these cases.

The question was of interest to the general practitioner, as well as to the psychologist. It became every physician to acquire such a general, and even special knowledge of the subject as to be able to acquit himself creditably in the witness box without bringing personal discredit on himself or the profession.

Dr. T. F. MACMAHON upheld Dr. Russell with regard to forming a competent commission to deal with insanity cases in law.

NOTES OF A CASE OF TORTICOLLIS.

Dr. D. C. MEYERS (Toronto), presented a patient, a married woman, aged 39. The trouble came on at the age of 25 years, just after the birth of her last child. At that time she was very sensitive as to people looking at her. About three years ago first noticed head would turn voluntarily to the left shoulder, slight at first, in any position but the recumbent one. She is obliged to keep her hand to her chin to keep her head in position. The right sterno mastoid is prominent and much hypertrophied. Her neurasthenic symptoms have gradually disappeared. The treatment consisted in separation of the patient from her friends, Swedish movements gradually increased, galvanism and the internal administration of the iodide of potash and salicylate of soda.

ACUTE DIABETES.

Dr. A. F. MCKENZIE (Monckton, Ont.), reported a very interesting case of this condition. It occurred in a young man of 21 years, a cheese-maker. He was passing about four times the normal quantity of urine of a specific gravity of 1032. Continued slow pulse and sub-normal temperature were noted. The termination of the disease was fatal, through an intercurrent attack of influenza.

TREATMENT OF ECZEMA.

Dr. GRAHAM CHAMBERS read a creditable paper on this subject. He thought the first step towards the successful management of a case of eczema is to make a thorough examination of the patient with the object of determining the etiology and the course of the disease. Bacteria, no doubt, takes an important part in the etiology. There is one principle in the treatment of acute eczema, that is to give rest to the skin as completely as possible. Repeated washings with water are contra-indicated. Dr. Chambers uses externally a mild antiseptic sedative astringent lotion, a combination of black wash and calamine lotion, and recommends it very highly. The internal treatment is equally important. In the majority of cases there is some systematic disturbance. Rest of mind and body are sedatives to the skin and should be secured.

Confinement to bed is sometimes a great aid. Wine of antimony is a valuable remedy in subduing the inflammation of the skin.

Dr. COVENTRY upheld the internal treatment with mercuric chloride, $\frac{1}{4}$ of a grain, and calomel at times, dry, locally.

THE PRESENT STATUS OF ERGOT IN OBSTETRIC PRACTICE.

Dr. K. McILWRAITH (Toronto), read a paper with this title, Administration during Pregnancy where there has been Post-partum Hemorrhage at previous Labors. Given in small doses, t. i. d. in combination with strychnine, it delays the onset of labor and prevents the post-partum hemorrhage. In the first stage it is never given now. In the second stage to hasten lingering labor. Its advocates limit its usefulness to cases in which there is absolutely no impediment to delivery, even in the passages or in the size or position of the child. It must never be given in a primipara. These conditions exclude its use in most cases. It should not be used in p. p. h. in view of the trouble it causes with the secundines. Its routine administration throughout the puerperium retards involution instead of hastening it, and it diminishes milk secretion.

Dr. ROE.—The use of ergot has changed very much during the last twenty years. He used to give it when the head was on the perineum and he never had any bad results.

Dr. MACHELL—Dr. McIlwraith has put the question very fairly. He has given both sides of the question. For the first stage ergot is never given now. In post-partum hemorrhage it is of very little use. For some years now, Dr. Machell had given no ergot at all. He thought that pressure on the fundus was the best.

Dr. G. GORDON.—There is a tendency to go to extremes in this matter. If all was clear in the second stage and pains slow, he would not hesitate to give ergot.

Drs. HUNTER, C. J. O. HASTINGS and CRUIKSHANK further discussed the cases in which the drug is or is not indicated.

GENERAL SESSION, 2 P.M.

A CASE OF LOCCIDIAL INFECTION.

Dr. D. W. MONTGOMERY (Los Angeles, Cal.) gave a clear description of this case. First there were general symptoms of the lungs simulating tuberculosis. The process went on for some little time—a few weeks—and then he got a disease of the skin which was well shown in the photos the doctor exhibited. The disease of the skin consisted of large tubercles, which at first appeared as little maculæ, then grew to be small tubercles, then large tubercles. These tubercles ulcerated and were covered with crusts, and

when you would grasp one and squeeze it between the fingers, you could see that the inside was granular looking, like a fig. We examined some of his sputum but there was no tubercle bacillus to be found in it. The doctor took a piece out of one of the crusts and the first thing he struck was the small round bodies, as shown under the microscope. These have a clear double contoured membrane and granular contents. Just exactly what these organisms are we do not know. Previous to this case two other cases have been reported. As far as the diagnosis of the disease is concerned from the symptoms alone would be rather difficult. He came to the conclusion that it could not be iodide of potash poisoning—for these tubercles looked very much like the iodide rash—because the man had not been taking iodide of potash. We exclude the mycosis fungoides from the fact that there was no preceding erythematous stage nor such lesions on the body. He here exhibited a photo showing a case of mycosis fungoides. In this you can get an idea of the eczema of the hands and arms, and the tomato-like masses were well shown. There was no history of syphilitic disease. In one of Rexford's cases, the disease started in the lungs to later break out on the integument. What we call this micro-organism, we do not know. Rexford's cases were submitted to the best experts we have on these micro-organisms. We expect the disease will be fatal in this case. The disease occurs in a young German of 21 years, who came to California at three years of age.

DISCUSSION IN SURGERY—DISEASES OF THE KIDNEY AMENABLE TO SURGICAL TREATMENT.

Dr. CHRISTIAN FENGER (Chicago) read this paper. The subject was a large one, he stated at the outset. The origin of the surgery of the kidney was in 1869—thirty years ago. This new field of surgery developed rapidly, as is well seen from a review of the literature, for instance, from 1889 to 1899, what he called the third decade, no less than 800 papers had been published on this one subject. Within the last five years came the surgery of the ureter. It is represented in the literature for the last ten years by about ninety papers. We can divide the surgery of the kidney into two periods. The first ten years we can term the period of nephrectomy. During this term the loss of one kidney was not considered so much as a cure of the patient. This period did not terminate after this ten years, but the dawn of the second period or the period of conservatism commenced. Instead of nephrectomy, a less radical operation to locate the disease, without sacrificing the tissue of the kidney at its beginning. In 1881 Hahn made nephrorrhaphy for floating kidney. But by far the most important step, and one whose consequences have been most far-

reaching, covering the entire field of surgery, we owe to Henry Morris, of London, who on February 11, 1880, had the courage to open up the healthy kidney tissue and remove an oxalate of lime stone from the healthy kidney by an incision through the renal parenchyma. No operator had had the courage to do this before, but from suppurating and distended kidneys which did not bleed when we cut through them. From Morris's important operation dates the possibility of the development of conservatism, which is pressing forward, fighting its way toward the goal of renal surgery, which is not the cure of the patient, but it is the preservation for the patient of the tissue that is valuable for secretion. Morris's operation has made it possible to save the kidney from the destroying influence of stone, to operate on the healthy kidney with a stone in it. In the third decade, the latest step forward in conservatism is the surgery of the ureter. It is a somewhat limited field. With the exception of ureterectomy for tuberculous infection, which is only a small part of it, the whole of the field of the surgery of the ureter has for its aim absolutely nothing but conservatism of the kidney. It is a matter of vital necessity for any one who operates on the kidneys to examine the urine for the quantity of urea before any operating is done. There is compensatory hypertrophy of a healthy kidney when its fellow has been removed or destroyed by disease. The urine must be withdrawn and collected in sterilized test tubes. Examination of the urine must be made without delay, because urine changes rapidly by decomposition. There should be a chemical examination for albumen, blood and sugar. There should be a quantitative examination of the urine. We have got to know the quantity of the urea for twenty-four hours. The life of the patient depends upon that. Dr. Fenger spoke of the use of the cystoscope and the most important step in diagnosis, the last step—the step that gives us the final answer to the question, what the matter is, *i.e.*, direct examination of the kidney through an incision in the lumbar region or the peritoneal incision. The lumbar method permits of much more direct examination of the kidney than the abdominal one. The peritoneal is seldom resorted to, whilst the lumbar incision is the one in daily use. The essayist then spoke of the manner of controlling renal hemorrhage by compression, either with the fingers or the clamp. If that does not stop the hemorrhage, it is sutured. Failing this we have to pack the opening of the kidney into the pelvis and trust to the compression of the gauze. Dr. Fenger next took up the different diseases of the kidney for which we operate, and in a classical manner described each and the indications for and against operation. In concluding his very able and exhaustive paper, Dr. Fenger returned his sincerest thanks to the association for the

opportunity that had been extended to him to meet the medical gentlemen of the Province of Ontario.

Drs. R. B. Nevitt, I. H. Cameron and J. F. W. Ross discussed the paper and congratulated Dr. Fenger upon his highly classical deliverance.

GENERAL SESSION, 8.30 P.M.

ELECTION OF OFFICERS.

First Vice-President, A. H. Wright, Toronto; Second Vice-President, M. I. Becman, Newburgh, Ont.; Third Vice-President, R. J. Trimble, Queenston, Ont.; Fourth Vice-President, A. F. McKenzie, Moncton, Ont.; General Secretary, Harold C. Parsons, Toronto; Assistant Secretary, E. H. Stafford, Toronto; Treasurer, George H. Carveth, Toronto.

Dr. Wm. Britton presented the report of the Committee *re* Health of Public and High School Children.

In connection with this report it was recommended:

1. That the number of subjects of study prescribed by the Education Department be lessened.

2. That home work be curtailed.

3. That less exacting examinations be imposed on the pupils.

4. That more time during school hours be devoted to physical culture.

5. That trustees should confer with members of the medical profession as to lighting, ventilation and capacity of school-rooms.

6. That the curriculum generally should be framed with full consideration of the paramount necessity for preserving the physical health of the rising generation.

The report was adopted.

HOSPITAL ABUSE.

Dr. W. J. Wilson read the report of the committee appointed for this purpose.

Your committee find on investigation as follows:

1. The general tax paid by the public for medical and surgical attendance is dwindling, and the willingness of the public to be pauperized increasing.

2. This is due mainly to the mode of management of the hospitals and the operation of "The Charities' and Public Health Acts," under which \$110,000 is expended in a *per capita* rate on the hospital alone. Successive changes in the law tend towards the socializing of the profession and the curtailing of the domain of the private practitioner.

3. Particular instances of the evil are as follows :

(a) Out-patient departments, so far as we can find out, with only one exception, are in the habit of handing prescriptions to the patients, who carry them away and frequently hand them around among their friends.

(b) The Emergency Hospital of Toronto is being utilized, at practically no expense to the patients, for daily accidents of all kinds, which, till this hospital began operation, invariably went to private practitioners.

This we find to be a direct violation of our Code of Ethics, Art. V., Sec. 8.

Therefore, your committee beg leave to suggest :

1. That the Committee on Legislation be requested to present to this association at its next meeting a review of the operation of "The Charities' and Public Health Acts," and their effects upon the status and emoluments of the profession.

2. That the committee has confidence in both the ability and the willingness of the various hospital boards to remedy the evil complained of, particularly after attention has been directed to specific instances of what your committee humbly believe to be wrong.

3. Your committee recommend that it be made a rule in all hospitals that no patients be entitled to free treatment whose hospital maintenance is provided for, including society patients paid for by lodges, except as an act of charity.

4. That all prescriptions in the out-door department of our hospitals and of the various dispensaries be kept on file and not taken away by the patients.

That emergency hospitals should simply render "first aid," and relieve the patient until his family physician, or substitute, arrives, when the further care of the case is handed over to him unless it be a case which will receive a municipal order, when it will be treated by the usual hospital staff.

6. That the sending of accident cases by wealthy corporations, and especially when there is an accident insurance carried on employees, be carefully looked into and any abuses remedied.

This report was unanimously adopted.

Dr. E. J. Barrick presented the report of the committee dealing with the consumptive poor, which was adopted.

Dr. William Oldright presented the report of the Public Health Committee in regard to the treatment of inebriates, which was adopted.

The treasurer and secretary presented their reports. Motion for adoption carried.

Dr. G. B. Smith presented the report of the Committee on Necrology: Drs. Pattullo and H. H. Wright, Toronto; H. P.

Wright, Ottawa; J. H. Mullin, Hamilton; William Younker, Belleville.

The usual *honoraria* and votes of thanks were then passed, and the meeting adjourned to meet in Toronto in June, 1900.

CANADIAN MEDICAL ASSOCIATION.

The thirty-second annual meeting of the Canadian Medical Association will be held at Toronto on Wednesday, Thursday and Friday, August 30th, 31st, and September 1st, 1899.

Through the kindness of the Honorable Minister of Education for Ontario, the building of the Education Department has been placed at the disposal of the Association, and in it the meeting will be held. This building is most centrally situated, as the Church Street cars pass the building, and the Yonge Street line is but one block away.

The programme will be of exceptional interest, and the very important subject of Inter-Provincial Registration will receive full discussion at this meeting.

A number of entertainments have been provided for, including a Reception and Musicales for members and their friends on the first evening; a Lunch at Exhibition Park; an Afternoon Tea at the Royal Canadian Yacht Club on the Island; a Smoking Concert, and other entertainments.

There will be an exhibition of instruments, drugs and physicians' supplies in connection with the meeting.

The Committee of Arrangements is making every possible effort to insure a successful meeting, and trusts that there will be a very large attendance. As the meeting is held during the first week of the Industrial Exposition, railway tickets to Toronto and return may be obtained for a single fare. We earnestly urge upon the members of the profession, to a man, to turn out to this meeting and make the thirty-second annual gathering by a long way the biggest on record.

PROGRAMME.

The President's Address will be delivered on the afternoon or evening of the first day by Irving H. Cameron.

The address in Surgery will be given by W. B. Coley, of New York.

The address in Medicine by J. T. Fotheringham, of Toronto.

In the Skin Clinic, G. Chambers and A. McPhedran, of Toronto, and A. R. Robinson, of New York, and others will take part.

The following is a partial list of the papers to be read:

"The best method of dealing with the consumptive poor." E. J. Barrick, Toronto.

"Floating kidney simulating disease of the ovaries and tubes." A. Laphorn Smith, Montreal.

"Observations on adenoids and enlarged tonsils and their removal, with notes of eighty cases in private and hospital practice." D. J. Gibb Wishart, Toronto.

"The methods and ultimate results of operations for halox valgus." N. A. Powell, Toronto.

"Report of a case of abdominal pregnancy." H. Meek, London.

"An experience in formaldehyde disinfection." F. Montizambert, Ottawa.

"An inquiry into the etiology of chronic Bright's disease." A. G. Nicholls, Montreal.

"Operations for extra-uterine gestation." H. H. Chown, Winnipeg.

"Tuberculosis in cattle and its prevention." J. George Adami, Montreal.

"The hospital room in each dwelling." W. J. Telfer, Montreal.

"The treatment of spina bifida." Geo. A. Bingham, Toronto.

"Complications and treatment of fractures of the skull." J. M. Elder, Montreal.

"Recurrent paralysis of the third nerve (Charcot's ophthalmoplegic migraine)." J. W. Sterling, Montreal.

"Tuberculosis and insurance." J. Hunter, Toronto.

"(a) Typhoid infection without intestinal lesion; (b) Gastroptosis. A. McPhedran, Toronto.

"Some observations on the treatment of cancer." A. R. Robinson, New York.

"Gall-bladder surgery." J. F. W. Ross, Toronto.

"Typhoid epidemics I have met." Wyatt Johnston, Montreal.

"The treatment of cataract." R. A. Reeve, Toronto.

"Christian Science." J. H. Richardson, Toronto.

"Anesthesia by chloroform and ether." William B. Jones, Rochester.

"Treatment of the acute digestive disorders of infancy." A. R. Gordon, Toronto.

"Rhinoliths." Hubert D. Hamilton, Montreal.

"Observations on the relations of the thyroid gland to the uterus." C. R. Dickson, Toronto.

"The question of operation on thyroid tumors." George A. Peters, Toronto.

"A case of malignant disease of the gall-bladder, simulating hydronephrosis (feeding through the gall-bladder for three days)." F. N. G. Starr, Toronto.

"An original method for the direct estimation of proteid digestion in the stomach." A. L. Benedict, Buffalo.

"Nephro-lithotomy." B. L. Riordan, Toronto.

"The mastoid operation in chronic middle ear disease." J. M. MacCallum, Toronto.

"Ringworm in Toronto." Graham Chambers, Toronto.

"The Great Lakes as a health resort." E. H. Adams, Toronto.

"A case of subcutaneous emphysema." Frederick Fenton, Toronto.

Papers have also been promised by G. H. Burnham, A. B. MacCallum and J. J. Mackenzie, of Toronto, and a number of others.

During the meeting, T. G. Roddick, of Montreal, will address the Association on the subject of "Dominion Registration."

The Pathological Museum, in charge of a committee with A. Primrose as chairman, will add much to the interest of the meeting. A great many specimens have been promised, among which are the following:

Lower half of rectum removed for cancer. A. L. Smith, Montreal.

Ectopic pregnancy. A. Meek, London.

Extra-uterine gestation, and others. H. H. Chown, Winnipeg.

Rarer forms of aneurism. Hearts. Calculi. Disease and fractures of bone, and others. J. Geo. Adami, Montreal.

Cast of hand from a case of acromegaly. J. M. MacCallum, Toronto.

Congenital atresia of small intestine. W. B. Jones, Rochester.

Eustrongylus gigas in kidney of mink. Formaldehyde preparations. Dry anatomical preparations. F. N. G. Starr, Toronto.

Obstruction of colon by large gall-stone. Superfoetation, abortion at 4th month, 2 sacs 4 months and 6 weeks. Elevated fracture of skull. Heart and aorta. Fusiform dilatation of latter due to syphilitic endarteritis. Carcinoma of prostate with terminal suppurative cystitis. Columnar-celled carcinoma of stomach. Diffuse infiltration from cardiac to pyloric orifices. Solid ovarian tumor (*Filseo-Myo-Sarcoma*) twelve pounds, etc. W. T. Connell, Kingston.

Lung—Chronic tuberculosis, Acute miliary, Tubercular broncho-pneumonia, etc. *Female Generative Organs*—Adhesions of pelvic organs, Pyosalpinx, Cysts, Tumors, etc. *Bladder Urinary*—Prostatic changes, Sacculations, Calculi, etc. *Bladder Biliary*—Hydrops, Calculi, etc. *Kidney*—Cirrhotic changes, Cysts, Tumors, Hydronephrosis and Pyonephrosis, Calculi, Tuberculosis, Anomalies and faults. *Œsophagus*—Stricture, New growths. *Stomach*—Ulcer simple, Carcinoma. *Intestine*—Adeno-carcinoma, Colitis, Enteritis chronic, Typhoid changes, Tubercular ulcerations. *Ap-*

pendices: Heart—Anomalies and developmental faults, Pericarditis, Myocarditis, Myomalachia cordis, Endocarditis, Chronic valvular disease, New growths, Dilation and hypertrophy without valve lesion. *Blood Vessels*—Atheroma, Aneurisms, Ectases, Varicose veins. *Liver*—Abscess, Cirrhotic changes, Venous congestion, Amyloid, Syphilis, New growths. W. Goldie, Toronto.

For further particulars address—

F. N. G. STARR,
General Secretary Biological Department, Toronto.

THE fifth triennial prize of five hundred dollars, under the Deed of Trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Various Manifestations of Lithemia in Infancy and Childhood, with the Etiology and Treatment." The conditions annexed by the founder of this prize are: that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children"; and that "the trustees, under this deed for the time being, can, in their discretion, publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may, in their judgment, be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia." The prize is open for competition to the whole world, but the essay must be the production of a single person. The essay, which must be written in the English language, or if in a foreign language, accompanied by an English translation, must be sent to the College of Physicians of Philadelphia, Pennsylvania, U.S.A., before January 1, 1901, addressed to Richard C. Norris, M.D., chairman of the William F. Jenks Prize Committee. Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

JAMES V. INGHAM, M.D.,
Secretary of the Trustees.

Special Selections.

**MODERN PARISIAN PRACTICE.—THE FRENCH
THERAPEUTICS OF THE PERIOD.***

TRANSLATED AND CONDENSED BY THOS. C. MINOR, M.D.

DISEASES OF INTESTINE—ACUTE ENTERITIS.—When the enteritis is not very intense, light diet with milk and eggs. If diarrhea is profuse, repose in bed, laudanized poultices over the bowels. Give opiates, especially tincture of opium, paregoric; the subnitrate of bismuth or the salicylate of bismuth may be associated with intestinal antiseptics, salve, betol, naphthol, benzonaphthol. To calm thirst give citronade, or, better still, lactic lemonade (2 to 500), that acts against the diarrhea at the same time. For the fever, prescribe antipyrine or the bromhydrate of quinine. For the weakness, give tea or rum punches. Among children, forbid all solid food; give sterilized milk, or go so far as to even suppress all food for twenty-four hours, using only boiled water (hydric diet) or decoction of barley water or bran; sometimes a little weak tea. Purgatives, calomel in particular, are often used in the commencement of diarrhea; this is bad practice. The subnitrate and salicylate of bismuth, associated with one or two drops of laudanum or ten drops of paregoric, with internal antiseptics—benzonaphthol, betol, salol—often afford happy results. Lactic acid is a good agent in green-colored diarrheas. For colics, poultices, oil of chamomile, or hot cloths to belly. Give paregoric and watch its action carefully. For the fever, subcutaneous injections of bromhydrate of quinine. For weakness, sinapized baths, injections of camphorated oil. For nervous excitation in diarrhea of children, tepid baths, bromides, chloral.

CHOLERA INFANTUM.—Absolute diet during dangerous period of the disease, simply give sterilized or albuminized water; tea with the addition of rum or peppermint alcohol, or sterilized milk diluted with Vichy. Purgatives are useless and calomel dangerous; intestinal antiseptics, too, give no good results. The diarrhea and vomiting must be arrested by opiates and astringents. Among the opiates, laudanum or paregoric are best; among the astringents, the extract of rhatany, subnitrate of bismuth and nitrate of silver give good results. Injections of ipecac in decoction and

*From the work of Debove and Gouvin, Paris, 1898.

lactic acid have also been recommended. Washing out the stomach and intestines with hot boric acid water. In the algid period give stimulants—alcoholic drinks, injections of ether, caffeine, camphorated oil. Sinapized baths, followed by rubbing, hot water bags around the patient. When reaction occurs discontinue stimulants, but go on with the opiates and astringents.

TYPHLITIS—APPENDICITIS.—In stercoral typhlitis, open the bowels with a mild purgative, castor oil or carmel, and practise intestinal antiseptics with naphthol, benzonaphthol, salol, betol, or use boric acid injections. If pain and induration persist, apply leeches or wet cups. If extension of the inflammation to the appendix is suspected, or if the typhlitis appears to be caused by the enclosure of a foreign body in the cecum, keep the intestine quiet by means of extract of thebaine. Calm pains by application of an ice bladder and subcutaneous injections of morphine. Combat the vomiting by iced drinks. Be cautious in the use of purgatives, that increase peristaltic action and may induce a perforation of the bowels. Keep the intestines quiet, then, with extract of opium given every two or three hours in proper doses. The patient should be placed on a milk diet and absolutely kept in bed. In presence of suppurating centres of cecal or appendicular origin, surgical intervention is imposed.

DYSENTERY.—Prophylaxis: Disinfect patient's stools and all articles soiled by dejections. Boil and filter all potable water. Forbid use of indigestible foods, and especially preserved fruits. Avoid chilling the skin; recommend the wearing of a flannel belly band. Treatment: Absolute milk diet. Cold milk diluted with lime water, broken in small and oft-repeated quantities. If the diarrhœa is very intense, give bismuth and opiates. As the stools are modified, a return to ordinary diet may be gradually allowed. In dysentery, substitutive or evacuant medication usually gives good results. Saline purgatives and cholagogues are recommended, notably sulphate of soda or calomel in large doses. Ipecac alone, or associated with small doses of calomel, give good results. One may also administer internal antiseptics—salicylate of bismuth, solol, betol, benzonaphthol, iodoform. Modifying and antiseptic injection with sugar of lead has also been much praised; nitrate of silver and sulphate of copper are often valuable, too, under certain circumstances.

CHRONIC ENTERITIS (TUBERCULAR ENTERITIS).—Milk diet—milk diluted with lime water. Treat diarrhœa with opiates, tincture of opium, paregoric, or by astringents, such as bismuth, tannin, rhatany, columbo, quinine. Injections of nitrate of silver, tannin, boric acid, are all useful in inflammation of large intestine.

MUCO - MEMBRANOUS ENTERITIS.—Evacuate stercoral matter and pseudo-membranous products, and prescribe mild:

purgatives two or three times a week—castor oil, magnesia, olive oil. Use washes for the bowels—lime water, boric acid water or tannin, in the proportion of 3 to 1,000. Calm pains with alkaline bromides, menthol, cocain, cannabis indica; avoid—opium and morphine, as they induce constipation. Combat internal fermentation and intestinal auto-intoxications by injections; betol, benzonaphthol, salicylate of bismuth, salicylic acid, borax, phosphate of soda. Massage, hydrotherapy and change of climate may render service.

CANCER OF INTESTINE.—Calm the pains with opium in small doses or by injections of morphine. Facilitate the running off of matter by mild purgatives and injections. In cases of intestinal obstructions surgical intervention is needed.

INTESTINAL WORMS.—*Tenias* (*Tenia Solium*): The teniafuges are etherial extract of male fern, kousso, pumpkin seeds, pomegranate bark, and pelleterine. Half-hour after the administration of one of these remedies give a purgative; castor oil is about the best. *Ascaris Lumbricoides*: Corsica moss and santonine are the most valuable agents, and the ones commonly used. Absinthe, mugwort (*artemisia*) and valerian are not often given. A mild purgative is given after the vermifuge. *Oxyuris Vermicularis*: Application of gray ointment around the arms and in the rectum. Give for two or three days calomel or sulphur; at times santonine is useful. Afterwards give injections of salt water, soap suds, vinegar water, or cod-liver oil.

INTESTINAL OCCLUSION.—Acute occlusion: Internal strangulation, valvular invagination, cancer, biliary calculus. Forbid purgatives, the employment of which is useless and often dangerous, for by increasing the contraction of the intestine they exaggerate the pains and may induce perforation. Opiate medication is indicated to attenuate the pain and vomiting; administer a pill of aqueous extract of opium every two hours, or use hypodermics of morphine three times a day. The use of injections of simple water or water charged with gas (Seltzer water) are at times efficacious. Washing out the stomach will cause the vomiting to stop when it is feculent, preventing stercoremia, and may even provoke peristaltic contractions of the kind to relieve the obstruction. Electrotherapy (electric injections) often give very good results. Continuous currents are used. One pole, covered with moistened chamois skin, is applied on the abdomen or back; the other, a gum sound covered with metal, is introduced into the rectum. By means of this sound a pint of salt water is injected, that serves as a conductor for the current and prevents any local caustic action. Currents of much intensity can thus be used, and each application may last about a quarter of an hour. If, at the end of two or three sittings, the obstruction is not reduced, it becomes necessary

to have surgical intervention (laparotomy or enterotomy). Chronic Obstructions: In obstructions caused by contractions, by slow compression of intestine, by hardened fecal matter, saline and oily purgatives render good service. Rectal irrigations by simple or gaseous waters, and electric injections are likewise valuable. In case of failure, surgical intervention is required. Pseudo-Strangulations: In pseudo-strangulations we can always remedy the symptoms by purgatives, rectal douches and electric injections; we may also employ opium, belladonna, applications of ice, baths, massage.

INTERNAL HEMORRHAGES.—Absolute repose in bed; ice bladder on abdomen; cold liquid food. Keep bowels quiet by use of morphine. Administer astringent preparations or hemostatics—bismuth, tannin, rhatany, ergotine, perchloride of iron.

HEMORRHOIDS.—Avoid constipation by injections and laxatives—magnesia, castor oil and cascara. Lotions on anus every morning and evening after defecation. Use boric acid water (very cold). As medicaments having an influence on hemorrhoids, extract of hamamelis virginica and capsicum annum are recommended at moments of fluxionary attacks. Repose in bed, sitz baths, application of hot water to anus, tampons of warm boric acid water. To calm pains, suppositories and ointment containing belladonna, cocain, iodoform. For hemorrhages, ice-cold injections into the rectum; fragments of ice are good. Extract of rhatany, tampon of iodoform gauze, or apply antipyrine in powder. Strangulated piles should be treated by local emollient applications, hot baths, phenic acid spraying. Do not incise. Surgical Treatment: Forced dilatation, cauterization, and even excision.

CONSTIPATION.—In transitory constipation give saline purgatives that increase intestinal secretions—sulphate of magnesia, sulphate of soda, citrate of magnesia, tartrate of potash, purgative mineral waters, sweet and oily purgatives, manna, tamarind, castor oil. In rebellious constipation, give drastic purgatives, that induce, besides hypersecretion, more or less violent contractions—jalap, scammony, senna, aloes, colocynth, croton oil. When hepatic secretion seems indicated, cholagogues are indicated—calomel, podophyllin, enonymus, cascara sagrada, rhubarb. Certain purgatives appear to have a purely mechanical action—castor oil, white mustard seeds, linseed, psyllium. In transitory or habitual constipation we may employ cold-water injections or medicated ones (glycerine, honey, salt, senna, sulphate of soda or of magnesia). Hygienic Treatment: Green vegetables, fruits, cider, beer; exercise after meals; attempts at defecation at given hours; hydrotherapy; abdominal massage.

DIARRHEA.—Hygienic Treatment: Rest, milk diet, hot drinks, warm applications to abdomen. Internal Treatment: At the be-

gining of acute diarrheas it is often necessary to relieve the intestines of toxic elements by administering a saline purgative, or a good dose of calomel. Use intestinal antiseptics—salol, salicylate of bismuth, betol, naphthol, benzonaphthol or lactic acid. Diminish peristalsis and intestinal secretion by opiate preparations—aqueous extract of opium, laudanum, paregoric. Administer at same time inert powders—bismuth, prepared chalk; astringents—tannin, rhatany, columbo, subgallate of bismuth. Treat the cause of the disease.

ACUTE PERITONITIS.—At the commencement use wet cups or leeches applied over points where pain is at the maximum. If revulsion does not arrest the peritonitis calm the suffering by applications of various liniments to abdomen, such as laudanum, chloroform, belladonna, or by ice-bags. Use hypodermics of morphine associated with atropine. Keep intestines quiet by administering opium in fractional doses—a pill of the aqueous extract of opium every two hours, for instance. Use intestinal antiseptics at same time. Purgatives are contra-indicated. By provoking intestinal contractions they aid the spread of the peritonitis, that is always localized at the start, so that the pain is increased. Vomiting should be combated by alcoholic iced drinks, cracked ice, or hypodermic injections of morphine with atropine. Alimentation should be reduced to the minimum; give patient iced milk in small quantities. If medical treatment fails the art of the surgeon may be invoked.

CHRONIC PERITONITIS.—Local Treatment: Revulsives, blisters, tincture of iodine, iodine collodion. General Treatment: Milk diet, tonic medication.

TUBERCULAR PERITONITIS.—In acute form, repose, milk diet. Make revulsion by means of leeches or wet cups. Apply belladonna ointment to abdomen or bladder of ice. To quiet the pains give hypodermics of morphine. In chronic forms the local treatment consists of making revulsions by means of blisters or tincture of iodine. If the dropsy is too abundant, practice tapping (paracentesis of abdomen). In certain cases of tubercular peritonitis injections of camphorated naphthol, sterilized boric-acid water, or antiseptic intestinal washes do good. The general treatment of tuberculosis must not be neglected in the meantime.

ASCITES (DROPSY).—Rest, milk diet, revulsives. Favorize the reabsorption of liquid by diaphoretics, diuretics and drastic cathartics. Diuretics: Alkalies, calomel, acetate or nitrate of potash. Squills, digit.alis. Drastic purgatives: Scammony, jalap, aloes. Diaphoretics: Jaborandi, pilocarpine, Dover's powder. The dropsy, by its abundance, may give rise to serious symptoms, and it may become necessary to practise abdominal tapping. Puncture should be made on the level of a line that connects the

umbilicus to the anterior superior iliac process. The operation of paracentesis should be made with all the usual antiseptic precautions.—*Cincinnati Lancet-Clinic*.

THE PREVENTION AND TREATMENT OF CANCER OF THE UTERUS.*

BY A. LAPHORN SMITH, B.A., M.D., MONTREAL.

In the author's opinion cancer of the uterus is not an hereditary disease, because in more than half of his cases the family history was absolutely free from it for three generations back. This may shock those who have been brought up to believe in the tradition of its heredity, just as it did those who believed in the heredity of consumption when they were told that it was a contagious disease, as everyone now admits it to be. Cancer of the uterus has been proved by numerous experiments to be a contagious disease, probably due to a microbe which does not flourish on healthy tissues, but which luxuriates on tissues of low vitality, such as cicatrices, or on women whose whole vitality is below par.

Its prevention.—The author has noticed that it is frequent and increasing in countries where little or no attention is paid to laceration of the cervix, while it is becoming quite rare in countries where these lacerations are promptly repaired. The author makes it a practice at his clinics and hospitals to repair every lacerated cervix that comes before him, with the result that out of over five thousand cases of which he has a complete history there are at present less than twenty-five with a marked laceration unrepaired. If we believe, as Emmett has conclusively proved, that cancer of the cervix almost always begins in the cicatricial tissue in the angle of the wound, then by removing the cicatricial tissue and repairing the laceration we would put a stop to this dreadful disease. Moreover, if it is contagious, as it must be if due to a microbe, physicians and nurses should take greater precautions to disinfect their hands after touching a cancerous patient. The author knows of three cases of cancer occurring in nurses attending patients who died of cancer, and there was no trace of cancer in the family history of any of them. When its contagiousness is more fully recognized it may yet be possible to stamp it out by isolation of the patients.

* Read before the American Medical Association, at Columbus, June 6, 1899.

Its treatment.—If the disease was always detected early while still limited to the angle of the tear or to the mucous membrane of the uterus, total extirpation would in most cases be followed by cure. Unfortunately, the majority of these women do not consult their family physician during the early stage; while in the cases in which he is consulted in good time he often fails to recognize the disease, or he fails to do the right thing promptly, viz., to send her to a specialist for vaginal hysterectomy. If the hundred thousand physicians of this continent would each make one hundred and fifty mothers to understand that irregular hemorrhages at the change of life are not natural, but, on the contrary, constitute one of the earliest and strongest symptoms of cancer, then vaginal hysterectomy would be performed much earlier and the results would improve in proportion. Provided that the organ is freely movable, even if the disease has invaded the whole of it, vaginal hysterectomy with ligatures gives good results. If less movable the clamp method is more feasible. If firmly fixed and the disease has extended to the broad ligaments the author prefers to make a thorough curetting and apply pure carbolic acid freely to the mucous membrane and then to perform Schroeder's amputation of the cervix. Before closing up the flaps it is well to sear them lightly with the cautery to destroy the microbes. This has, in the author's experience, prolonged life from two to five years. In all cases care should be taken to disinfect all cut surfaces.

SKIN ERUPTIONS CAUSED BY ANTIPYRIN.—Wechselmann (*Deut. med. Woch.*) gives a brief description of the varieties of skin eruptions met with in cases of antipyrin poisoning, and also relates the conditions which he had observed in five cases: (1) In a man aged thirty-six, who had suffered from attacks of migraine for several years, and had been in the habit of taking antipyrin pretty freely without medical advice, a vesicular eruption suddenly occurred round the mouth and front part of the tongue; the penis, scrotum, and anus were similarly attacked. The eruption was extremely painful. When the antipyrin was discontinued the patient soon recovered. As an experiment a small dose was again administered, and in an hour and a half the eruption reappeared. (2) A woman, aged forty, had taken antipyrin for migraine. The lips, eyelids, tongue, and dorsal aspect of both hands were attacked with a painful vesicular eruption. On inquiry she admitted having taken antipyrin for her headaches. At a later date she took $\frac{1}{2}$ grain of antipyrin. This small dose was sufficient to cause an eruption identical in every respect to the former one. (3) A man, aged sixty-two, suffering from diabetes, after taking antipyrin for some time, noticed a hemorrhagic eruption on the dorsal surface of his left hand; the skin was edematous. The drug was discon-

tinued, and the eruption immediately began to subside; pigmentation was noticed for a considerable time after the eruption had disappeared. (4) A diabetic man, aged sixty-six, for six years had suffered from a vesicular eruption, which occurred every second year. The parts attacked were the dorsal aspect of both hands, the lower lip, anus, and scrotum. After a short time the vesicles burst, leaving a scale which gradually died away. (5) A man, aged twenty-nine, had suffered from periodic attacks of "eczema," which one doctor had called syphilitic. In May, 1893, he took 3 grains of antipyrin for headache, and in half an hour he began to feel a burning sensation in the perineal region, also between the fingers and on the dorsal aspect of the hands; later the toes became affected. Vesicles formed, and the whole progress of the case coincided with his former attacks of so-called eczema. The patient was advised never to take antipyrin; he had no further skin trouble.—*Brit. Med. Jour.*

MICROBIC ORIGIN OF CHOLELITHIASIS.—Gilbert (*Arch. Gén. de Méd.*) first draws attention to the authors who have investigated this subject. Gilbert himself with Dominici and Fournier examined calculi from seventy cases. They found the bacillus coli communis either in a living or dead state in one-third of the cases. This microbe is also known to set up cholecystitis and cholangitis. In the more recent calculi it was living, but in the older ones it was dead. These authors were apparently able to establish that the microbes were present in the bile before the calculi formed. They have also made an experimental study of the subject. Some five years ago they found small green concretions in the bile of a rabbit in which they had set up a cholecystitis by means of the typhoid bacillus. After many investigations they succeeded in obtaining a small but perfect biliary calculus from a dog injected with the *B. coli communis*, and later they obtained a similar result in the case of a rabbit. Recently Mignot has obtained three small experimental calculi also in animals injected with the colon bacillus. Mignot has been able to perfect his operative technique so as to regularly obtain similar results. Gilbert hopes to be able to produce calculi without the intervention of microbes by the action of chemical irritants upon the walls of the gall bladder. He contends that the development of calculi in animals as the result of microbic inoculation cannot be made to prove that human cholelithiasis is also of microbic origin, and that it gives no indication as to the microbes which might produce cholelithiasis in man. The author looks upon this calculus formation as a defensive mechanism by means of which a baneful agent is rendered powerless. It can only be by means of observations upon man that the causes of cholelithiasis in the human subject can be found out.—*Brit. Med. Jour.*

MONTHLY REPORT.

Issued by the Provincial Board of Health of Ontario for June, 1899. Showing the deaths from all causes and from Contagious Diseases in the province, as reported to the Registrar-General by the Division Registrars throughout the Province.

Issued July 23, 1899.
P. H. BURCK, Secretary.

Year.	Month.	Total population of province	Total deaths reported from all causes.	Rate per 1,000 from all causes.	Scarlatina.	Rate per 1,000	Diphtheria.	Rate per 1,000	Malaria.	Rate per 1,000	Measles.	Rate per 1,000	Whooping cough.	Rate per 1,000	Typhoid.	Rate per 1,000	Tuberculosis (Consumption).	Rate per 1,000
1899	June	2,983,182 91%	1,521	0.06	9	0.12	22	0.01	5	0.03	4	0.02	13	0.06	157	0.05	0.9	
		Total population reporting 2,168,636 73%	Total deaths reported from all causes 1,167		10	0.17	18	0.01	3	0.01	7	0.03	18	0.09	230	0.12		
1899	May	2,218,263 37%	1,767	0.09	10	0.17	18	0.01	3	0.01	7	0.03	18	0.09	230	0.12		
		Total population reporting 2,065,286 93%	Total deaths reported from all causes 2,073		11	0.28	33	0.02	4	0.02	7	0.03	15	0.08	257	0.13		

Year.	Month.	Total population reporting	Total deaths reported.	Rate per 1,000 from all causes.	Scarlatina.	Rate per 1,000	Diphtheria.	Rate per 1,000	Malaria.	Rate per 1,000	Whooping cough.	Rate per 1,000	Typhoid.	Rate per 1,000	Tuberculosis.	Rate per 1,000
1898	June	1,676,935 71%	222	0.06	9	0.2	20	0.05	7	0.05	7	0.05	10	0.07	160	1.1
		Total population reporting 1,684,500 75%	Total deaths reported 238		17	0.1	16	0.1	15	0.1	9	0.05	13	0.06	168	1.2
1898	May	1,684,500 75%	238	0.1	17	0.1	16	0.1	15	0.1	9	0.05	13	0.06	168	1.2
		Total population reporting 1,720,501 70%	Total deaths reported 210		14	0.09	12	0.09	7	0.01	4	0.02	9	0.06	173	1.2

* The months of April, May and June, 1899, include deaths from all causes, but the other months from contagious diseases only.

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No. 1.

DUSTING POWDERS.

KIONKA, who takes this up in the *Ther. d. Gegenw.*, 1899, p. 179, says: Iodol, the tetra-iodide of pyrrol, is an odorless and tasteless, yellow, crystalline powder, which is only slightly soluble in water, but more soluble in alcohol and ether, and contains about 89 per cent. iodine. Its toxicity is less than that of iodoform. It is used as iodol gauze, iodol collodium, etc. Insufflations of iodol are especially to be recommended in laryngeal tuberculosis. As very sensitive patients complain that it is not odorless, 1 per cent. menthol is added to the crystallized iodol, and this combination introduced under the name of mentholiodol. Iodol, like iodoform, is decomposed in the body, and potassium iodide appears in the urine, and although the decomposition proceeds slowly yet toxic symptoms may appear. Calomel should not be applied to mucous surfaces while iodol is being used, as the free iodine formed from the iodol may combine with it, forming the caustic mercuric iodide. There is also the possibility of the appearance of symptoms from iodine intoxication. Under the name of soziodol preparations is embraced a number of salts of di-iod para phenol sulphonic acid. Owing to the phenol, iodine and sulphur which they contain they possess tolerably marked disinfectant powers. Potassium soziodol, on account of its drying properties, is to be recommended as a

dusting powder. It is used mixed with five parts of talc or made into a salve with lanoline, etc. In case a solution is desired, it is better to use the sodium salt, as it is more soluble. The zinc and mercury salts have been especially recommended in blepharitis, conjunctivitis and eczema of the eyelids and nose. Chiaparella uses the zinc salt in one to five per cent. solutions, or as a dusting powder with ten parts of talc, the mercury salt in 0.5-2 per cent. ointment. The mercury salt contains about 32 per cent. mercury and is used especially in luetic affections. A 10 per cent. solution of this salt has a caustic action. No very marked toxic symptoms have yet been seen from the soziodol preparations. AiroI is another substitute for iodoform. In composition it is similar to dermatol. It is a combination of gallic acid and bismuth—the bismuth being substituted for the hydrogen of the carboxyl group and one of the hydroxyl groups being replaced by iodine. Dermatol contains 52 per cent., and airoI only 44.5 per cent. of bismuth oxide with about 25 per cent. iodine. Andrjasczenko has proved for it inhibitory action upon the growth of bacteria. It can be sterilized dry, but in contact with moisture it decomposes. AiroI is a greenish gray powder without odor or taste, and has given satisfaction as a substitute for iodoform. At times eczema appears after its use. Nosophen, formerly called iodophen, is the tetra-iod phenalptalein. It is insoluble in water and is recommended as a dusting powder in place of iodoform. Its soluble sodium salt is called antinosin, and its insoluble bismuth salt eudoxin. They possess marked disinfectant powers against anthrax, pus organisms, etc. Nosophen and its salts are less toxic than iodoform. If the sodium salt is injected directly into the blood a good deal passes into the intestinal tract, and, like iodoform, it hinders suppuration by paralyzing the white corpuscles. Infected wounds heal well under it, but clean wounds are comparatively more irritated than by other powders. Nosophen can be easily sterilized dry. Iodoformogen is an iodoform preparation in which the iodoform is so closely united with albumen that it can only very slowly be extracted from it. It is a fine yellow powder, insoluble in water, and only gives off a slight odor of iodoform when placed in a closed bottle. Granulations are stimulated by it and the epithelial covering soon forms. It possesses all the properties of iodoform, save its odor. Iodoformin is not to be confused with the above. Iodoformin is a combination of iodoform with a mild disinfectant body, probably hexamethylentetramin, and contains about 75 per cent. iodoform, which is split off under the action of acids and alkalis. Eka-iodoform is a combination of iodoform with 0.05 per cent. paraformalin.

ONTARIO MEDICAL LIBRARY ASSOCIATION.

In our March issue we gave our readers a list of books the first annual instalment for the "Bovell Library," purchased through the generosity of our old friend, William Osler. The list will repay a glance over it again, containing as it does many of the latest works on medical subjects proper.

In order to enable the association to keep up with the times an "Endowment Fund" was established some months ago for the prompt purchase of the best new publications as issued. As the interest alone can be used, and as the fund is only in its infancy, and therefore very little interest as yet available, it is hoped that a generous response will be made to this fund by many of the profession, who will not miss a small contribution in so good a cause.

Many may not feel justified, for one reason or another, in giving to this fund, but we are all able to help along the library in another way, and that is by sending it all the old journals about the office. These can be utilized in "exchange" with other libraries. All that is necessary is to pack them in a box, address it to the Ontario Medical Library, corner Bay and Richmond Streets, and freight will be paid on arrival and an acknowledgement made through this Journal.

Books of any date will also be gladly received. They are of some use to the library—the great majority of old issue are of no use whatever to the regular practitioner except to remind him that he is "getting on in life."

Therefore look over the old book-cases, cupboards, store-rooms, and out-of-the-way corners, and send on all you do not need and never look into from one year's end to another. You will earn the gratitude of your better-half at every house cleaning, and at the same time the thanks of the library.

A cordial invitation is extended to the members of the Ontario Medical Association to visit and make use of the library in any and every way during the meeting this month.

SUBCUTANEOUS NOURISHMENT.

LUETHJE, H. says there are (*Ther. d. Gegenw.*, 1899, p. 220) three artificial methods of feeding—by the stomach tube, by rectum and subcutaneous tissue. The last method is the most recent. The problem has never been thoroughly solved, as it is difficult to inject the three chief food stuffs in sufficient quantity

subcutaneously. The main difficulty has been with the albumens; albumens, like casein, cannot be metamorphosed subcutaneously into soluble products—albumoses and peptones—while albumoses and peptones, on account of their toxicity, cannot be used; again, other proteids cannot be sterilized, and some irritate too much on subcutaneous use. The subcutaneous use of carbohydrates has yielded better results. Concentrated sugar solutions irritate very much and may lead to the formation of abscesses, this has even resulted with sterilized solutions, in fact 20 per cent. solution may cause necrosis (Leube). The pain is very severe. These irritative symptoms are in proportion to the concentration. It has been used in v. Leyden's clinic in 10 to 15 per cent. solutions, and in this way 50 to 100 gm. have been injected a day. Clinically, the injection of fats have proved the most serviceable. Fats give about nine calories pro gram, that is about twice that from albumen and carbohydrates, so that in this they possess an advantage over the others. Leube showed that fats thus given could be assimilated. A dog which he had rendered almost free of fat was given butter subcutaneously for some time, and the laparotomy showed that the animal had accumulated a tolerably large collection of fat, consisting mainly of butter fat; when this dog was again dieted the fat disappeared almost entirely, and Mesnil de Rochemont in a large series of cases in man found that it protected the albumens under all conditions. Fats can be easily sterilized, and they do not irritate. Jacob, in v. Leyden's clinic, injected subcutaneously 2 to 300 gm. of olive oil without any marked difficulties. The simplest and most suitable fat is olive oil. Sesam oil is also valuable. An ordinary Pravaz syringe (10 c.c.) may be used and its contents injected three times in various places. No great force should be used, so that the tissues are not torn. This injection may be made once a day. The femoral triangle is to be prepared as a site for injection.

Editorial Abstracts.

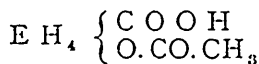
GLYCERINE IN RENAL CALCULUS.

At the Seventeenth Congress for Internal Medicine, held at Karlsbad, Hermann reported on the use of glycerine in the treatment of eighty-five cases of nephrolithiasis. In thirty-one cases glycerine caused the passage of the gravel in six to thirty-six hours. In twenty-one cases there was no such action, but it caused a subjective improvement, while in the remaining thirty-three it proved inactive. The greater part of the glycerine appeared in the urine. Hermann

claims that it lubricates the passage so that the stone passes more easily. He noted no untoward symptoms from the glycerine; the urine contained neither albumen nor sugar, but only much mucin and many leucocytes. In case of albuminuria, glycerine caused no increase in the amount of albumen. Hematuria, which appeared five times with 300 doses, he believes due to the stone, and not to the glycerine. The dose is from 40 to 130 gms., with equal parts of water; the tr. aurant cort. may be used as a corrective. Rosenfeld says the relief it gives to the dull pains in the renal region is surprising. He orders 2 gm. pro. kilo. v. Jaksch said that glycerine may act a blood and renal poison, and advises care with large doses.—*Ther. d. Gegenw.*, 1899, p. 214.

ASPIRIN, A NEW SALICYLIC PREPARATION.

WITTHAUER, K.—Aspirin, a new salicylic preparation. (*Therap. Monats.*, 1899, p. 330.) Aspirin has the following chemical structure:



It forms white needles and dissolves in water up to 1 per cent. The advantage of it is that it splits up under the influence of alkalis into its two constituents, so that it will pass the stomach, not irritating it, and be decomposed in the intestine. The author has tried it on fifty patients, and they spoke of its more pleasant taste. In fact, he has reported elsewhere cases which had gastric disturbances from sodium salicylate and bore the aspirin well. It acted as well in rheumatism and pleuritis as sodium salicylate, exercising no unfavorable influence upon the heart and stomach. The appetite remains good, and the tinnitus is not near so marked. It may be given to adults in gram doses, four to five times a day, with sugar and water.

RELATION OF THYREOIDS AND BILE.

WIENER, F.—The changes in the thyreoid after making a gall bladder fistula. (*Cent. f. Physiol.*, 1899, v. 13, p. 142.) Huertle claimed that after trying the biliary duct characteristic changes occurred in the thyreoid, but these results have been questioned. Wiener believes that if the gall is completely removed from the body by means of a biliary fistula the thyreoids are influenced in a peculiar manner, different from that resulting from damming back of the bile by tying the bile ducts. The size of the follicles increases markedly; in many places one gets the impression as if several follicles had united by disappearance of their walls. The contraction and formation of vacuoles at the border of the colloid

material and epithelium is much less than normal and may even be absent, while the staining power of the colloid material is much diminished. The bodies of the secreting epithelium is much diminished in height and appears pressed flat. The normal cell structure is lost, and the staining power is diminished.

BACTERIAL POISONS AND INTESTINAL PUTREFACTION.

GANS.—On the influence of bacterial products upon intestinal putrefaction. (*Muench. med. Woch.*, 1899, p. 643.) Two to four days old culture of the colon bacillus increased markedly the ethereal sulphuric acid, without any demonstrable indican. Four to seven days' culture of proteus vulgaris increased very much the indican elimination, once the ethereal sulphuric acid increased, and once there was no increase. Two to four days' culture of bacterium acidi lactici sometimes increases the ethereal sulphuric acid, sometimes not. No indican separated. Ten gm. of yeast suspended in 200 gm. of water caused an elimination of indican without exercising a marked influence on the ethereal sulphuric acid. Simultaneous administration of bacterium acidi lactici and the colon bacillus increased distinctly the ethereal sulphuric acid without increasing the indican.

ICTHYOL IN RENAL TUBERCULOSIS.

GOLDBERG, in the *Berliner klinische Wochenschrift*, 1899, No. 6, refers to Palet's statistics and shows that of 136 cases of nephrectomy done for renal tuberculosis, fifty-one, that is 40 per cent., died, and that only one-third of those operated on lived over one year. This is due to infection of other organs. He recommends ichthyol internally.

℞ Ichthyoli sulpho-ammoniac
Aq. distil. ää 20.0

Ten to seventy drops in water three times a day after eating. The larger the dose the sooner the curative action. Besides causing a general improvement, the local action was good—the hemorrhages ceased and the suppuration diminished, as did also the tenesmus and pain. It may be given for years.—*Ther. d. Gegenw.*, 1899, p. 238.

SUBCUTANEOUS USE OF GELATINE.

The subcutaneous injection of gelatine has been recommended by Dastre, Lancereaux, etc., in cases of severe internal hemorrhage, and in aneurisms. They base their recommendation on both experimental and clinical evidence. It increases the coagulability

of the blood. Recently, Poljakow reported his experience in one case of severe hemorrhoidal hemorrhage, and one of profuse hematemesis. He promptly quieted the hemorrhages by the use of a 10 per cent. solution in one case, used per rectum; in the other, per os. Curschmann, in fourteen cases of hemorrhage, obtained remarkable success in thirteen. He used subcutaneous or intramuscular injections of 200 gm. of sterile gelatine solution, repeated for several days.—*Ueber in Ther. d. Gegenw.*, 1899, p. 237.

DEGENERATION OF THE SUPERIOR AND INFERIOR LARYNGEAL AND VAGUS NERVE AFTER REMOVING THE THYREOIDS.

KATZENSTEIN, J.—On the degenerative changes in the superior and inferior laryngeal and vagus nerves after extirpation of the thyroids. (*Arch. f. Anat. u. Physiol.*, 1899, p. 84.) In an earlier work Katzenstein showed that cutting the nerves of the thyroid caused degeneration of the thyroids; now he reverses his experiments. In four dogs and one monkey, from which the thyroids had been removed a long while, he finds degenerative changes in the nerves—in Schwann's sheath, medullary sheath, and in the axis cylinder. The degeneration did not affect the whole nerve but many of the fibres. He concludes that it is the centripetal secretory and vaso-motor nerves which degenerate.—*Cent. f. Physiol.*, 1899, p. 150.

OXYCAMPHOR.

Oxycamphor is a camphor derivative which was made by Manasse. In it one hydrogen atom is replaced by an hydroxyl. It is a sedative with special action on the respiratory centre, and is especially valuable in the dyspnea which accompanies advanced pulmonary and cardiac cases. The dose is 1 to 2 gm., and there is no occasion for using over 3 gm. a day. No unpleasant untoward symptoms have yet been seen. On account of its chemical properties it is hard to prescribe in powders, and is therefore used in a 50 per cent. alcoholic solution under the name oxaphor.—*Muench. med. Woch.*, 1899, p. 543.

COD LIVER OIL.

The unpleasant taste and odor of cod liver oil may be masked by eucalyptus. Two drops of the ethereal oil to 150 gm. of cod liver oil. (DUQUESNEL.)—*Therap. Monats.*, 1899, p. 64.

IN irritative skin lesions with moderate exudation, Lewith recommends coating the skin with thin layers of egg albumen. One egg is more than sufficient for the whole body.—*Therap. Monats.*, 1898, p. 642.

Physicians' Library.

Practical Diagnosis.—The Use of Symptoms in the Diagnosis of Disease. By HOBART AMORY HARE, M.D., B.Sc., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Fourth edition, enlarged and thoroughly revised. In one octavo volume of 623 pages, with 205 engravings and 14 full-page colored plates. Cloth, \$5.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York.

It is not difficult to understand the popularity which has brought this work to its fourth edition in three years. The author is peculiarly apt in selecting the pith of his subject and presenting it in practical shape. This is evidenced by the plan of the present work, in which the subject is treated precisely as the disease presents itself to the physician, namely: symptoms first. The book thus saves the reader the always more or less difficult process of mental reversal which is manifestly necessary when following the usual method of books on diagnosis which begin with diseases and then detail their symptoms. By dividing his work into two parts, "The Manifestation of Disease in Organs," and "The Manifestation of Disease by Symptoms," the first being regional, the second dealing with general and special symptoms, such as fever, headache, vomiting, pain, etc. Dr. Hare has aimed at maximum convenience and the ingenious system of cross-indexing consummates the ease and facility of the book for ready reference. This book is a companion to the author's work on "Practical Therapeutics," and taken together they form a complete and up-to-date work on practice of medicine.

Progressive Medicine, Vol. II.—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, 472 pages, 56 illustrations and 3 full-page plates. Lea Brothers & Co., Philadelphia and New York.

The second volume of "Progressive Medicine" presents carefully prepared and exhaustive papers upon the following subjects: "Surgery of the Abdomen, including Hernia," by William B. Coley, M.D., of New York City; "Gynecology," by John G. Clark, M.D., of Philadelphia; "Diseases of the Blood, Diathetic and Metabolic Disorders, Diseases of the Spleen, Thyroid Gland and Lymphatic System," by Alfred Stengel, M.D., of Philadelphia. "Ophthalmology," by Edward Jackson, M.D., of Denver. This volume shows more clearly than even the previous

issue that in "Progressive Medicine" the practitioner possesses a narrative statement of the scientific progress of medicine made for him on a plan quite different from any of those heretofore employed. There is the personal element in every page of the book. Given certain subjects, men who are special authorities therein, have deliberately set themselves the task of forming definite conclusions as to the value of the progress made in each, and have furnished the data for these conclusions, not in useless detail but with sufficiently full statement to make the subjects clear. Such a personal presentation involves mature thought, large experience and most careful handling on the part of the authors, but it is the ideal method of recording useful knowledge for the prompt service of the busy practitioner. The high literary and scientific standard set by the first volume is amply maintained, and the several sections appeal to the reader by their very practical character. Thus in one convenient, substantial volume, beautifully printed and abundantly illustrated, is given in practical shape that which the busy physician requires for an intelligent comprehension of the real advance in medicine. The warm welcome with which the first volume of "Progressive Medicine" was received is easily understood, and this second volume will surely increase the rapidly growing popularity of this quarterly.

Obituary

DR. J. E. GRAHAM.

The death of this eminent physician at Gravenhurst, July 7th, came as a shock to the profession. While it was known to some that he had been in failing health for some time, and had spent several weeks in the South on this account, yet even to those the news was unexpected. Although he had long been a sufferer from diabetes, the direct cause of death was the "white plague"—tuberculosis. The immediate members of the family were present at his death, and his physicians, Drs. Caven, Davison and Hamilton.

James Elliot Graham was born in Toronto at the family homestead, "Richview," June 12th, 1847, and hence at the time of his death was 52 years of age.

His education was received at the Weston Grammar School and the Upper Canada College, preparatory to his university training. In 1869 he was granted the M.B. degree at Toronto University, receiving the gold medal and Starr medal of his year. In 1870 he received the degree of M.D.

His work in his profession began in 1869, when he became resident physician in the Brooklyn City Hospital for one year.

Then on the outbreak of the Franco-Prussian war he was appointed surgeon of the Prussian army without rank, and served throughout the whole war.

He walked the hospitals in Vienna, Austria and London, receiving the diploma of L.R.C.P. in the last city. In 1872 he returned to Toronto and began the practice of his profession.

In July, 1873, he married Mary Jane, second daughter of the Hon. J. C. Aikins, Senator. His wife, one son (a medical student) and three daughters, all unmarried, survive him.

All matters concerning medical education received deep interest from him, and he exerted a powerful influence in the affairs of his profession.

In 1887 he was made professor of clinical medicine and medical pathology, and lecturer on dermatology in Toronto University, and in 1892 succeeded Dr. Wright as professor of medicine.

He was an admirable clinical teacher, and possessed a manner that endeared him to the students.

He had a wide and active medical association, both in Canada and the United States. He was president of the Canadian Medical Association in 1887, of the American Dermatology Association in 1889, and was one of the original members of the Association of American Physicians. In 1893 he was made a member of the Royal College of Physicians, London.

At the meeting in June of the Ontario Association of Physicians he was present and was elected president.

His position in the University of Toronto was unique, for, besides his professoriate, he was a member of the senate for years, first for the Toronto School of Medicine, and afterwards, in 1895, as the choice of the graduates in medicine.

In religion he was a Methodist, in politics a generous Conservative. He was a member of the Toronto Club.

He was a physician of the Toronto General Hospital, St. Michael's Hospital, consulting physician to Gravenhurst Sanitarium, and other institutions.

He was the first physician in Ontario who gave up general practice and devoted himself to pure medicine, being purely first consulting physician.

At the meeting of the Medical Council the news of Dr. Graham's death was received with sadness. Dr. Geikie feelingly referred to it, and moved a resolution of condolence. Dr. Moore, in seconding it, spoke of the high esteem in which the deceased was held by his brother physicians.

Dr. Bray, Dr. Thorburn and others, all intimate friends of the deceased, made brief speeches testifying to their high regard for him.

We may well say, "When shall we look upon his like again."



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THE FUNERAL.

As a token of the respect and esteem in which the late Dr. J. E. Graham was held by his brother physicians, more than two hundred city doctors attended the funeral. It was one of the largest and most impressive funerals Toronto has ever seen. Besides the physicians there were present representatives from Toronto University, Victoria University, Trinity University and all the churches in the city. Seldom or never have so many persons, occupying such prominent positions in life, assembled spontaneously to do honor to one whose life was given to heal the ills of man. It testified, as nothing else could do, to the lofty niche the deceased occupied in the hearts of his fellows.

The services at the house were brief, but full of feeling. They were participated in by Rev. Dr. Briggs, Rev. John Fish, Rev. R. P. Bowles and Rev. James Allen.

The floral tributes were unusually numerous, and formed a veritable bed for the casket. A broken column was contributed by the family and another by the medical faculty of the University of Toronto, a pillar of roses and mauve sweet peas, from the three sisters of the deceased; a pillow from the trustees of the Gravenhurst Sanatorium; a crescent from Dr. W. H. B. Aikins; a cross and an anchor from Senator Aikins' family; an anchor from Dr. William Osler, of Johns Hopkins Hospital, Baltimore; a wreath of pink roses from Sir Frank Smith; the class of '99 of medicine in Toronto University sent a wreath. There were many other beautiful tributes.

The pall-bearers were: Dr. H. H. Wright, Dr. W. P. Caven, Dr. W. Oldright, Dr. Charles O'Reilly, Dr. A. A. Macdonald, Dr. Grasett, Mr. W. J. Gage and Mr. Goodwin Gibson (the only surviving member of the University class to which Dr. Graham belonged).

The chief mourners were: Joseph Graham, only son; Hon. J. C. Aikins, James Jackson, Dr. H. J. Hamilton, George Mercer, James Graham, Dr. Bowles, W. Wilberforce Aikins and Fred Aikins.

A large cortege followed the remains to Mount Pleasant Cemetery, where the service at the grave was performed by Rev. R. P. Bowles.

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