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Original Communications.

A CASE OF PRIMARY ABDOMINAL PREGNANCY.

BY J. E. PICKARD, M.D., VIRGINIA CITY, NEVADA.

Mrs. R., aged 35, short and stout in stature. Nationality, Swiss. Has always been fairly healthy, except that she had a long and severe attack of inflammatory rheumatism about nine years ago, which left her with a weak and irritable heart.

Has given birth to three children and had two miscarriages.

Menstruated last on April 28, 1900, and at the usual time began showing the usual symptoms of pregnancy.

About the third month, or perhaps sooner, began to have frequent attacks of intermittent abdominal pains, especially at night, and I thought of tubal pregnancy; but these attacks were never severe, nor did they last long, and a few doses of viburnum would allay them. Besides, there never were any discharges of blood or signs of menstruation. On a former occasion, when pregnant, she had frequent pains, and finally miscarried at the fourth month. All of which made me feel that I was not warranted in either performing laparotomy or exploring the uterus, since the only sign of extra-uterine pregnancy was the frequent attacks of pain. When the fourth and fifth month passed without any tubal rupture, and the child continuing to live and grow, I concluded that my fears of extra-uterine pregnancy had been ungrounded. From the fifth month on she felt fairly well and did not suffer so much, considering the fact that she assisted in nursing two children, one after the other, through an attack of mild typhoid fever, during the months of October and November. In January of this year, I was called to see her, and found her with fever of a bilious character, a

great deal of bile in stools and urine. She was quite sick for a few days and developed some jaundice. Soon, however, the fever passed away. The kidneys and liver resumed their usual function, and her condition was about the same as before the attack, excepting that the pulse continued weak and rapid in spite of tonic containing strophantus and strychnia.

A few days after recovering from the fever she told me that the fetal movements had ceased, and upon applying the stethoscope found the fetal heart sound had ceased. These on several previous examinations were distinct and strong. I attributed the death of the child to bile poisoning, there having been so much in the mother's blood.

We expected labor to take place between the fifth and eighth of February. On the night of the seventh I was sent for, but on arriving found the pains feeble and far apart, but enough to show that labor was being attempted. The cervix and os, however, showed no signs of approaching labor. In a short time pains ceased and patient in the same condition as before.

The examining finger could distinctly feel breech in front of uterus.

Hoping from day to day labor would set in, I waited until February 22, then asked for a consultation. Dr. P. T. Phillips, of Reno, was called. I told him that on account of the early history of the pregnancy and the ease with which I could feel the upper parts of the child through the abdominal wall, I feared the case to be one of abdominal pregnancy. He made as careful and thorough an examination as was possible without an anesthetic. This was difficult on account of the high, backward position of the os and the long cervix. However, he was able to get tip of examining finger just within the internal os. He gave it as his opinion that although it was impossible to make an absolute diagnosis without going farther into the uterus, it was a case of intra-uterine pregnancy with breech presentation, as he could feel the breech so distinctly, and suggested it might possibly be a case of missed labor, since many cases of gestation went 300 days. He advised that as the child was dead and would not grow larger that we wait until the 8th of March, to see if labor would not set in naturally, and if it did not to give anesthetic and dilate, and deliver if child was intra-uterine, and if extra-uterine to proceed as the case required. To this I agreed, and kept patient on tonics and nourishing but easily digested food, and attended to the functions of kidneys and bowels.

Went on in this way until March 13, but no signs of labor appeared. I then asked for assistance, and Dr. McDonald, of this city, was called in. He administered ether and I proceeded to dilate the os with my fingers; when sufficiently dilated to

admit finger into uterus, having hand in vagina, found the uterus empty, with the exception of a thin desidual membrane, resembling cast one would find in membranous dysmenorrhœa. The uterus was no larger than one would expect in an unimpregnated multipara. Of course this examination proved the case to be one of abdominal pregnancy. The patient was under the influence of ether only a few minutes, and stood the anesthetic better than we expected, in fact pulse improved. But an hour or so afterwards the pulse was again weak and rapid. Vomiting set in and was a prominent symptom up to the time of her death, three days after. During this time there was great weakness and exhaustion, and was cause of death. Had hoped to get her in a condition favorable for laparotomy, but failed.

She died on the 17th, and on the 18th I performed an autopsy, assisted by Drs. McDonald and Manson, of this city. The body was in a good condition of flesh. Very little emaciation. On opening abdominal wall found a fully developed female child, weighing $8\frac{1}{2}$ pounds, lying in abdominal cavity, with breech lying well down in front of uterus.

After removing child, found a large placenta in right inguinal region, the edge attached to right inguinal abdominal wall, and the main body intimately attached to intestines. It was also attached to fimbriated extremity of right Fallopian tube.

The uterus was about the size of an ordinary empty uterus. Both ovaries normal and both Fallopian tubes normal and intact. There was no sign of the ovum ever having entered the fallopian tube, or to show that the pregnancy had ever been tubal.

My opinion is that when ovum escaped from right graafian follicle it became fecundated and never reached the Fallopian tube, but continued to develop in abdominal cavity and, therefore, a *primary* abdominal pregnancy.

I have thought this case of sufficient interest to the medical profession to report, because of the fact that so many writers on obstetrics and gynecology deny the probability of primary abdominal pregnancy ever existing.

Had I diagnosed the case correctly in the early months, an operation might have saved the patient's life, but from so little data I cannot see how a correct diagnosis could have been made.

Had the case been operated on during the latter months, am sure the result would have been a failure, since the placenta was adhered to so large a surface of intestines.

I invite discussion of the case through the PRACTITIONER.

HISTORY OF A CASE OF SMALLPOX.

REPORTED BY MR. J. GODFREY.

Disease.—Smallpox.

March 11th.—Patient was well and worked as usual.

March 12th.—She did not feel well, though she was around all day. Bones and muscles were all sore. She had no headache. she thought she had grip.

March 13th.—She was up and served dinner—went to bed in the evening, feeling the same as on previous evening.

March 14th.—Stayed in bed all day.

March 15th.—In the morning she vomited after taking a glass of hot brandy. She noticed a few "small red spots" on her wrists, and a few (four or five) on her cheeks (none on forehead first). They were red and watery-looking. Dr. Maloney, the family doctor, called morning and evening, and diagnosed it measles (W.B., her baby in the house, had measles at this time).

March 16th.—The "red spots" were all over her body. They looked like small blisters. Face was very red. Headache began, she had had none previous.

March 17th.—Dr. Maloney called. Many people visited Mrs. F. in her room. More or less headache all day.

March 18th.—The "pimples" became filled with fluid and had a clear appearance. At noon Drs. Reeves and Maloney said they thought the case was smallpox. The house was quarantined at noon and placarded. Headache persisted.

March 19th.—Headache persisted. Mrs. F. had a choking spell, and Mr. F. was unable to get any of the town doctors to come into the house and render assistance to his wife.

The above history was given by Miss —, sister of Mrs. F. March 19th, at 4 o'clock, I received a telephone message from Dr. Bryce to go to Eganville and get my orders from Dr. Reeves the medical health officer there.

Wednesday, March 20th.—I arrived in Eganville, and after listening to the Board of Health of the town discussing the event, I went into the Central Hotel at 4 o'clock p.m., where I found Dr. Maloney, who told me his course of treatment.

Treatment.—Liquid diet—broths, chicken and lamb, beef-tea, milk, albumen water, beaten white of eggs. Spray for nose and throat, which were sore and had pox: R glycerine, listerine.

She was completely covered from head to foot with vesicles, which were thicker on the face than the rest of the body. On the body one could lay a twenty-five cent piece on many patches of clear skin. On the face a five cent piece would be as large

as the spaces. In some places two, three or four vesicles had run together, but nearly all of them were discrete.

The vesicles varied in size from that of a five cent piece to that of a pea. They were red and inflamed and sharply defined at the base. The other vesicle was raised and of a pearly color.

She had a slight headache, but otherwise comfortable; eyes blood-shot and scummy—washed these with warm water. Temperature normal. Used spray on mouth and pharynx, which had pox, also gave ice to suck. Ice to forehead.

March 21st.—Patient felt fairly well, vesicles still not itchy, no headache, complained of soreness of nates (bathed with alcohol). Patient in bed all day.

March 22nd.—Vesicles now became darker in color and became a cream color. No headache. Patient quite comfortable, but still kept in bed. Eyes somewhat sore, bathed with warm water, and saturated solution boracic acid ordered to be dropped into each eye after washing, four times a day. A pock noticed on the sclerotic of right eye, also a small ulcer on conjunctiva of lower lid. On enquiry I found patient's bowels had not moved for five days. Gave calomel grs. $\frac{1}{4}$, sulphur and acid tartaric. Then gave an enema which was effectual.

March 23rd.—She was allowed to sit up for half hour. Gave a little roast beef and potatoes for dinner, quinine grs. vi. Enema. Patient felt well; no headache or backache.

March 24th.—Pus exuding from some of pustules, noticed a few umbilicating. Enema. Some scabs forming. Sat up for one hour.

March 25th.—Patient felt fine. Sat up. Toast, meat and potatoes given. Gave sponge bath twice a day from this out—1 in 40 carbolic. Face, body and scalp anointed with ac boracic grs. xl, vaseline \bar{z} i., used camel's hair brush. Face covered with a mask. Enema stopped, bowels moved regularly.

March 25th to March 31st.—Scales kept coming off in great numbers every day. The hands and feet were the last place, here they remained as copper colored spots; these the patient and myself picked out. They were disc-shaped, tough and dry, consisting of dried pus, placed between two layers of epidermus.

Tuesday, April 2nd.—All the scales were off. April 1st, was called at 7 a.m. and found patient with labor pains. I went for Dr. Maloney, and came back and found pains following one another very rapidly. At 8.30 a.m. child was born, in about five minutes ligated cord. Then Dr. Maloney arrived and took charge, placenta was taken away, bandage applied, a folded towel being placed over the uterus. Child was washed, dressed and left in the bed with its mother. She washed the parts herself after this with 1 in 40 carbolic

after each stool or micturition. The urine came away right after labor and was quite clear.

April 6th.—No pain or discomfort, had had afterpains before this time. Right eye somewhat sore, to which hot water was applied, also solution of zinc sulphate. Eyes still inflamed and sore. Boil on back of neck and under left mamma.

During illness from smallpox, temperature ranged between 98 and 100°, pulse 56 to 116.

Note—Woman with smallpox, pregnant, last menstruation June 28th, 1900. Child born April 1st, an apparently healthy child, weighing about 10 lbs., with no signs of its having had smallpox in utero. Labor came on just as the smallpox scales were all off the body. Patient had been vaccinated when a girl. This was her fifth child.

[This case is especially interesting from an obstetrical standpoint. The patient had variola (not varioloid). Labor took place eighteen days after she took to her bed, and sixteen days after eruption appeared. Smallpox is generally supposed to be a very severe disease under such circumstances, and dangerous to mother and fetus. In this instance the mother made a good recovery, and a healthy child was born without any symptoms of smallpox. As a general rule, in the intercurrent disease of pregnancy, a high temperature is a serious matter for the mother and child. In this case the temperature was never more than 100°, although the smallpox was to a certain extent at least confluent. One of the lessons to be learned is that the poison of smallpox without high temperature may have no bad effect on the fetus.]

A. H. W.

DIPH'THERIA VS. ACUTE FOLLICULAR TONSILLITIS.

By JOHN GUNN, M.D., DURHAM, ONT.

Every now and again, here and there over the country, the cry gets up that diphtheria is rife. On such occasions many interests suffer, in our smaller communities especially; but one interest very much, the Public school. Parents and guardians are very properly alarmed at the approach of so fell a disease as diphtheria, and forthwith, without giving the rumor any further consideration, withdraw their children from the Public school, very often though to the great injury of those children themselves, and as well of the school as a whole.

My attention has been recently directed to this matter by the report of a case of throat trouble which appeared in a late number, that of the 6th of April, of the *British Medical Journal*. Dr. Esterre, of Eastbourne, England, was called to see a lady, herself the wife of a practising physician, said to be ill with sore throat. On a careful examination of the case, the condition of things was so obscure that both gentlemen had great difficulty in determining the true nature of the affection, whether the case was one of diphtheria or acute follicular tonsillitis (ulcerated sore throat), although they had the advantage of a bacteriological examination of the exudate upon the surface of the tonsils, and which informed them that the diphtheria bacillus was not there. However, the medical gentlemen agreed upon a line of treatment, the means were used, and, fortunately, in a few days the patient was convalescent and made a rapid recovery.

Some three months afterwards the same lady was taken ill and affected in a similar way, from sore throat with patchy exudation and general *malaise*. The same difficulty in making a diagnosis presented itself as on the previous occasion, but with the experience of the first attack before them, the medical gentlemen adopted a similar course of treatment as on the last occasion, and with similar results—the patient was convalescent in a few days.

Just as in these cases, so in all acute throat affections of an inflammatory character, there are two conditions in which diphtheria markedly differs from acute follicular tonsillitis (ulcerated sore throat): (1) The temperature which, indeed, in diphtheria rises rapidly and maintains a high level from the beginning to the close—a variable period to be sure—but usually lasting for weeks. On the other hand, in acute follicular tonsillitis, however high the temperature may be on the first day, it rapidly falls to the normal, and usually gives no

further indication of rising again. (2) Equally distinctive with the temperature is the condition of the throat. In follicular tonsillitis the exudate is distinctly patchy and mucopuriform. It may be easily removed, and leaves no raw or bleeding surface. The patches may indeed run into one another and coalesce, but they are normally of a segregate and patchy character, and varying in diameter from a fourth to half an inch, but larger, of course, when the patches coalesce. The diphtheritic exudate, on the contrary, as its name indicates, is of a distinctly membranous character, and of a whitish or greyish white color. It proceeds from a centre, and extends, often invading the uvula and hard palate, and often stretching backwards into the pharynx and larynx. But further, it does not disappear in a day or two; on the contrary, it often remains for weeks together, and when removed, leaves a bleeding surface behind. These are surely very distinctive differences. In follicular tonsillitis there are no sequelæ, properly so-called. There may be a feeling of *malaise*, but this soon passes away, and the affected children in a few days may resume their school work, as they often do, and are none the worse. The tonsillar streptococcus seems to be quite satisfied with crawling about on the tonsils and finishing its course by embedding itself in its follicles. Not so with the diphtheria bacillus. Not satisfied with destroying the vitality of the covering of the tonsils, it destroys their substance and even invades the very citadel of life, destroying the nerve cells and the muscles, obtaining their energy from them, and thus precipitating deaths when entirely unlooked for.

What inference may be fairly drawn? Plainly this, that if these things are so, and anyone can verify them for themselves, seeing that the two diseases in question, diphtheria and acute follicular tonsillitis, are somewhat similar in appearance to the ordinary observer, anyhow in their beginning, although, alas, too often so very different in their results, that when the cry of diphtheria is heard, the community, under the guidance of its medical advisers, would do well to possess its soul in patience for a day or two, before taking the matter into its own hands, paralyzing the industries of the place and upsetting the work of the children attending the Public school, for a term or two at least, they would await the finding of some central authority, the Board of Health, for instance, and so govern themselves accordingly.

Selected Articles.

THE MEDICAL TREATMENT DURING THE ADOLESCENT PERIOD.

BY EDWIN ROSENTHAL, M.D., PHILADELPHIA.

Chairman of the Section on Diseases of Children of the American Medical Association; Pediatricist to the Franklin Free Dispensary, etc.

The adolescent period in the female may be said to be as critical in results as the menopause, and by reason of the methods of our education may be said to be one of the best known conditions universally recognized, and, as such, the common property, not only of the profession, but also of the laity. For this reason, it is not an uncommon fact to witness, not only the diagnosis of this condition being made by the "officious meddler," but also treatment. And it is very often, when such treatments have failed, that the patient is brought to the doctor. In such instances great care and discernment must be the weapons of the doctor, for it will be noted that recourse to all the old well-known remedies had been applied before further advice is sought. The commonest symptom that presents itself is the one that refers to the menstruation. And it is in all probability that this disordered condition is the most conspicuous factor that needs correction.

Two classes of cases are most numerous, and may be divided into: 1st. That class that has never menstruated, and 2nd. That class, that may have begun, shown a very slight discharge at infrequent intervals—once in six or nine months—but which has never grown to an extent at any time that may be termed a normal flow. The history of these cases are very generally of the same character, and may be briefly summarized: Digestive disorders, headache, languor, flushing, sensations of fulness in the abdomen, disturbed or unnatural sleep, or sleepy conditions during the daytime; often some cutaneous affection—acne the most common. Whilst the symptoms may be present in some, frequently only part of them may be present in certain cases, as the skin affection. During the period that should be termed the "menstrual" period the symptoms are generally aggravated. If the "acne" be present, at this time, a fresh crop of pimples appear, and thus can be noted other symptoms.

In all cases of menstrual disorders in the young, the cause must be sought for, and if found, corrected. This of certainty directs the treatment. In cases where the menstruation has

never appeared, it should always be a certain rule to have the sufferer examined by the mother. In quite a number of instances, anatomical reasons have shown the reason. In four cases an "impervious hymen" was the cause. In two cases the "uterus" became the receptacle, and contained the result of numerous menstruations, becoming enlarged even above the pubic bones; the cervix being impervious. In several instances there was an entire absence of the uterus and ovaries. This I noted in two cases, both married, and were examined for the reason. In one case, an otherwise well-developed young woman, age 21, there was an absence of a vagina. Such cases as thus enumerated, nothing can be done in the line of medication, but judicious surgical procedures may in indicated cases (impervious hymen or cervix) make a cure. Where, however, no necessary organs exist, nothing can be done, except such rules as the regulation of the bowels, etc., at stated intervals, give much relief to the frequently present nervous symptoms. Where, however, no anatomical reasons exist, and the patient suffers from suppression of the menstruation, entire or in part, much can be done to aid a cure.

The question of age frequently enters as an answer to results. We have with us such a conglomeration of different nationalities that the "age" question is a very vital one, inasmuch as, frequently, the treatment of menstrual disorders may be wrongly applied, as an example: to attempt treatment of a girl of 13 or 14, when her mother only began menstruation at 12. Experience has taught me that girls born in warmer countries, or descending from such parentage, begin to menstruate much earlier than those of colder climes. For instance, girls from Italy or Cuba begin at 12 or 13, where those from Norway or Sweden begin at 15 or 16. Again, in races, I have seen some surprising differences. The colored race have presented a girl of 10, and often I have seen girls of Russian-Jewish parentage begin at 10 or 11. So that the question of age should always enter into the treatment.

Whilst the most common symptom of disordered menstruation is "anemia" and as the better known "chlorosis," or vulgarly "green-sickness," its absence need not preclude the use of the most common of all our remedies—iron. Anemia alone may be the cause of suppressed menstruation, and while its presence may be looked upon as a certain cause, its treatment is as essential for the appearance of the menstruation as it should be for the general health of the patient. That anemia in girls is most frequently found at this time leads to the common belief that anemia, green-sickness, or whatever name this blood condition may receive, is the chief factor in menstrual disorders.

The treatment of such conditions are numerous, and should divide itself into the causative factor first, and then, after this has been relieved, to the specific symptom. In other words, it will be wrong to attempt by the use of specific remedies the appearance of the menstruation, if the physical condition of the patient is such that should not permit it.

Besides the condition of the blood as a cause of suppressed menstruation, other well-known conditions equally play a prominent part. Even if the patient should suffer from such diseases (tuberculosis as an example), the presence of a menstrual flow has such an encouraging influence upon the mind of the sufferer that some attempt should be made, and as the method pursued by myself for many years can only be of benefit, such conditions are not contra-indications for its use.

Iron is the chief remedy in menstrual disorder, and may be given at all times—before, after and during the flow. A certain time in the life of the patient should be set apart for active and specific treatment. The time chosen should be when the symptoms are most aggravated. The days, one, two or three, should be set apart, and our treatment should always culminate to this period. If we fail at the one, then we should begin again, and pursue our treatment until the second period, when the specific method should again be applied, and thus on. Even if failure should mar the first, second, or even the fifth period, the menstruation will appear, if the treatment be applied in a rational way.

Between the periods I always order the use of iron in three or four daily doses. I have used all forms and varieties, from the tincture of the chloride, which is so often objected to, to the different kinds of Pharmacopeial preparations, in pill form, as the Blaud pill, simple or modified. My experience brings me back to Gude's Pepto-Mangan. Gude's Pepto-Mangan is now the most common in use, and there are so very many similar preparations in the apothecaries that care should be exercised in obtaining the genuine. I have a simple way of distinction. I always order Gude's Pepto-Mangan given with milk. If the mixture is clean, uncoagulated and palatable, then I know my patient has received what I ordered. For a further distinction, I invariably place on my prescription the name "Gude." My reasons are these: So very many so-called similar products are on the market that are inferior, and in a measure do not act in a manner you wish, clinically as well as physically. For my own defence, as I have been so frequently disappointed, I detect the fraud of substitution by mixing with liquids, especially milk; the "Gude" preparation always gives the palatable mixture.

I order of this preparation a teaspoonful in a wineglassful of

milk every three or four hours, depending upon the patient's condition. If she be very anemic, and with this very nervous, I place her upon the milk diet, and by the addition of Gude's Pepto-Mangan I reach my object, giving the food as well as the medicine. I increase the dose until a tablespoonful, three or four times daily. This treatment is kept up, and even continued through each period, until the purpose is obtained, perfect health, as regards not only the menstrual flow, but also the general physical condition.

Medical treatment is never sufficient in this class of cases, and failure is apt to result if no attention be given to other conditions; the very common class, the school girl who desires to reach the head of her class, or who studies for a prize or the like. Take the following case:

CASE I.—E. L., aged 17; large growth, over 5 feet 8 inches; reddish hair. A student of the Girls' Normal School, preparing for the teachers' certificate, which required two more years of study after the graduation. Complains of constipation and headache. Has acne on each cheek. Has occasional backache, and has occasional attack of "nervousness," crying, etc. Her menstruation is scant, very irregular, and when it does appear, not more than one day, or probably one-half the next. Appetite erratic, though spoiled by the method of eating, as buns or cake or pie for lunch, whilst the breakfast, hurriedly eaten, was only a cup of coffee, or a roll. Her main food was the "supper-dinner," when she was "too tired or too long hungered" to eat. Once or twice I was called to quiet an hysterical attack. In this case the pimples were the bane of the young lady's life, and while she was not anemic in any sense, I placed her upon the (Gude's) Pepto-Mangan, telling my patient this medicine was for the pimples, and that I left the further treatment in her hands. This with purgative pills of aloin, with nux vomica was the whole treatment. Vanity came to my assistance, as the patient desired to be rid of the eruption. Persistent use of the iron was the only medicine used, and whilst the schooling was persisted in, she passed through the period, and eventually recovered.

The second case is one that is too frequently met with, the child of the poor, who is sent too early to the "mill" or "store," and who has never been taught the commonest rules of hygiene; the girl who spends her time in work, and whose only outing, a dance or picnic, is equally as hard work.

CASE II.—Aged 14. Attended school until 12 years, and then became a cash-girl in a department store. Rather large for her age. Flabby built, and of a distinct pallor. Complains of obstinate headache, relieved by the so-called bromos; indiges-

tion, languor, sleepy during day-time, and at night a sleep that was heavy, unnatural and disturbed by dreams; at intervals flushing with sensations of chilliness. Menstruation scanty, probably a half of one day, and very light in color. In this case work was a necessity, and even proper food could not be obtained. However, milk was the easiest and cheapest food, and from one to two quarts daily was the constant supply. To this food I added a teaspoonful of the Gude's Pepto-Mangan at each glassful, once every three hours, increasing until a tablespoonful dose was attained. This, with a purgative pill (the compound rhubarb pill of the Pharmacopœia), was the treatment persisted in for over eight months, with complete recovery. In this case the treatment was begun in the fall of the year, persisted in through the winter months, and during the following summer months a vacation of but two weeks was obtained, and the patient sent to the seashore by one of our charitable institutions. This patient was convinced of the utility of this method of treatment, as I found the following winter the same course was followed with a gratifying result, preventing any loss of time by reason of illness or otherwise.

I have also met with cases that the menstrual period came on correctly at a certain age, and continued so for a year or two, when, for some unknown reason, there was total suppression. There was no history of tubercular disease, nor could I obtain any certain cause. In one case marriage was undertaken as a hope for cure. This patient, aged 18, came to me with the following history:

CASE III.—Mrs. B.; began menstruation at the age of 13 years; regular intervals until 15 years, when the flow became scanty and scantier until only half a day, and then entirely disappeared. She had not seen a flow for two years. Examination revealed the uterus two inches in length, somewhat anteflexed. The ovaries on each side could be felt, the size of an almond; the tubes could also be felt. This patient had been under the care of many physicians, and had had several operations, even a laparotomy, for the abdominal scar was visible. Nothing had been removed, she assured me, and the examination showed this also. Dilatation of the uterus had been performed, as well as the curettement, for what I was not informed. She had also undergone electrical treatment. I treated this patient constantly for six months before a flow of blood was in evidence. My sole treatment was the internal use of the Pepto-Mangan (Gude's) in tablespoonful doses in milk, and the use of a stem pessary for a period of nine months. After this time an examination revealed the uterus two and one-half inches in length, larger in size. The tubes could be felt, and the ovaries on either side somewhat larger. Monthly flows have now been

the rule for the last three months. This patient is still under treatment, and whilst the iron is still persisted in, the result of the treatment is uncertain. I am firmly persuaded that many cases can be benefited by a correct application of our remedies, and when applied for a certain purpose.

This last patient appeared hopeless, and at the start I had little hope myself that much could be looked for. It appeared as a case of early ménopause. I have seen such cases, with atrophy of the organs. Here, however, this was stopped, and I have still hope of seeing further improvement.

I have seen such good results in the use of Gude's Pepto-Mangan in septic diseases that I have applied it fearlessly in other conditions. None give better promise than those conditions that are coupled with the menstrual flow, especially when seen at the adolescent period.—*Medical Fortnightly*.

517 PINE STREET.

HOW SHALL WE DISPOSE OF OUR SEWAGE?

By R. M. BUCKE, M.D.,

London Insane Asylum, Ontario, Canada.

This is one of the most vital and important questions at present before the hygienic world. By way of making a small contribution to the discussion of it, I will state here the experience of this institution and show to what conclusion it has led us.

The London Asylum was opened for patients in November, 1870. At that time the sewer opened into a small creek a few hundred yards to the east. This creek runs nearly or quite dry every summer, and its condition after having received our sewage for a few years may easily be imagined. In answer to the clamors of the farmers, whose lives we were constantly threatening, and sometimes taking, a filtration plant was put in. The sewage was, now supposed to be made innoxious by passing through a few feet of a mixture of gravel and charcoal. The worst of it was, it was found impossible to keep our filter in order; the attempt to do so involved much labor and some expense for material, neither did it wholly remove the nuisance when it was kept at its best. *Something more and better had to be done, but what?* At last it was decided to adopt what is called the "Intermittent Downward Filtration" system.

A piece of sandy land some four acres in extent, a few hundred yards west of the main asylum building, was chosen for the experiment. The field was graded to a perfect level.

It was then very elaborately under-drained, which doubtless in some cases is necessary, but was in our case a waste of tile and labor, as the water from the sewage has never, any of it, entered the tile in question but has passed away by diffusion into and through the sand. After being levelled the field was graded to a series of beds and depressions, so that when done these were alternately running east and west across it, first a bed ten feet wide, then a depression with sloping sides eight feet wide at top and two feet wide across its level bottom, and eighteen inches deep. Then another exactly similar bed and depression, until the whole field was thus graded. At the east end of the field a plank runway, somewhat similar to a mining sluice and provided with little simple iron gates, conducts the sewage to and into the depressions in the field.

All the sewage of the asylum, including waste water from the laundry and kitchen, is collected by sewers into a central tank placed underground, arched over, covered with earth and then grass, and ventilated into the tall boiler house chimney. Once a day this sewage, of which there may be sixty, seventy, or eighty thousand gallons, is thrown by a centrifugal pump into a shallow concrete well at the northeast angle of the sewage field, from which it runs into the depressions as already described. By means of the gates it is directed day by day to the depression or depressions where wanted. Within two to six hours after pumping the sewage has disappeared into the soil; it never has time to ferment, and there has never been any smell of sewage in any part of the institution since this method of disposal was adopted. At first what has now been told was supposed to be the whole story. There was no question of making any use of the sewage, and indeed the asylum was instructed by the Government to plant nothing on the beds between the depressions. But after a few years the temptation became too great to be longer withstood and I began planting the beds. My report for that year shows that in 1893 we grew on these beds 110 dozen watermelons, 216 dozen muskmelons, over ten thousand dozen cucumbers, beside squash, pumpkins, celery, peppers, tomatoes, peas, radishes, chillies, and that the total value of the crop on the four acres was over \$750.

Latterly we have extended the beds and depressions to about seven acres instead of four, not for purpose of sewage disposal, but so we could irrigate the beds, and attached to the sewage field a few acres of other land adjoining that had been lying waste. The result has been that last year on this sewage field we raised asparagus, beets, beans, cabbage, cauliflower, carrots, celery, lettuce, melons, onions, peas, rhubarb, strawberries, sea kale and tomatoes, to the value of \$1,840.15.

The field converted into the sewage field was high, sandy and

barren; it is now perhaps the most fertile field in Ontario; not only so, but the fruit and vegetables grown upon it are much superior in quality to those grown elsewhere, on our land at least.

Further, the barren sandy field, which had no beauty that one should desire it, is now as beautiful as it is fruitful. It has no unpleasant odor at any time, not even when the sewage is being pumped, there is nothing to offend the eye, for the sewage is converted by the centrifugal pump which handles it into a homogeneous fluid, having very much the appearance and smell of dishwater.

It is needless to say that the patients and caretaker who work on the sewage field are as healthy as any other people about the institution, or that the fruit and vegetables grown on this field are as wholesome as those grown elsewhere; in fact whatever prejudices existed in this regard at first it is now universally acknowledged that the produce of this field is in every way superior to that grown elsewhere on our farm or garden.

It seems to me that we have here in a nutshell the solution of the sewage difficulty. Wherever men upon the land are massed together permanently upon a given area—whether in city, town, village, or institution, this method can be practised, and not only by it can absolute and cleanly disposal be accomplished, but at the same time a large return of the best products of the earth may be had in exchange for a product which if not used is certain to become dangerous.

If we run our sewage into streams or bays we pollute the water, waste the sewage, and cause disease. To treat it with filters or chemicals is never, perhaps, absolutely safe from the point of view of health, is more or less expensive and the sewage itself is wasted. But if we return the sewage to the earth, to which it belongs, we obtain clean, wholesome and absolute disposal at a nominal cost, and at the same time secure the value of the sewage—a very considerable item.—*The Dietetic and Hygienic Gazette.*

Society Reports.

TORONTO CLINICAL SOCIETY.

STATED MEETING, MAY 1ST, 1901.

The President, Dr. W. H. B. Aikins, in the chair.

Visitors present: Drs. D. M. Anderson and Howland.

Temporo-Sphenoidal Abscess, Operation, Recovery—Exhibition of Patient.

Dr. Herbert A. Bruce presented this patient, and recited history of the condition. It occurred in a young man of twenty-four years. When he was a small boy, about five or six years of age, he had ear trouble, otitis media in the right ear, and was treated in Toronto by two or three ear specialists for a period of five or six months. He was taken home then, apparently cured, continuing to have a little boracic acid dusted into his ear, and the discharge ceased in a few months. Up to the 1st of March of this present year had no trouble apparently at all except occasionally a little discharge at times when he got a cold; but it was nothing to speak of at any time, only a few drops, and then it would cease. He was on the ice playing a wind instrument—a trombone in the band of a country town—and the next day he was taken seriously ill. He said he felt as though he had blown a hole through his ear. His temperature was 101 and pulse increased to 100. Headache, pain in the side of the head and sickness of the stomach were present. The local doctor was called in, and prescribed for him, and he lay in bed for two weeks. He had very few symptoms when seen by Dr. Bruce. He was lying in bed quite rational, with a temperature of $97\frac{4}{5}$, and a pulse-rate of 66, with pain in the side of his head, and sickness at times. The history was that he was sick every day three or four times without any apparent cause, which had no relationship with ingestion of food. He had not been out of bed then for two weeks, and enquiry about dizziness or giddiness showed that none had been present. Dr. Bruce got him up to walk a little through the room, when he felt a little light-headed, but not more than one would expect after lying in bed that length of time, so that was not looked upon as a symptom of importance. He had much exaggerated knee jerks, and ankle clonus on both sides, particularly well marked on the right side. Drowsiness was another condition present. He slept a great deal, and seemed

drowsy and willing to go to sleep almost any time. He took nourishment fairly well. These were the only symptoms present. There were no eye symptoms. On examination of the ear Dr. Bruce found a slight discharge at the consultation in the country, very slight, with perforation of the drum. Over the mastoid there was a slight amount of swelling. Dr. Bruce came to the conclusion that there was certainly mastoid disease, and probably also cerebral abscess. He advised his removal to Toronto General Hospital, where he was taken immediately on the advice, and after two days in bed he was operated on. The condition found was briefly as follows: An incision was made in the usual position down over the mastoid, from the base to the tip, one half inch behind the ear, and the antrum was opened. Pus was found here, and then on passing a probe down into the cells these were found filled with cholesteatomatous material. A portion of the squamous bone was then chiselled away, thus exposing the temporo-sphenoidal lobe of the brain. A grooved trocar was passed in, and pus was seen oozing along the groove. A considerable quantity of pus was then evacuated, between three and four ounces, and there was a cavity as large as a tangerine orange. The ossicles were then removed from the ear, and a portion of the posterior wall of the meatus removed. A drainage tube was placed in the cavity, and dressings applied, the whole wound being left open. This operation was performed on the 14th of March last, about seven weeks ago, and the result is very satisfactory. The cavity drained nicely, and Dr. Bruce thinks it entirely filled in, but a little opening remains, and syringing is still done through the opening, and out at the external auditory meatus. During the first week after the operation there was considerable delirium, the patient being noisy and restless, but that disappeared, and he made a satisfactory recovery. One peculiar feature of the pus was the extreme offen-iveness of the odor. The roof of the middle ear had been completely destroyed.

Dr. Hamilton asked Dr. Bruce the condition of the reflexes, which were much increased before the operation. Dr. Bruce then examined these, and found them still slightly exaggerated. Ankle clonus was also still slightly present.

Dr. Grasett thought Dr. Bruce ought to present the case again in the fall, when discussion could then take place.

Dr. Orr thought that chronic suppuration had been going on in the middle ear for many years, and that it was extraordinary that there should be such extensive lesion of the bone with so few symptoms.

Dr. Ross referred to the case of a boy who was shot in the temporo-sphenoidal region. A probe demonstrated that the

bullet had gone through the bone. He was perfectly conscious; no symptoms at all, until gradually and slowly he began to get weaker and weaker until he finally died, and on *post mortem* examination one-half of the brain was a great amount of pus.

The Fellows coinciding, Dr. Bruce agreed to the suggestion of Dr. Grasset, that he would give a more extended history of the case early in the fall.

Tumor of Thigh—Clinical Notes. Duodenal Ulcer--Specimens.

Dr. F. Le M. Grasset reported these cases, and presented the specimens. The second was a case of ulcer of the duodenum with rupture into the peritoneal cavity, and death following somewhere within forty-eight hours. It occurred in a domestic servant. The case was first seen by Dr. A. A. Small, and when seen by Dr. Small indicated that there was some trouble in the neighborhood of the appendix. There was dullness in the right flank, and the diagnosis was confirmed a few hours later by Dr. Nevitt. The woman was rapidly approaching a moribund condition, and if something were not done immediately death would intervene. Dr. Grasset then operated, and found everything in the right region normal. There was, however, a collection of fluid like thin green mucilage, the like of which Dr. Grasset had never seen before. He considered there must be a rupture somewhere, and if he had prolonged the incision upwards he thinks he would have found the rupture without any difficulty, but the anesthetist said the patient was collapsing, so Dr. Grasset desisted. The patient died one to one and a half hours afterwards. It was found *post mortem* that rupture had taken place in the duodenum from an old ulcer, probably the day before. Everything she had taken in the way of food went into the stomach, and then into the peritoneal cavity. By external palpation nothing could be felt, she was in such a tympanic state.

The tumor of the thigh was a fatty tumor. The specimen shows that it is broken down, forming a large cyst in the centre and a number of smaller cysts. It produced a large tumor in the back of the woman's thigh, a little above the popliteal region. It had existed there for eight years. Six months before she was seen by Dr. Grasset a doctor attended her in confinement, and during the confinement he noticed this tumor. Six months after this the tumor had grown enormously and there was great pain in the sciatic nerve, and the woman was rapidly becoming a cripple. Dr. Grasset then operated, and had no trouble in enucleating it. A large part of the tumor had lifted up the sciatic nerve and it took considerable time separating the nerve and tumor. The wound healed by first

intention from end to end. Gradually power came back into the limb and the woman got perfectly well. She sat up in the hospital and got an attack of grippe, followed by trouble in the middle ear. From this she recovered. Examination of the tumor by Dr. Anderson and pronounced a lipoma. An interesting feature of the case was the manner in which the tumor was hugged by the sciatic nerve.

Dr. A. A. Small, enlarging on the case of duodenal ulcer, said the patient, a very healthy looking young girl of seventeen years, came to him complaining of nausea and only nausea, for which he prescribed a mild stomachic. He was called to see her early the following morning, when he found her complaining of very severe abdominal pain, which pain was confined to the right inguinal region. She was sent at once to the hospital; and as it was thought that it might be coprostasis a high enema was given, with very slight result. Suction was then advised, and the results found as given by Dr. Grassett.

Dr. George A. Bingham spoke in reference to the lipomatous mass. There is danger in connection with these tumors, and mentioned a case of a woman of sixty years who had for twenty years a small mass situated over the anterior aural nerve. Ulceration occurred from irritation of underclothing, and there was general breaking down of the whole mass. The temperature rose to 101 or 102, and there was a slight cardiac murmur also prior to operation. The growth was removed, and for some time after the operation this cardiac murmur persisted. It was probably due to septic endocarditis as a result of absorption, owing to broken down tissue from a simple fatty tumor. This gradually got well and the patient left the hospital recovered.

Dr. Ross referred to a case of duodenal ulcer occurring in his practice. Patient was taken suddenly with pain, with severe hemorrhage from the stomach and died. *Post mortem* showed old duodenal ulcer which had suddenly perforated into a vessel, resulting in death. Also spoke of a case in consultation, a man who for years had very severe hemorrhage from the intestine at long intervals. This case was jocularly referred to as "onionitis," from pieces of green onion being found in peritoneal cavity when operated on. From this the man made a good recovery, but some months after came back to the hospital. He died, and on *post mortem* found old ulcer.

Operation for Deformities—With Photographs.

Dr. George A. Bingham presented photographs and recited the history of this case. A cripple, a young lad of fourteen years, although he looked seventeen, came to the Children's Hospital, having heard of the wonderful surgical operations

done at this institution. From his head to his knees his physical condition was normal, but from his knees down he was not so. This lad had a dog and a sleigh, to which he harnessed the dog and drove down in winter time to the Children's Hospital from Uxbridge, not having other means of getting there and being bound to get there somehow. The right leg below the knee was rudimentary, eight inches in length. There was but one bone in the leg—the tibia. There were only four metatarsal bones and four toes. The foot was turned, looking directly upward in the direction of the knee. The toes were also webbed. Dr. Bingham amputated at once and obtained an excellent stump. The bones of the left leg were twisted inward. The internal malleolus was lower than the external; as a matter of fact he walked on the internal malleolus. The metatarsal bones were turned inward toward the toe. This leg was perfectly useless, and the problem was what to do with it. Dr. Bingham chiselled the bones and broke them down in order to bring the foot back into proper relation with the leg. There was great difficulty in getting the bones to co-apt properly.

Dr. Meyers' motion to elucidate the meaning of Clause 2, Article IX of the Constitution, fixing the April meeting of each year for the nomination of officers, was carried.

Dr. Pepler, as treasurer, was authorized to remit \$25 to Dr. Conerty, of Smith's Falls, and also to open a subscription list towards a fund for Dr. Conerty from members of the Clinical Society.

GEORGE ELLIOTT,
Recording Secretary.

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. M. McMAHON, H. J. HAMILTON,
AND INGERSOLL OLMSTED.

Nutrition and Stimulants.

Dr. I. N. Love, of New York, in his address on medicine, before the Mississippi Valley Medical Association (*Jour. Am. Med. Assoc.*, March 2nd), calls attention to some important questions on foods, alcohol and tobacco.

Foods are readily divided into the mineral, such as water, salt, ashes of plants and animals; the carbonaceous or respiratory, such as starch, sugar, fat, etc.—these are heat-giving; the nitrogenous or flesh-forming, tissue-building, as albumin, fibrin, caseine, gluten, etc. Throughout all ages the mineral and respiratory foods are required in full amounts. When the individual has attained full maturity, at about 30, a smaller quantity of nitrogenous food will suffice, and by 40, one-half or one-third the amount of animal consumed during the period of growth will supply the needs of the body. If this regulation of the diet be not observed, the person is very liable to become rheumatic and gouty, with all their evils. Water should be indulged in freely at all periods of life, and fruits and vegetables after mid-life become more than ever necessary.

With regard to alcohol, Dr. Love takes the ground that it is entirely undesirable as a beverage. He is very strong in his opposition to the use of alcoholics by women during nursing. He claims that alcohol has a much worse effect on women than men, owing to their more emotional nervous system. The indulgence in alcohol by women works terrible physical, moral and intellectual ruin. As a food it is of very little value; and, as we have so many good foods, should never be used as such. In acute diseases it is not as much employed as formerly, and is still employed oftener than it ought to be. In the advanced stages of typhoid fever, pneumonia, tuberculosis, and sepsis, it is of undoubted value: but, in many of these cases, we can substitute hot milk, tea, coffee, strychnia, normal salt solution, and other remedies, to advantage. Alcohol has been more abused, more excessively and needlessly used, more misapplied, than any other one remedy.

As to tobacco, smoking to excess is more harmful than chewing, as the nervous system and the mucous membranes are more injured in this form of use. The heavy smoker, owing

to diseased mucous membrane, is more liable to pneumonia, la grippe, tuberculosis, than those who do not smoke, or smoke moderately. Heart trouble is common among those who use tobacco to excess. Cigarette smoking is more injurious than pipe or cigar smoking, because of the fact that a milder tobacco is employed in cigarettes, and the smoker gets into the habit of inhaling the smoke. Children who smoke have their growth seriously interfered with, as the use of tobacco, in the young, deranges digestion, assimilation, elimination, metabolism and lays the foundation for early decay. The excessive use of tobacco has caused many a mental wreck and filled many a suicide's and premature grave. It is one of the prominent duties before the medical profession to inculcate habits of moderation in the use of both alcohol and tobacco.

Poisoning by the Solanine of Potatoes.

Pfuhl, last year, from May 21 to June 1, observed in fifty-six soldiers a marked poisoning, accompanied by chills, fever, headache, abdominal pains, diarrhea, vomiting, vertigo, syncope and in one case convulsions. In most of the patients there was present a yellowish condition of the conjunctiva, and, in some cases, of the skin. The fever fell on the fourth day. In the feces there was found no residuum of potatoes. In the urine there was a little albumen. On the third day, 47 of the patients were able to go on duty again. The treatment consisted of rest in bed, calome¹ and tincture of opium.

The potatoes, of which the soldiers had been eating, were examined, and it was found that in them the solanine, instead of being .36 per cent., was .38 per cent. in the raw and 24 in the cooked.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

Encephalic Circulatory Disturbances Associated with Convulsive Phenomena.

Convulsions may originate from direct contact of the convulsive matters with the nerve cell (Vulpian).

The beginning of convulsions seems to have a relation with a disturbance of the cerebral circulation. From experimental and clinical facts it seems to be proved that congestion exists during the convulsions. But that does not prove that congestion is the initial fact which determines the convulsion. From experiments and from clinical facts, it is proved that a short, intense anemia may produce convulsions. When the latter have been brought on, then the anemia is replaced by a congestion arising from the dilatation of the arterioles, and from the filling up of the capillaries and small veins. In some cases the convulsions may be attributed to a complex cause—circulatory

disturbances, associated with a change in the blood cells. In auto-intoxications there may be also contact of the nerve cell with toxic substances. Whatever be the cause and the mechanism which produce the convulsive phenomena, the latter are not produced equally and in a uniform manner in all subjects, since the production and the intensity of the convulsions depend on the convulsive attitude of the subject. This is a fact we ought always to bear in mind, in order to understand the varying reactions of the motor cells with respect to the convulsive agents, which at first seem identical (Dide. of Paris).—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

Spontaneous Ecchymoses in Diseases of the Nervous System (ROUMENTEAU).

Spontaneous ecchymoses are observed in many diseases of the nervous system. Hemophiliacs, arthritics, herpetics are particularly prone to have these subcutaneous manifestations. In diseases of the medulla, the medullary lesions, and especially those of the column of Glarke, make it clear that it is a question of vaso-motor changes. In some diseases of the encephalon, the production of the ecchymoses is due to a vaso-motor paralysis. In the peripheral neuroses and in the neuralgias, the nerve lesions show that the ecchymoses arise from vaso-motor changes. According to the happy expression of Gilles de la Tourette, hysterics and neurasthenics have a real vaso-motor diathesis, which explains the localization of the vascular disturbances. Another case is to be found in the condition of the arteries at the points where the ecchymoses occur. When the arteries have lesions of any sort, the vaso-motor changes produce an arterial hyper-tension, which sometimes leads to the extravasation of corpuscles. This extravasation which, at other times, depends on the rupture of the capillaries, is favored by the lesions of the arteries. These two causes, which act in the same way and simultaneously, explain the genesis of the formation of spontaneous ecchymoses.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

Hemiplegia.

Dr. David Ferrier, of London, in the *Clinical Journal* for February 20th, directs attention to a few features in the study of hemiplegia of considerable importance from a diagnostic point of view.

When a person stricken down with hemiplegia, whether unconscious or semi-conscious, is examined, there will be conjugate deviation of the eyes. That is, they look to the side of the brain injured, or away from the paralyzed side. This sign soon passes off.

With regard to the paralysis of the face, it should be remembered that in ordinary facial paralysis the person loses power over the palpebral muscle. In hemiplegia the eyelid can be closed, but not so in facial paralysis. When the eyelids are closed forcibly there is some weakness.

When the patient has recovered from the first stage, it will be noticed that the paralysis is not complete in the arm. The fingers, hand and wrist are more affected than the elbow and shoulder. On recovery the shoulder movements return before those of the hand.

In the lower extremity the foot suffers more than the leg, and the leg more than the thigh. The foot is last in regaining its movements, and the last movement of all to return is dorsiflexion of the foot. The recovery is rarely complete, and so some degeneration sets in along the lateral tract. There is late rigidity and increased knee jerk. So also are the periosteal and tendon reflexes of the wrist, elbow and shoulders.

In the toes, especially the big toe, there is a sign of great importance. When the lateral tracts are normal, if the finger nail be drawn along the sole of the foot, the toes are flexed upon the foot. If there is degeneration in the lateral tracts, the toes, and especially the big toe, is slowly extended upon the foot when the nail is drawn along the sole of the foot. This is a valuable means of distinguishing organic from functional paralysis.

When the hemiplegia is functional the face usually escapes. In hysteria the leg is usually more affected than the arm, which is contrary to the rule in organic paralysis. In true hemiplegia the leg is circumducted in attempts at walking, while in the hysterical form the leg is dragged like an inanimate object. In organic cases there is always a good deal of movement about the big joints, shoulder and hip.

When the sensation is affected as well as motion, and the same parts are affected, there is frequently hemianopsia. This is a valuable sign of organic disease. In hysterical hemiplegia, there may be hemianesthesia, but then eye symptoms are crossed amblyopia, with blunting of touch, taste and smell. In the hysterical paralysis the muscle may be excited with the strongest currents and the patient not feel it. The loss of sensation is never so complete as this in organic hemiplegia.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD,
H. C. SCADDING AND K. C. McILWRAITH.

Puerperal Infection.

In the April number of the *American Journal of Obstetrics* will be found a long and interesting article on this subject. The object of the study was "to determine the practical value of douching and the indications for diagnosis and treatment that may be drawn from bacterial examinations of the uterine and vaginal secretions and exudates during pregnancy and the puerperium." The work was done in the Department of Pathology, College of Physicians and Surgeons, Columbia University, New York City.

A new "tube" was used for collecting the material for examination. The author states that "care is necessary in the withdrawal of the tube to avoid any flowing of the secretion into the lumen of the tube," but does not say how this is avoided. The success of the technique seems to us to depend on just this point, and we regret that the directions are not more explicit. Some changes were also made in the culture media.

Many of Dr. Wadsworth's experiences agree exactly with our own, e.g.: "The number of species found by culture seldom represents the total present, morphologically, in the smears." When found "they were very exceptionally identified." "Organisms were much less frequently present in the lochia, which were collected from the vagina six to twenty-four hours after labor" (than in those collected before labor). "When characters (of organisms) are determined, the standard descriptions for accurate comparison are inadequate." These are some of the numerous difficulties which confront the investigator.

In reference to streptococci, three cases are cited, in which repeated examinations, both before and after labor, demonstrated the presence of streptococci in the vagina. In two of these cases the organisms proved fatal to rabbits, but the puerperium was normal in all these cases.

In reference to douching, douches were used in these three cases, and in others also, and were found quite ineffectual in removing the organisms.

So much for cases in which the puerperium is normal.

In cases in which infection has taken place the author concludes that "a sufficiently accurate diagnosis may be quickly and readily made" (between infection by saphrophytes and infection by septic organisms). We have found on several occasions that the bacterial findings have enabled us to predict

the clinical course of an infection, but we confess that the author's findings rather perplex us. If streptococci, and they, too, fatal to rabbits, can be present in the puerperal vagina without giving rise to symptoms, how are we to tell, when cocci and symptoms are both present, that the symptoms are due to the cocci?

The author decides against routine vaginal douching, favors douching in sapremia, and condemns it in septic infection, all of which is in accord with established practice. K. C. M.

The Causes and Significance of the Obstetric Hemorrhages.

J. Clifton Edgar reviews the above subject ably in the *N. Y. Medical Journal* of March 30th.

The only thing new in it is the author's assertion that a low situation of the placenta is a much more frequent cause of early hemorrhage than is generally supposed. He says:

"From an examination of a large number of membranes and placentæ, the result of interruptions of pregnancy in the third, fourth, fifth, and sixth months, I am convinced that hemorrhage due to a low situation of the placenta is much more common than is usually supposed.

I mean, by this, that a large portion of the supposedly simple abortions and miscarriages are really instances of the implantation of the placenta in the lower uterine segment, with resulting hemorrhage and evacuation of the uterus as a consequence of partial separation of the abnormally situated placenta, due to changes in the shape of the lower uterine segment dependent upon the growth of the uterus.

"It is generally thought, and usually taught, that hemorrhage from a placenta previa does not show itself until the twenty-eighth or thirty-second week of gestation. I have in my collection a uterus with the fetus and membranes intact, and a central placenta previa, from a woman who died within a few hours from the first hemorrhage, which occurred at the sixteenth week of pregnancy. A careful autopsy showed that death was due to acute anemia produced by the hemorrhage from the partial separation of the central placenta previa.

"Further, I am convinced that a careful study of the site of rupture of the membranes in instances of supposedly accidental hemorrhage, will prove that hemorrhage during pregnancy, and also during parturition, from the premature separation of a normally situated placenta, is a very, very rare condition indeed.

"I have found that several cases of presumedly accidental hemorrhage were really those of lateral placenta previa: a more complete examination after fuller dilatation, and the

examination of the rupture in the membranes *post partum*, indicating the condition that caused the hemorrhage.

"Severe hemorrhage from the partial separation of a normally situated placenta I believe to be a very rare condition; severe hemorrhage from a low implantation of the placenta I believe to be much more common than is generally thought."

K. C. M.

PEDIATRICS.

IN CHARGE OF ALLEN BAINES, W. J. GREIG, AND W. B. THISTLE.

A Case of Meningitis.

Dr. Alfred Stengel, of Philadelphia (*Archives of Pediatrics*), reports a case in a six year old child, coming on suddenly with vomiting and convulsions. On the third day lumbar puncture was performed and one ounce of clear watery fluid removed. Improvement after this was immediate. She used her right side freely, whereas previous to the puncture it had hardly been used at all. Recovery has been continuous, is now almost complete. Case was shown as an example of the improvement that so often follows lumbar puncture.

He also showed a case of osteo-arthritis in a girl of twelve. Right hand exhibited a subluxation of the carpus at the wrist, the metacarpo-phalangeal joints were flexed, and the inter-phalangeal joints were in straight extension. In the left hand, there was marked adduction of the metacarpus and striking projection of the end of the ulna. Joints of the thumb and little finger were enlarged. The big toes were turned under the other toes. He spoke of the diagnosis of this condition from chronic rheumatism and from deformities the result of paralysis. He quoted Garrod as saying that the adduction of the metacarpal bones so common in osteo-arthritis is not seen in the deformities following paralysis.

Dr. Stengel also showed a case of esophageal stricture in a boy of seven years who had drunk lye. Even filiform bougies would not pass the obstruction, which was nine inches from the teeth. The case was interesting in that one half ounce of an emulsion of bismuth was given to the child, and a skiagraph taken shortly after showed the presence of a diverticulum. Kœing's method of treatment of these cases was also referred to.

Poisoning by Vapo-Cresolene. BY ADAMS, OF WASHINGTON (December, 1900, *Archives*).

A child one year old in coma, with cold, clammy sweat, thought to be dying. Marked pulmonary edema, and had

been passing black urine, but no urine at all had been passed for twenty-four hours. The child had had a cough, and a vapo-cresolene lamp had been recommended. The child had been kept in a small room with the lamp burning for twenty-four hours at a stretch. Recovery took place when it was removed to the fresh air and given plenty of water to drink.

An infant six months old with stridulous respiration, mucous rales over both lungs, cold, clammy sweat and dilated pupils. A vapo-cresolene lamp was burning in the room. The odor of carbolic acid was very perceptible. No smoky urine in this case. This child also recovered when taken into another room and given plenty of water to drink.

These cases are interesting because these lamps are frequently recommended by physicians and thought to be harmless.

Acute Nephritis following Influenza. BY FREEMAN (*Archives*, October, 1900).

A boy four years old, who had had influenza for three years past, about January 1st had the ordinary catarrhal symptoms, prostration, fever and carache of a few hours duration without any discharge. The highest temperature was 105° on February 5th; and on February 9th it varied between 100° and 101°. On that day the child passed some very red urine, which contained blood, albumin, casts, hyaline and hemorrhagic. Blood, albumin and casts disappeared in ten days, and urine was excreted in the normal daily amount of thirty ounces. There was no edema. The child recovered completely.

The author had collected eleven other cases (not all in children) of nephritis following influenza. In this series there were two deaths, and in one in which an autopsy was performed a glomerulo-nephritis was found to be present.

An interesting discussion followed this paper, the majority of the speakers claiming that it was a rare complication. Rotch dwelt on the fact that an acute interstitial nephritis occurs in children, and that this is the usual form after measles or diphtheria, while glomerular follows scarlet fever.

Melena Neonatorum due to the Bacillus Pyocyaneus. W. R. NICHOLSON, Jux. (*Archives*, October, 1900).

Male born at term who was well for sixteen days when a stomatitis developed. On the next day bleeding from the nose and throat occurred, and on the day after the stools contained blood, and clear blood was afterwards frequently passed. Death was due to anemia. Autopsy showed the presence of an acute triple infection, with the staphylococcus pyogenes aureus, bacillus erogenes lactis, and the bacillus pyocyaneus, the latter being

found in the bile and tissues of the liver. The former were supposed to be predisposing causes. Infection presumed to have been through the nipple.

Plantar Reflex in Infants. By J. L. MORSE (*Pediatrics*, January 1st, 1901).

In view of Babinsky's observations on the plantar reflex, a knowledge of the state of this phenomena in infants is important. Observations made by Babinsky, Cestan and LeLourd, Collier-Cohn, Kalischer, Selusler and others, varied very much. The author examined 254 cases from 1 to 24 months' of age. In 25% of the cases plantar irritation produced flexion of the toes in both feet; in 21% extension on both sides; in 5% flexion on one side and extension on the other; in 35% no reflex. Conclusion—there is no constant plantar reflex during the first year, and while during the second year the reflex approaches more the adult type, it is still inconstant. Therefore no conclusions can be drawn from the presence, absence or character of this reflex in the diagnosis of abnormal conditions.

Congenital Hypertrophic Stenosis of the Pylorus. JAS. H. NICHOLL, Glasgow (*Pediatrics*, February, 1900).

The child was five weeks old. Ever since birth in fifteen or twenty minutes after each meal it would vomit the entire contents of the stomach. This vomiting was not preceded by pain or any stomach symptoms, and after it occurred the child was comfortable until another meal was taken, when the same process was repeated. Emaciation was progressive. Ultimately through the thin abdominal walls there stood out the form of a dilated stomach, across the anterior walls of which peristaltic waves passed frequently. On operation, the pylorus was found represented by a bulky ring of muscular tissue. Loretta's operation was performed, and the infant, which was five weeks old, made a perfect recovery. The symptoms of this condition are vomiting, constipation, emaciation, and the physical signs which, however, can be made out only when the emaciation is marked. They are: 1st. Peristaltic gastric waves; 2nd. Periods of normal dilatation after a meal, alternating with periods (after vomiting) during which the organ may be felt firmly contracted like a ball; 3rd. Marked dilation of the stomach rendered more prominent by the collapsed condition of the rest of the abdomen consequent on the empty state of the bowels; 4th. Pyloric tumor felt by palpation. This, however, has been felt only in a few cases. The article deals very fully with the whole question.

Influence of Organic Phosphorus on the Nutrition of the Young Child.

Cronheim and Muller performed a series of experiments on a year-old child to ascertain the effect of lecithin (in the form here of yelk of egg) on the nutrition of young children. In the first experiment they added the lecithin to the food, and collected all urine and fœces for analysis. Then they gave the same diet to the child, minus the egg, and analyzed the discharges. They conclude that the lecithin favors greatly the assimilation of phosphorus and azote. In the first experiment more than twice the amount of azote and phosphorus taken into the alimentary canal were absorbed than in the second.

Post Nasal Adenoids and Thyroid Disease.

Rivière in *La Médecine Pratique* insists on the close affinity between post nasal adenoids and disease of the thyroid. In 25 per cent. of his cases the children had goitrous ancestors or were themselves troubled with defective action of the thyroid, more especially the grave cases, that is, those in which there is a large amount of nasal discharge, great stupidity and backwardness, or those who are very deaf. In several of his cases the children were deaf and dumb, and he notes great improvement in these cases since he began to treat them, and hopes for complete cure. In all the bad cases, whether he can get a history of goitre in the family or case or not, he uses thyroid extract, as well as curretting, and finds he gets much better results than ever before.

Indigestion and Chronic Nose and Ear Disease.

How often are cases of dyspepsia in children seen in which careful dieting and medication alike fail to cure. In these, it would be worth while to look for chronic rhino-pharyngitis or middle ear trouble. The discharges in young children from nose and throat are invariably swallowed, and are capable and often do cause and keep up the indigestion, the effect being due to local imitation from the discharges, as well as to the general systemic condition being below normal. It is a point well worth noting.

Editorials.

CAUSATION OF CANCER AND OTHER GROWTHS.

There has long been a keen debate waged over the etiology of tumors. Some hold that a cancer is malignant from the first moment of its origin, others hold that tumors of benign nature may change their characteristics and become malignant. Prof. J. George Adami, of Montreal, recently delivered an address on the origin and growth of tumors before the Yale University Medical Association, in which he makes some observations of very great importance.

In the first place he reviews the parasitic theory of the origin of cancer. It must be admitted that he makes a fair statement of the case as advocated by those who advance this opinion. The application of special staining methods to the cells has made it appear that "the histological evidence that cancer is due to parasites becomes, to say the least, singularly frail."

The statement is made in the address that a clear line of demarcation cannot be drawn between malignant and benign tumors. All growths that are classified as true tumors may take on the two main features of malignancy, namely, the local invasion of surrounding tissue, and the formations of new growths of like nature in distant organs. In this way enchondroma and lipoma may undergo morphological changes and become malignant; but there can be no doubt "that this sarcomatous tissue is the direct outcome of the cells forming the primary tumor."

There are three ways of viewing the parasitic origin of tumors: that all tumors are caused in this way; that infection is only one of the ways; that tumors begin without parasitic aid, but become infected later. It must be declared at once as without doubt that "there are tumors which assuredly are not of parasitic origin." "We cannot go to the opposite extreme and say that no tumor is due to the action of parasites on the tissues." In the body there are cells of varying degrees of activity and resistance. The toxins produced by parasites, if acting in an energetic manner, may cause necrosis; but, if acting less severely, may give rise to proliferation and growth. From a careful study of the schizomycetes, the coccidia, and

the bilharzia, we must come to the conclusion that parasites may be one of the causes of tumor growths.

In the origin of tumors, we recognize a series of growths, at one extreme of which tumors grow from misplaced tissue without the aid of parasites, while at the other extreme of the series there are growths originating in normal tissues, and growing as the result of irritation induced by parasites. Between these extremes there are growths that approximate and belong to one or the other group. There have been many attempts to find a common bond of union between these two groups. Cohnheim and his followers tried to explain everything in connection with the origin of tumors on the cell "rest" theory. Others again on the parasitic theory. Two problems are to be solved: Certain tumors arise from misplaced cells, certain other tumors arise from cells originally normally placed.

The presence of cell "rests" do not explain the origin of tumors. There is something more required. It is necessary that these cells be acted upon by surrounding influences to establish an active proliferation. There must be a periodic irritation of the cells, and this irritation must be sufficiently prolonged that the relationship of the cell to those in its neighborhood are completely altered. The irritation that has set up the requisite changes in the cell must continue, otherwise the process of new growth would cease, the cells become again latent, or revert to the formation of cells with normal functions. When once the process of abnormal cell formation has been established by continuous periodic irritation, some of these cells wander away from their proper relationships to other cells, and become heterotopic. The continuation of the irritation that started the abnormal cell process creates in the cells a tendency to growth rather than a tendency to work or function.

The microbial theory of the origin of cancer and sarcoma, argues that these organisms and their toxins cause localized cell proliferation. They bring about stimulation and mild irritation, and give rise to that activity in the cells that leads to growth rather than function. The more the cells depart from their normal characteristics, the more active may the microbial toxins become in the way of promoting the new growth. While this is possible, it is by no means necessary that there be microbes or their toxins acting on the tissues. It must be

admitted that if parasites start malignant growths, they do not continue the process, and have not as yet been demonstrated as present. This is quite contrary to what has just been shown, that the irritation starting the growth must continue in operation.

SANITARY CONDITION OF SLEEPING CARS.

The citizens of Canada and the United States have taken considerable pride in our so-called palace sleeping cars. The fittings of the modern sleeper are certainly luxurious, if not gorgeous. During recent months we have noticed many adverse criticisms respecting these same gorgeous trappings, and especially respecting the comfortable plush-covered seats. The *Montreal Star* and the *Toronto World* have joined in a crusade against the sleeping cars. They say that they are badly ventilated, badly heated and unsanitary in many respects. The *World* says that a properly constructed sanitary car should have no plush in it. The woodwork should have a smooth varnished surface, which can be easily kept clean. All the fittings should also be of some kind of varnished or enamelled work, which can be easily kept clean. The *World* goes on to say that, in the modern sleeper, the panellings, ornaments, fretwork and coverings of seats are simply nests of dirt and dust, and consequently dangerous to the health of the passengers. There is really not room for much argument on the subject. When we consider the modern car from an aseptic point of view, we can only arrive at one conclusion, and that it is impossible to keep them absolutely clean. However, a great deal depends on the care that is bestowed upon the cars, and we have reason to think that our modern cars are kept in a fairly clean condition. The most strenuous efforts are put forward to exclude those who are suffering from infectious diseases, and the cars are well cleaned and well ventilated at regular intervals. Moreover, it must be remembered that travellers desire something in the shape of comfort, and a fairly large proportion of them would not be very enthusiastic if they were asked to sit for twelve or twenty-four hours on varnished pine or oak boards. Some would be inclined to compromise the matter by allowing the sanitary cranks to go into the second and third-class cars, where the fittings and trappings are less luxurious.

SMALLPOX IN ONTARIO.

The present outbreak of smallpox in Ontario, of such immediate interest to ourselves, is but an illustration of what a number of States in the Union have been suffering from for two years, and which has now extended to every province of Canada. Smallpox has been so long known and so frequently discussed that the subject seems almost threadbare; but there are some peculiarities about the present epidemic which call for comment. The essential feature of the disease in most outbreaks is the mildness of the attack, which, however, does not seem to have notably lessened the infectious character of the disease. An illustration, which might be multiplied again and again, will show this. The Secretary of the Local Board of Admaston Township, Renfrew County, replies regarding cases as follows:

R. Proctor's son came home, February 15th, from lumber camp in Sudbury, suffering from what the doctor called chickenpox. There were five more cases, mild, in house. Mr. Proctor, aged 65, alone escaped; youngest was 12 years.

At R. Hilliard's were three cases, mild. He is son-in-law of Proctor, and has three-year-old child. Was there when disease was pronounced smallpox and taken home. Fourteen days after child sickened, also father and mother later.

The relation of the disease to vaccination is equally pronounced in illustrating the characteristics of smallpox. Taking as an illustration the Toronto Junction outbreak of January, 1900, Dr. Bryan, who attended the cases, reported as follows:

In the Taylor boarding house were twenty-five persons. Of these thirteen contracted smallpox, four of those being vaccinated, nine unvaccinated. Of the fifteen who did not take smallpox, though exposed for weeks, fourteen were vaccinated and one unvaccinated. This one was successfully vaccinated by me after an indefinite exposure. Of the total cases, six might be termed severe and confluent. These were all unvaccinated, but all recovered. Cases in the vaccinated were very mild; my experience in other outbreaks during the past three years, he states, have been similar to the above.

Many additional illustrations can be given of how vaccination with good lymph, up to the fourth day after exposure, has again and again prevented future cases. On the other hand, a

number of instances have occurred where vaccination performed with an inert lymph have failed to protect against the disease.

The interesting question naturally arises—Why, with these well established facts, have we seen probably half the first cases in the outbreaks of the past year and a half diagnosed as chickenpox, such as in several municipalities in Essex, in Toronto Junction, in Port Arthur, in Sudbury Hospital, in Massey, in Renfrew Hospital, in McNab Township, in Lucan, in London Township, and so on ?

Setting aside the case that while many practitioners of the present day, never having seen smallpox, in many instances do not expect it, and in other instances, even if suspicious, are slow to create alarm by calling a comparatively mild eruption smallpox ; yet the fact remains that smallpox has always been a very difficult disease to diagnose. Only a year ago the staff of the Winnipeg Hospital were deceived, and a death certificate of purpura hemorrhagica was given to a case of hemorrhagic smallpox, which was seen subsequent to death by the health officer, who diagnosed it, but too late to prevent a serious outbreak arising from the mistake ; and similarly, last year, a corpse due to smallpox was unsuspectingly placed in the dissecting room of the Detroit Medical College, causing a serious outbreak. On the other hand, such cases as the following occur. In a lumber camp, whence several mild cases had been sent out to the Sudbury camp, others exposed remained. Two of these men who were friends and worked and slept together, sickened at the same time, and both with equally prominent initial symptoms of smallpox. One developed an abundant rash, while the other practically had none at all. Variations in the cutaneous inflammations and eruptions are so well known in scarlatina, measles, Rotheln, chickenpox, and vaccinia, that there is nothing unusual in finding this in smallpox—the differences having to do perhaps as much with the temperament of the patient as with the type of the disease, as may be seen in the difference in the arms of a series of persons of about the same age, vaccinated by the same operator and with the same lymph.

The variations in type of smallpox have been illustrated in the outbreaks in every camp and district. Thus the history of the family of F—K——, in Renfrew, illustrates this:

A boy, 22 years, came from camp near Sudbury, suffering with what doctors called chickenpox. He remained in Reufrew Hospital until pronounced cured for chickenpox, and then went home to Admaston Township. His father, aged 55, and mother, aged 50, and two brothers and two sisters, the youngest twelve, all took the disease. There was one very severe case, semi-confluent, and the patient, old Mr. K., very sick, and recovered.

Variations of these may be seen in cuts set forth, in a circular on diagnosis issued recently by the Provincial Board of Health.

It is quite apparent, however, that remembering the extraordinary mildness of the present outbreak as regards type, the well-known variations due to temperament, age, surroundings, and general health, and the notable effects of former vaccinations on the disease, every physician must recognize that not only should he preserve a memory-picture of the normal disease, but he must, even more, remember its variations from the normal as influenced by the above conditions. Especially will he by a careful process of exclusion, such as noting the antecedents of the patient for a fortnight or more, his environment at home, his occupation, his previous vaccination, and indeed every circumstance calculated to throw light on the history of the case, determine whether smallpox could have been contracted. Assuming that thereafter any doubts exist, he then must follow hour by hour the progress of the case. From the moment the suspicion crosses his mind he cannot morally neglect to isolate the patient and vaccinate him. In ten days' time, the case, if vaccinated with a clean lymph, will have either taken and shown that the disease was not smallpox, or will have confirmed the diagnosis of smallpox by its being unsuccessful. The clinical histories of some 100 cases, which have been under the supervision of an officer of the Provincial Board of Health in the Tent Hospital at Sudbury will shortly be available for study, and other interesting facts will doubtless be brought out, which will serve, however, only to substantiate the facts so repeatedly made known regarding this disease.

AN ACADEMY OF MEDICINE.

We have advocated, on former occasions, the formation of an Academy of Medicine for Toronto. The time is ripe for such. The various medical societies of the city could perform the present work as sections of the academy. The fee could be placed at such an amount as to enable the academy to publish its transactions in an annual volume. This would have a wholesome and stimulating effect. Many who do not now take any interest in our societies would, if there were such an academy as would result from a union of the several societies. The publication of the proceedings of the sections would give to the work of the academy a stable character, and make the members feel that there was something valuable and permanent in their work. We would suggest that the present societies take the matter up and appoint persons to meet and report a plan of action. J. F.

THE VALUE OF VACCINATION.

At a time like this, when smallpox exists in a number of places throughout the Province, it may not be amiss to review the position of the medical profession on the protective value of vaccination. This is especially important, as there are always a considerable number of the laity who do not believe in vaccination; and a small, but active, minority who are constantly agitating against it. There are in the medical profession a few who doubt its utility, on what grounds, however, it would be difficult to understand.

Such an eminent scientist as Alfred Russell Wallace strenuously opposes vaccination. His main grounds are that it is an interference with the liberty of the citizen. But the imprisonment of a criminal or the isolation of a smallpox patient is an interference with liberty, but for the general good. Another argument of Wallace's is that we have no right to introduce a disease into a person's system in order to prevent one that he may never have. But a moment's reflection will show how short-sighted this objection is. There can be no valid objection

— that all should be subjected to a mild illness that a large number may escape a severe and fatal illness. Another argument against vaccination is that there is no scientific warrant that one disease can protect against another. To this it may be answered that the ablest authorities on the question of vaccination, including the immortal Edward Jenner, agree that variola and vaccinia are one and the same disease, and therefore it is a sound position to take that vaccination can protect against variola.

In pre-vaccination days, smallpox was a disease of childhood. Every few years it would spread in epidemic form, attacking all who had not been protected by a previous attack. The mortality was very high, and many who escaped with their lives did so only to be blind, deaf or maimed.

In Prussia, prior to compulsory vaccination in infancy, and re-vaccination at twelve years of age, the death rate was 90 per 100,000 of the population, to which must be added all the disfigurement. Now the death rate is 2 in the same number. In Belgium the death rate was formerly 95 in every 100,000; but since all the school children have to be vaccinated, the death rate has fallen to 3. The records of the Italian army for 30 years show that of those troops who had not been vaccinated, 300 in every 10,000 took smallpox with 50 deaths, whereas among those who were well vaccinated only 5 in 10,000 took the disease, with practically no deaths. At the time of the Franco-Prussian war the Prussian army lost some 400 or 500 soldiers by smallpox, while the French army lost 23,000. In the former the vaccination regulations were very strict, in the latter very lax. The experience taught France a stern lesson, and all her troops are carefully vaccinated, or re-vaccinated on entering the army.

Turn to the experience of Great Britain. On a basis of 1,000,000 of the population the following are the average annual death rates in the respective periods: 1660-79, 4,170; 1728-57, 4,260; 1771-80, 5,020; 1801-10, 2,040; 1831-35, 830; 1838-53, 513; 1854-71, 388; 1872-82, 262; 1885-92, 73. Taking vaccinated and unvaccinated as a means of comparison, we find that in one thousand vaccinated children the attack rate was 5 per cent., and the death rate 0.09. In the unvaccinated the attack rate was 101 and the death rate 44. And

this only tells a small portion of the real difference between the two classes.

Many vaccinations are of no value, owing to the careless manner of their performance, or inert lymph. These persons readily fall victims to the ravages of smallpox, and are quoted as instances of the failure of vaccination. This is entirely unfair. The vaccination must be properly performed to yield protection.

It may be laid down as a rule that careful vaccination in infancy, and re-vaccination at puberty, protects the persons as well as the disease. In the face of all that is known of the great value of vaccination, one would think that there should now be no opposition; and that when a person had to run any reasonable risk of contagion, his first act would be to have himself vaccinated, or re-vaccinated. Among the vaccinated 80 per cent. of the cases are mild, whereas among the unvaccinated 80 per cent. of the cases are severe. One final word. In the case of attendants upon smallpox patients, those who are properly vaccinated and re-vaccinated do not take the disease.

Were it not for vaccination, how could an epidemic of smallpox be brought under control? It will readily appear that this could not be accomplished until the disease had lasted long enough to permit of the recovery of a certain number of persons who could wait upon the new cases. What a slow and costly way this would be, as compared with the thorough and prompt vaccination of the community, and especially the first attendants upon the sick! Many say, "I don't believe in vaccination." For this lack of faith the success of vaccination is largely responsible. It has so reduced the frequency and severity of smallpox that many have lost fear of the disease because they have seen none of its ravages, and have no practical knowledge of the value of vaccination. They begin to think that the absence of smallpox is due to other causes than vaccination. Herein lies their error.

TORONTO CLINICAL SOCIETY.—The following officers were elected for the ensuing year at the regular meeting held May 1st: President, Dr. J. F. W. Ross; Vice-President, Dr. E. E. King; Recording Secretary, Dr. Geo. Elliott; Corresponding Secretary, Dr. A. A. Small; Treasurer, Dr. W. H. Pepler; Council, Drs. Anderson, Hamilton, Bruce, Bingham and Thistle.

SANITARY LEGISLATION.

During the recent session of the Ontario Legislature two important additions were made to our sanitary laws. It has been proved by actual bacteriological experiments that the germ of tuberculosis is one possessed of the greatest vitality, ranking with that of anthrax, and exceeding that of smallpox in its resistance to the action of germicides, and that it may be dried and blown about as dust, and again give rise to fresh colonies. And yet up to the present time the health authorities had no specific power to regulate the location and conduct of sanatoria or boarding houses for cases of tuberculosis. This anomaly has been removed by sections 28 and 29 of the "Act to amend the Statute Law," which provides under a penalty of \$25 per diem that "no sanatorium, institution, or place for the reception, care or treatment of persons suffering from consumption or tuberculosis shall hereafter be established, maintained or kept within 150 yards of an inhabited dwelling, without the owner, manager, or persons to whom the same belongs, having first obtained the consent by resolution given in writing of the local Board of Health of the municipality wherein it is proposed to establish the same."

The other reform was an Act to empower the Government, through the Provincial Board of Health, to make such provisions and regulations as shall tend to limit the spread of disease in the unorganized districts, in lumbering and mining areas; to take early measures of prevention, and to throw on to large and wealthy companies a portion of the responsibility and expense of preventive and remedial measures, which in the past have been a burden and a grievance to the tax-paying public at large, and to neighboring municipalities in particular.

In our next issue we hope to give some interesting details regarding camp life and its sanitary aspect.

A minor amendment to the Public Health Act extends the safeguards regarding impure food to animals affected with "diseases of a cancerous nature" in general.

We congratulate the Legislature, the Government, the Provincial Secretary and the Provincial Board on their fresh evidences of regard for the health interests of the people.

WESTERN UNIVERSITY, LONDON.—The following gentlemen have satisfied the examiners for the diploma of M.D.: Mr. Atkinson, Avon; Mr. Clarke, Mr. Craig, Mr. Doyle, Mr. Elliot, Mr. Fawcett, Mr. Grant, London; Mr. Meek, Port Stanley; Mr. Reason, London; Mr. Rogers, Belmont; Mr. Russell, London; Mr. Smith, Mr. Turner, Dutton. Gold medallist—Mr. I. W. Atkinson, Avon.

DR. RYERSON RECOGNIZED.

LOCKINGE HOUSE, WANTAGE BERKS, March 7, 1901.

DEAR COLONEL RYERSON,—I am very much pleased with the very ample and interesting report that you have furnished to the Red Cross Society. I look forward with great pleasure to the time when, owing to your successful operations on the staff of Lord Roberts, and representing the British Red Cross Society, great harmony will exist between England and the Dominion. Lord Roberts speaks in the highest terms of your services, and I, as Chairman of the Red Cross Society, desire to add my testimony to that of the commander-in-chief.

I must also add my thanks for the deeply interesting pamphlet of your "experiences" during the war, kindly sent to me.

With kind regards, believe me,

Yours very truly,

(Signed) WANTAGE.

P.S.—I am about to send you a proof copy of a photogravure of myself, which has been reproduced, at the wish of some of my friends, from a portrait by Sir William Richmond. I shall be very pleased if you will accept it, with my best wishes as a "souvenir."

PRETORIA, 27th February, 1901.

MY DEAR COLONEL RYERSON,—I trust you will pardon me for not writing and thanking you long before this for your very great assistance to us in our difficulties.

I have often intended to write, but I could never secure a time when I could quietly sit down and say to you what was in my mind.

To others who have assisted me I could write appropriate letters of thanks, but you seemed to have placed on me a debt so large that I am unable to repay. I do, however, acknowledge it, and I thank you sincerely in the name of the service to which I belong. You came to this country with most useful stores. You placed them at the disposal of the sick and wounded, when and where most needed. Your work was most untiring and unselfish, and, I fear, will never be appreciated as it should be. I doubt, however, if this last will trouble you much. If I ever visit Canada I will avail myself of the honor and pleasure of calling on you, and I will, I trust, then have a talk over past events.

Believe me, yours sincerely,

(Signed) W. D. WILSON,

Surgeon-General.

Principal Medical Officer of the Army in South Africa.

Dr. Ryerson has been gazetted a Knight of Grace of the Order of St. John of Jerusalem in England, in recognition of his services.

The following circular letter speaks for itself:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

TORONTO, 19TH APRIL, 1901.

DEAR SIR:

Permit me to call your attention to the resolution of the Medical Council, passed 15th of June, 1900:

"That the Registrar be instructed to carry out the provisions of sub-section 5 of section 44 of R.S.O. 1897, entitled, 'The Ontario Medical Act,' and that after such provisions have been carried out, he notify all whose names have been erased of the provisions of sub-section 6 of said section 44, and that unless they avail themselves of the provisions of said last-mentioned section, that they are liable, under section 46, to all the penalties imposed by the said 'The Ontario Medical Act.'"

The Registrar informs me that you have been duly notified in accordance with above resolution, and that your name has been erased from the Register for non-payment of assessment dues amounting to \$—.

I have been instructed by the Medical Council of Ontario to take proceedings against all unregistered practitioners. I beg to refer you to clause 44, sections 3, 4 and 5, also to clauses 46 and 49 of "The Ontario Medical Act," in reference to the same.

Desiring to give you time to communicate with Dr. Pyne, the Registrar, so that you can reinstate yourself upon the Register, I will after thirty days proceed against you in the usual way as against unregistered practitioners.

(Signed) CHARLES ROSE,

Prosecutor for Coll. Phys. and Surgs. of Ont.

May 1901

Obituary.

JOHN WANLESS, M.D.

Dr. John Wanless died at his late residence, Toronto, April 14th, aged 88. He was born in Dundee, Scotland, and came to Canada shortly after graduating in medicine. After practising in London, Ontario, for fifteen years, he came to Toronto, where he took a second course in medicine, and graduated, University of Toronto, in 1861, and received the degree of M.D. in the following year. He then went to Montreal, where he remained until 1897, when he returned to Toronto.

JAMES ARCHER WATSON, M.D.

Dr. J. A. Watson, of Toronto, was accidentally killed while horseback riding, April 11. While crossing the C. P. R. tracks at Dundas Street, the horse became frightened by an approaching engine, and, turning suddenly, dashed against the side of the locomotive, striking the bumper beams. Horse and rider were both instantly killed.

Dr. Watson was born in York County in 1856. He was educated in the Weston High School and Trinity Medical College, graduating in 1884. He was an expert horseman, and for many years an active member of the Ontario Jockey Club and the Country and Hunt Club. He was at one time champion of the Toronto Chess League, and was also well known as an expert bowler and lawn tennis player. He had for years a large and laborious practice, and was well liked by his patients. He was unmarried, and is survived by three brothers and one sister. He was buried in Riverside cemetery, Weston, April 13.

CHARLES WILLIAM COVERNTON, M.D., M.R.C.S., Eng.

Dr. Covernton died at his residence, 404 Huron Street, Toronto, April 14th. He was born at Walworth, London, England, August 12th, 1813. His primary education was received in London, and at Boulogne in France, and his professional in London and Edinburgh; M.D., St. Andrew's, 1835; M.R.C.S. (Eng.), 1835, L.S. Apoth., London, 1836. In the latter year he came to Canada for his health, but being pleased with his visit decided to remain. After two years in Vittoria, he moved to Simcoe, where he engaged in active practice until 1878, and then came to Toronto. He was President of the

Council C.P.S.O., in 1871; of the Ontario Medical Association in 1882, and was a member of the Provincial Board of Health from its inception until a year before his death, and was its second Chairman. He was for many years Professor of Hygiene in Trinity Medical College.

Having commenced practice in Canada at the age of 23, Dr. Covernton lived to see many interesting changes and episodes. During the stirring times of 1837 he was for a short time a surgeon in the militia. We have heard him laughingly tell the story of how he unwittingly aided in the escape of Dr. John Rolph; though we believe he did not subsequently regret the incident. It was done in all innocence; he was attending Dr. Rolph's sister, Mrs. Salmon, and at the suggestion of Mr. Salmon, he wrote a letter to Dr. Rolph summoning him to his sister's bedside. Coming from an undoubtedly loyal source, this letter served as a passport through the loyalist lines.

Dr. Covernton and his professional brethren had the mutual satisfaction of his representing them on many occasions during the last decades of his life; on one of these he had the gratification of being one of the forty-five members of the International Congress of Hygiene, presented by our now King to our late beloved Queen. Dr. Covernton was a type of the fine old English gentleman, and generally beloved and respected by the profession. Early in life he married a Dublin lady resident in the County of Norfolk, Frances Elizabeth Williams, whose death we had to deplore some years ago. Of a family of nine there remain to mourn his loss two daughters—Miss Alice Covernton and Mrs. Christopher Baines, of Toronto, and Mr. Carlton Covernton, of Montreal. To them we offer our heartfelt sympathy.

T. H. LITTLE, M.B. (Tor.), M.D. (Vic.)

It is with very deep regret that we announce the death of our friend, Dr. Thomas H. Little.

It always seems specially sad to see an active member of the profession cut down in the midst of his work. The medical profession has supplied its full quota of those who die in the discharge of their duty. The dangers that beset the medical man are neither few nor trifling. He is exposed to all sorts of weather, and at the most untimely hours. He is ever encountering the most virulent forms of infectious and septic poisons, the inception of which into his system may rapidly prove fatal. So it was with Dr. Little. In his professional capacity his advice was sought. The case proved to be smallpox; he contracted it from his patient, and became a victim to a very

virulent attack of the disease. It is peculiarly sad to see one, in the midst of health and energy, and enjoying a large practice that his devotion to his patients had built up, cut down so suddenly.

Dr. Little took his medical course in the medical department of the University of Toronto, and graduated in 1888 as M.B. (Tor.) and M.D. (Vic.). He started practice in Toronto, and soon became deservedly popular. He was held in equally good repute by the profession and the public. We extend to his devoted wife our deepest sympathy.

A word of recognition is due Dr. Sheard. In his capacity of Medical Health Officer he was most assiduous in his attendance upon the deceased. In this we have one more example of the true courage of the physician, who shrinks not from his duty, regardless of the personal danger he encounters.

Personals.

Dr. Hugh Watt, of Fort Steele, B.C., spent a few days in Toronto last month.

Drs. Adam Wright, W. P. Caven, and J. F. Fotheringham sailed for England April 20th.

Dr. Bertram Spencer, of Toronto, has quite recovered from his recent attack of septicemia.

Dr. James Patterson, of Buffalo, came to Toronto, April 9th, to act as best man at the wedding of his brother, Mr. Dickson Patterson.

Dr. Robert J. Dwyer, of Toronto, is still engaged in post-graduate work in London, England. He expects to return to Canada early in June.

Professor Ramsay Wright has been appointed by the Dominion Government to the position of Assistant Director of the Marine Biological Station.

Dr. J. O. Orr leaves for England on the 11th of this month to prosecute his special work in connection with diseases of the eye. He expects to return by the 20th of August.

Henry W. Miller, M.B. '95, has lately been appointed pathologist and clinical director in the Taunton Insane Hospital, Taunton, Mass., after three years special study in other hospitals in Massachusetts.

Dr. Alan Sheppard received a serious injury while playing hockey in Michigan in the second week of March. He came to Toronto a few days ago, and at the time of writing is domiciled at the residence of his mother.

Dr. Edmund E. King, who was confined to his bed for some weeks from an attack of grip, with pleurisy, is now rapidly recovering and able once more to engage in active work.

Dr. John E. Pickard (Tor. '85), Virginia City, Nevada, President of the Nevada State Medical Association, expects to come to Toronto in June, to attend the meeting of the Ontario Medical Association.

Dr. J. T. Fotheringham, of Toronto, left for Manitoba, April 2nd and returned April 11th. While in Winnipeg he saw Dr. Chown, President-elect of the Canadian Medical Association. He learned from Dr. Chown and his friends that the Western physicians continue to take a lively interest in the coming meeting of the Dominion Association in the latter part of August, and are very anxious to greet a large contingent from the Eastern Provinces on that occasion.

The following are officers of University of Toronto Alumni Association local organizations:

Dr. J. S. Sprague, of Stirling, is one of the Vice-Presidents for Hastings County.

Drs. H. A. Yermans and J. A. Marshall are two of the Councillors for Hastings County.

Dr. M. J. Beeman, of Newburg, and Dr. W. W. Meacham, of Odessa, are two of the Vice-Presidents for Lennox and Addington County.

Dr. F. W. Simpson is one of the Councillors for Lennox and Addington County.

Dr. N. H. McCoy is one of the Vice-Presidents for Lincoln County.

Dr. J. Sheahan is one of the Councillors for Lincoln County.

Drs. H. Meek and W. M. English are two of the Councillors for Middlesex County.

Dr. D. Fraser is one of the Vice-Presidents for Peterborough County.

Dr. J. E. Shaw is one of the Vice-Presidents for Peterborough County.

Dr. W. D. Scott is one of the Councillors for Peterborough County.

Dr. Morley Currie is President for Prince Edward County.

Drs. John W. Wright and A. C. Bowerman are two of the Councillors for Prince Edward County.

Dr. G. M. Aylesworth, of Collingwood, is one of the Vice-Presidents for Simcoe County.

Drs. S. M. Wells, W. H. Clutten, Geo. Hunt, J. C. Evans, and J. A. Ross are among the Councillors for Simcoe County.

Book Reviews.

Self-Examination for Students. P. Blakiston's Son & Co., Philadelphia. Price, 10c.

This is a small volume of questions on the several subjects of the medical curriculum. These questions are taken from a number of medical college and state examination papers. They furnish the student with a good idea of what he may be expected to know.

International Clinics. A quarterly of clinical and especially prepared articles on medicine, neurology, surgery, therapeutics, pediatrics, pathology, dermatology, diseases of the eye, ear, nose and throat. Edited by HENRY W. CUTTELL, A.M., M.D. Vol. I. Eleventh Series. 1901. Philadelphia: J. B. Lippincott Company.

The *International Clinics* have been published for over eleven years. Most medical practitioners are familiar with them. The articles in the present volume are of a high order of merit. In addition to the clinical lectures, there are a number of review articles at the end of the volume. These deal with the progress in medicine, surgery, therapeutics, neurology, etc. The make up of the volume is attractive. Good paper, type and illustrations form a prominent feature of the work. The publishers deserve no small share of credit for maintaining such a high standard of merit in these quarterly volumes.

A Manual of Operative Surgery. By LEWIS A. STIMSON, B.A., M.D., Surgeon to the New York and Hudson Street Hospitals; Consulting Surgeon to Bellevue, St. John's, and Christ's Hospitals; Professor of Surgery in Cornell University; Corresponding Member of the Societe de Chirurgie, Paris; and JOHN ROGERS, JUN., B.A., M.D., Surgeon of Gouverneur Hospital, New York; Instructor of Surgery in Cornell University. Fourth and revised edition. With 293 illustrations. Philadelphia: Lea Brothers & Co., 1900.

We have before us the fourth volume of Stimson's "Operative Surgery," and have so recently reviewed the third edition that it is superfluous to make the review detailed. Of this edition we can say, as we did before, that it is one of the best operative surgeries that we know of. It deals with the subject concisely, and illustrates the facts in a manner that is easy of comprehension. It is very beautifully illustrated by black and white cuts, which are accurate enough to bring the subject more vividly to the mind's eye than many pages of text. It is a most useful volume, and we can recommend it as an authority in operative surgery. The general typographical appearances are of the best.

Practical Points in Gynecology. By H. MACNAUGHTON-JONES, Master of Obstetrics (*honoris causa*) Royal University of Ireland, etc. With twelve plates. London: Baillière, Tindall & Cox. Demy 8vo. Price, 4/6 net.

In the words of the author, "These chapters are reprints of a series of communications which appeared in the *Edinburgh Medical Journal*, and which were written for it by the author at the request of the editor." There are six chapters, each giving a clear presentation of a separate subject. Throughout the work there is abundant evidence of the author's large experience, extensive information and sound judgment.

The first chapter, on "Some points in gynecological asepsis," is especially interesting, coming as it does from the pen of one who began his operative career in the earlier days of "Listerism," and who has followed the progress of that system up to the present day. "Some pitfalls in gynecological diagnosis," "The therapeutics of disorders of menstruation," "Conservatism and its influence on operative technique affections of the female genitalia as causal factors in the etiology of neurosis and insanity, and their special bearing on the operative treatment of the insane," "The indications for the operations of hysterectomy and myo-hysterectomy in myoma," are the subjects of the remaining chapters. The plates which illustrate the book are good photographs, well reproduced. We heartily recommend this little book for its operative and therapeutic points.

Appendicitis and its Surgical Treatment, with a Report of One Hundred and Eighty-five Operated Cases. By HERMANN MYNTER, M.D., Copenhagen, Professor of Clinical Surgery in University of Buffalo, Buffalo, N.Y. Third revised edition. Philadelphia: J. B. Lippincott Co.

We have before us the third edition of the above work, which deals with the subject of appendicitis from early-historical times to the present, presenting accurately the history of the disease through its many names and stages. The volume was written in 1898 as a thesis for the doctorate degree of the University of Copenhagen. It has been considerably enlarged since its original issue, and brought entirely up to date. It is only two years since the original was written, yet changes have taken place in the opinions on appendicitis. Dr. Mynter has made a most close study of this subject, and his description of the anatomy, histology, physiology and pathology of the appendix is most concise and complete. He has not confined himself entirely to the surgical aspect of the disease, but has examined thoroughly into appendicitis from a medical, as well as a surgical, standpoint. Although it is his belief that it is purely a surgical disease. He devotes considerable space in the

work to the treatment of the disease as adapted by the leading men in the different countries, as Germany, Sweden, France, England, America, etc., and, while their opinions vary somewhat, the general concensus leads to operative interference. We can recommend this work to the profession as one that should be in the hands of every physician, dealing as it does with a disease which occurs with such frequency and with such suddenness that anyone may meet it at any time, and should be prepared at a moment's notice to give an intelligent opinion. The typography, paper and binding are of the usual excellent style of the publishers

Diseases of the Nose and Throat. By DR. SHURLEY, Detroit. D. Appleton & Co., New York, 1900.

"Of the making of books there is no end," but in the present instance the end is justified, for Dr. Shurly's is really an excellent book. His chapters on hay-fever, tuberculosis of the upper air passages, and deformities of the nasal cavities are especially worthy of notice. The typography is good, and the illustrations what might be expected from the Appleton Company. The colored plates in this, as in other books on the throat, do not represent in any accurate way what is really to be seen, and might as well be left out, for they are liable to mislead the novice. It does not seem possible to get the right coloration in lithographic plates of disease.

The Bastinado as a Resuscitator of the Supposed Dead.

In the January, 1900, number of the *Homeopathic Journal of Obstetrics, Gynecology and Pedology* there is a short paper by Dr. Chas. B. Gilbert, in which he tells how he resuscitated a new-born child that would not breathe under the usual incentives, by vigorously slapping the soles of its feet with the handle of a hair brush. He credits Dr. Carleton, of New York, with originating this mode of treatment, and prints a letter from him. In this he relates how a patient stopped breathing under ether anesthesia, and did not revive, even after the faithful use of artificial respiration, electricity and other means of restoration, and was finally given up as dead as he entered the room. Bethinking himself of the policeman's effective mode of arousing drunks, he seized a slipper that lay handy, had the patient's stockings quickly stripped off, and flayed the soles of both feet as hard and as quickly as he could. Respiration was resumed within less than one minute. This is a simple and effective method, though hardly homeopathic.—*The Medical Council*

Selections.

SURGICAL HINTS.

In bad cases of burns or other severe and painful injuries, it is advantageous to give chloroform for the first dressing, or at least to give a hypodermic injection of morphia. This diminishes the pain and fear, and consequently lessens the shock.

The parents of children with hypertrophied tonsils often object to operation because they think the latter may interfere with the child's voice. This fear is groundless. Explain to the parents that the voice will suffer more from the child's continued bad health than from anything else.

In children with prolapse of the rectum it will often be enough to prescribe the daily use of laxatives; to see that the bowels are only moved while the patient is lying down over a bed-pan, and to strap the buttocks tightly together during the intervals between defecations with a wide strip of adhesive plaster.

It is seldom wise to consent to the parents being present when an operation has to be performed on a child. Children are bound to be terrified when first given an anesthetic, and their cries for help and appeals to their parents are often more than the latter can stand. More than one surgeon has been compelled to defer or even abandon an operation for this reason.

Sometimes in children who have undergone a tracheotomy and have been compelled to wear the tube a long while, it seems very difficult to get them in the habit of using their larynx again. A nervous dread of being without the tube has much to do with this condition. In such cases the surgeon may try occlusion of the tube with a cork, without removing the instrument, and persevering efforts must be made to get the child to talk, or to blow a cheap trumpet, or to blow out a candle.—*International Journal of Surgery.*

Treatment of Labial Carcinoma.

The only proper treatment for cancer of the lip is radical extirpation at the earliest possible moment, associated with removal of the anatomically related lymphatic glands. It is quite true that arsenic is frequently used in these cases. We admit that some cases have been cured by its use, but we consider that this treatment is absolutely improper, because it

entirely neglects the associated lymphatic glands. Whereas some cases have recovered after the local application of arsenic, a very large number of cases must have perished because the adjacent glands were not removed. The treatment is more painful, produces greater disfigurement, is just as dangerous, and is of infinitely less value than is operation by the knife. In every operation the surgeon must aim at radical removal, and in the majority of cases it is perfectly useless to take away the lips and leave the anatomically related glands.—*Da Costa, in Therapeutic Gazette.*

Treatment of Round Ulcer by Washing out the Stomach with a Solution of Perchlorid of Iron.

M. Bourget, in a case of simple ulcer where there had not been hematemesis, washed the stomach with an aqueous solution of perchlorid of iron, to which he generally adds $\frac{1}{2}$ part to 100 of potass. chlor. After evacuation of the stomach contents by the tube, he washes it out with 100 c.c. water; without removing this, he introduces the solution of iron to the amount of 100 to 150 c.c., then removes the whole. This is continued until a litre of the solution has been utilized; in the final evacuation he leaves 60 c.c. in the stomach and places the patient upon the abdomen. After five minutes he makes him take a glass of hot sodae bicarb. solution, 2 parts in 100, to precipitate the remainder of the iron in the stomach. Continue this once a day; in cases of hematemesis twice a day. After the first lavage the hematemesis is much lessened and the pain ceases rapidly. He is not a partisan of the repose of the organ; he feeds his patients with rice, which he considers the best food. He gives it alone or associated with milk, 50 gms. of rice to a litre of milk. After preparing, boil on a sand bath until it is the consistence of thick bouillon.—*Translated for International Medical Magazine from Gaz. des Hop.*

The Pathogenesis of Pellagra.

Babes (*Allg. Wien. Med. Zeit.*) gives the results of his experiments in connection with the study of the cause of pellagra. The writer secured diseased maize from villages in which pellagra was endemic, and had aqueous and alcoholic extracts made from the cereal. The injection of these into mice, rabbits and guinea-pigs convinced him of the toxic action of the extracts. Symptoms similar to those observed in man were often noted, such as loss of appetite, diarrhea, hemorrhages from the bowel, progressive emaciation and weakness, paralysis particularly beginning in the lower extremities, tetanus-like palsies, opisthotonos, and also cutaneous changes, such as falling out of

the hair and desquamation. Confirmatory experiments were undertaken as follows: Serum was secured from a cured woman who had suffered from pellagrous disease, and also from a man with an advanced pellagra cachexia. Two series of animals were inoculated, the one with the plain extract, and the other with the toxic extract mixed with the pellagrous serum. The first series of animals emaciated rapidly and died on the ninth, seventeenth and twenty-ninth days, whilst the second series survived to the thirty-second and sixtieth days, and the third still lives (more than 3 months). As a control test mice and rabbits were injected with (1) pure extract, (2) extract mixed with normal blood serum, and (3) extract mixed with pellagrous blood serum. The first animals died within 12 hours from a testicular hemorrhage; the second died 15 to 17 hours later, and the third survived the injection from 36 hours to 17 days. The animals of the third series did not emaciate, and seemed quite well, whilst the others lost weight and became cachectic. The writer concludes that there is in the blood of pellagrous patients a substance which possesses the property of paralyzing the action of the extract of diseased maize. This substance can be found in the blood of cured pellagra patients or those convalescing from the disease. It possesses specific characteristic properties against spoilt maize derived from pellagra-prevalent regions. Other kinds of serum possess no property of this character. These are the first studies to determine the origin and specific character of pellagra. They give us the experimental ground for vaccination trials, as well as for the prevention and specific treatment of pellagra.—*International Medical Magazine*.

Epilepsy and Adenoids.

Two cases of epilepsy in which marked amelioration followed the removal of enlarged tonsils and adenoids were brought by Mr. Lennox Browne before the last meeting of the British Laryngological Association. While these cases are by no means the first in his experience nor the first reported, Mr. Browne thought it only fair to say that the experience of throat specialists of the benefit of removal of adenoids in this class of cases would appear to be more favorable than that of neurological experts who, presumably, did not attach so much importance to their causal influence. The main point of interest, however, is that while large doses of bromide proved inert prior to removal of the adenoids, the drug, albeit in very small doses, appeared to be essential to complete subsidence of the peripheral irritation due to the glandular overgrowth. Dr. Dundas Grant confirmed the experience of his colleague by reference to the many cases he had seen and treated since his appointment at a special

hospital for nervous diseases; and the president, Mr. Mayo Collier, clinched the matter by pointing out to those who doubted the reasonableness of the association that the point of exit of almost all the cerebral nerves was so closely approximate to the site of the adenoids, that it was a subject for surprise that the causal relationship should ever have been in doubt.—*Med. Press and Circular.*

Anti-Cancerous Serum.

At the Surgical Society M. Regnier communicated some cases of cancer treated by him with the serum of Wlaiev, and with more or less success. Although in no case did he obtain a cure, he succeeded in relieving considerably the patient from the intolerable pain, while the general condition was improved. However, he did not believe any kind of serum would succeed in arresting its evolution. M. Tuffier said that he experimented with the serum of Richel, and found it gave similar results as that claimed for the serum of Wlaiev, and he was inclined to believe that any serum could do no more than produce a general effect on the patient.—*Paris Cor. Med. Press and Circular.*

The "Normal Salt Solution."

There is some variation in the formulæ given by different writers. Dr. Charles A. L. Reed, in his new *Text-book of Gynecology*, remarks that Locke has suggested the following formula and reported favorably upon it:

℞. Calcium chloride	3 $\frac{1}{4}$ grains	
Potassium chloride	1 $\frac{1}{2}$ grains	
Sodium chloride	2 $\frac{1}{2}$ drachms	
Sterilized, distilled, or tap water,		
enough to make		1 quart.

M. The solution may be injected subcutaneously, into the intestine, or into a vein.—*New York Medical Journal.*

For Toothache.

Gazette Hebdomadaire de Médecine et de Chirurgie for April 4th ascribes the following to Guillaumin:

℞. Crystallized carbolic acid	}	equal parts
Menthol		
Cocaine hydrochloride		
Chloral		
Guaiacol		

Triturate in a mortar. A pasty liquid is thus obtained, easy of employment, and both caustic and anesthetic. The caustic action may be augmented by increasing the carbolic acid.—*New York Medical Journal.*

Miscellaneous.

THE TRUE ARISTOCRAT.

In discussing social philosophy, the aristocratic point of view is usually mentioned only to be condemned. But the aristocratic point of view, while it may be one-sided, is not arbitrary. It is the result of natural development and experience. It is founded on the knowledge of human nature, the science of government and the weight of responsibility. The true aristocrat is *grown*, not born or made. He is Nature's handiwork, the product of her methods and processes. Experience, suffering, effort, insight, self-victory, culture, refinement, sensibility, all these contribute to train, discipline and mould the genuine aristocrat. Small wonder that the gentleman, developed by nature in this school, should feel a certain contempt for the levelling tendencies of a Socialistic Democracy. He knows that things cannot be equalized by going down hill, for Nature is "agin" it.

It is a mistake to say that aristocrats live by privilege. No one does this but fools and knaves. The price of privilege is slavery to something or somebody. Endow a man with great estates, and if he does not live soberly and discharge his responsibilities with a reasonable measure of right and justice, he begins to degenerate in health, mind and character. The administration of his estates, or his business, as the case may be, pass into the hands of abler parties by inalienable natural laws.

Such a man may remain the nominal owner, but he is not an aristocrat, and the only privilege he enjoys is that of being a glutton, a libertine and a wine-bibber. Do we really envy men the chance to indulge their lower natures—to commit moral and physical suicide? The forces which pull us down are stronger than those which lift us up. Few of us can afford to do without the continuous spur of necessity. In few is the spirit fine enough to hear whisperings from the other world.

The aristocrat seldom makes any defence of charges made against him. He knows it is natural to the crude and undisciplined to grumble, complain, denounce. He wastes neither time nor breath on deaf ears and near-sighted eyes. He realizes that hatred and envy, misunderstanding and misrepresentation are the price he must pay for his elevation. He knows the inconstant nature of the multitude, their reckless abandonment to the feeling of the moment, the gusts of passion, the hasty acts, the brief repentance, the innumerable mistakes and errors

which make up their lives. Pity for humanity in bondage to ignorance and passion, climbing the hill from which he looks down with such infinite pains and suffering, comes to soften his indignation.

All personal sense of offence fades from the mind of the true aristocrat. He stands in silent reverence and awe before the working of Nature's inexorable laws and forces.

Truly the arbitrary disposition is to be pitied. Always rushing blindly against these powerful unseen barriers and dams, rising half-stunned but unconscious what hit him, and rushing on with redoubled force and fury, only to catch it again. Such sights as these, while they call forth sympathy and compassion, make the true aristocrat impersonal in his attitude toward men. They enable him to steel his heart, to refrain from meddling interference and be willing to seem cruel in order to be kind, in affairs where governing and managerial capacity are called for.

A man is a true aristocrat only when he can say with reverence and truth: "Thy will, not mine, be done," yet work on courageously to the end.—*Indian Medical Record*.

A Warm Bath for a Restless Child.

A warm bath just before going to bed tends to allay the nervous irritability which prevents sleep in children, whether caused by temper or work, and it does so probably by dilating the blood vessels on the surface of the body, and so relieving hyperemia of the brain. A warm mustard foot-bath—an excellent remedy for sleeplessness—is also beneficial through its derivative effects.—*Indian Medical Record*.

A New Aphrodisiac.

The fertility of certain foreign therapeutists in the discovery of new aphrodisiacs is simply extraordinary, for all the world as if there were a ready market for drugs of this class. From a therapeutical point of view aphrodisiacs can have but a very limited field of usefulness; indeed, on thinking the matter over, we are rather at a loss to define ever so limited a field for their employment. The latest addition to the list is Yohimbin, the active principle obtained from a plant growing in equatorial Africa. Experiments have been made with this product on frogs and rabbits, and it is stated to produce marked hyperemia of the sexual apparatus. On this ground it is recommended for the treatment of sexual neurasthenia, and also in albuminuria, though we are unable to follow the train of reasoning which led up to this conclusion.—*Medical Press and Circular*.

Where the Crime of the Christian Scientist Lies.

The disingenuous methods adopted by the supporters of Christian Science were well displayed in a stormy discussion which, according to press reports, took place at a recent meeting of the Society for Medical Jurisprudence. One of the speakers, pleading for "toleration," is reported there to have said: "Why, the very things they do are done in every Protestant and Catholic church in the country. Go into any of them, and if one of their prominent members happens to be sick, you will hear them praying for his recovery without any regard to whether he has a doctor or not." But when has any objection ever been made to Christian Scientists, or any one else, not only praying for the recovery of the sick, but even bringing to bear the influence of the strongest possible suggestion toward it? The Christian Scientists do *not* pray "without any regard to whether he has a doctor or not," or, as we should prefer to express it, without regard to whether all known material or mechanical aids are used, or not. There could not be the remotest objection to their supplementing material and mechanical therapeutic efforts with any mental process they choose to employ. Every Christian, of whatever denomination, daily utters, or should utter, the simple petition, "Give us this day our daily bread," and that, or a similar tribute of reliance upon the Omnipotent One, is used by many who do not profess to be Christians; but none of them considers that that fact justifies him in sitting down idly and folding his hands, without making an effort to attain that for which he prays. Would any Christian Scientist exonerate the guardian of a child, should the child die of starvation because its guardian withheld all food, on the ground that matter was nothing and only Divine Mind fulfilled the process of nutrition and caused the progress of the being in growth and health? Suppose a Christian Scientist's own child were playing in front of a fast-speeding car, and a man standing by did not even stretch out a hand to drag it away, not believing, forsooth, in material measures, but relying solely on the strength of Divine Mind. We should like to hear the Christian Scientist's opinion of that inhuman creature. No. It is not what the Christian Scientist does, it is what he refuses to do, that constitutes his crime against religion, society, the community, and the individual.—*New York Med. Sour.*

THE road to happiness and content in summer leads to Nature, for the closer we get to the bosom of Nature the closer we get to real happiness, where everything is God-made, where things are fresh and sweet and pure, and where we live and come in daily contact with things that appeal to our finest and truest and highest impulses.—*Edward Bok, in the May Ladies' Home Journal.*

AN UNATTACHED SPECIALTY.—The ancient Egyptians were evidently a point or two ahead of us in other things besides pyramid-building. What says Herodotus (Euterpe, lxxxiv)? "The healing art is thus practised among them. Each physician confines himself to one disease, not more. There is an abundance of physicians. Some of them devote themselves to the eyes, some to the head, some to the teeth; others again to the bowels, and still others to more obscure disorders." It is true that in the present day we are once more approaching their level, but even now our specialization is far from complete. The *Lancet* for February 9th quotes the following amusing verses by "J. B." from the *St. George's Hospital Gazette*, detailing the woes of a titled invalid in search of an appropriate specialist:

A tumor he developed on
A spot that's quite neglected;
No specialist for just that point
He anywhere detected.

So curiously was it placed,
That, search from toe to crown,
You saw it not when he stood up,
Still less when he sat down.

From day to day the swelling grew,
So vast became that tumor,
You could not say which was the growth
And which Sir Francis Boomer.

And so at last it finished him,
Despite his numerous staff,
And he explained the cause of death
In this his epitaph:

"My ailment could not treated be,
The times were out of joint;
There was no specialist upon
The Perineal point.

"Some doctors find their work before,
And others theirs behind,
But none devotes attention to
The spot which I've defined."

—*N. Y. Med. Jour*

MAN does not "go to" heaven but he creates his own heaven, and enjoys the happiness and harmony associated with the term in exact proportion to the degree in which he has created them during his life on earth. Many a man still dwelling here experiences daily more of the joys of heaven, so-called, than many others who have passed through the changes we call death. *Margaret Bottome, in the May Ladies' Home Journal.*