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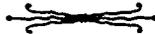
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WINNIPEG, APRIL, 1899.

No. 13.

SELECTED ARTICLES.

HYSTERIA.

By E. G. Wood, M. D., C. M., Professor of Practice of Medicine and Clinical Medicine, Medical Department, University of Nashville; Member of the British Medical Association, Etc.

To the general practitioner of medicine no diseases are so perplexing, so little understood and, generally speaking, so unsatisfactory in the results achieved by treatment as are diseases of the nervous system, with their varied and complex symptomatology, their frequent association with other acute and chronic affections, and the consequent difficulty experienced in distinguishing primary organic disease in the nervous system from conditions which are functional, reflex or secondary. This is especially true of hysteria, a disease with which every one is familiar, but which no one understands; a disease which is constantly before the physician in one or other of its varied forms, persisting for months or even years, or vanishing as by a magician's wand, or as suddenly being transformed into a new being clad in a garb new and strange and dancing before the discouraged physician as though scoffing at him in his impotence.

What hysteria is, where it begins or where it ends we know not, and a clear definition of the border line between the hysterical and the non-hysterical is as difficult to give as it is to say where sanity ends and insanity begins.

It was once believed that hysteria originated in the womb, and it was even thought that this organ traveled about through the body setting up the various symptoms in its train. This ancient idea has long ago been abandoned, and, occurring as the disease does in males, and in females, even when the uterine functions are inactive, it is now believed that there is no direct association between it and the female generative organs, which have no other influence than that of sometimes reflexly exciting the attack.

We now apply the term hysteria to an undefined morbid state of the nervous system, with its primary derangement in the higher cerebral centres, but affecting secondarily the functions of the lower centres in the brain, spinal cord and sympathetic system, and characterized by psychical disturbances with or without various disorders of the motor, sensory and vaso-motor systems.

What the exact nature of this derangement is either in the higher or lower centres is not clear. Certainly no macroscopic or microscopic changes have been observed by the pathologist that could in any way explain the various symptoms of the disease. On the other hand, careful and systematic examination of the nerve tissues by all the modern methods known to science goes to show that no abnormality of any kind can be discovered. Certain structural changes have occasionally been found, but they are undoubtedly secondary, as was the sclerosis

of the lateral columns of the cord in Charcot's well known case of a woman who died after many years of persistent contracture of the limbs.

In the light of modern pathology, it is claimed by many that no disease can be regarded as functional, but it is still the most convenient and probably the best term we have to apply to those various conditions and manifestations of disease which present no known change in the structure of the organ or organs whose functions are perverted, and therefore we must still speak of hysteria as a functional affection.

Whatever this functional derangement of the higher centres may be, it produces a disturbance of the proper balance between the higher functions of the brain, and is equivalent in most cases to a want of self-control, to a giving away to the feelings, and in its effects upon the lower centres it probably acts as Stephen MacKenzie holds by causing a suspension of functions in the so-called inhibitory centres, in this way giving rise to uncontrolled functional activity on the part of the motor, sensory or vaso-motor systems.

Walton, Voigt, Rosenthal and others claim that the various hysterical manifestations are due to anæmia of the centres involved owing to temporary vaso-motor contraction, and in support of this theory point to the peculiar irritability of the vaso motor system in this disease. Most authorities, however, incline to the view that molecular changes take place in the central nervous system, temporary in duration and not to be detected by any known methods of examination. Certainly whatever the conditions are the lesions cannot be of an organic nature, such as inflammation or sclerosis, or we could not account for the sudden recoveries in hysterical cases of the gravest kind.

Though we cannot resist entertaining the idea of some possible or even probable undiscovered structural change and must still be content to regard it as a functional disorder, it is undoubtedly a real malady which is to a large extent beyond the influence of the patient's will. The loss of control is genuine in most cases and is only regained by some profound impression upon the

higher centres: not voluntarily recalled by the patient, for in many instances there is an actual paralysis of the will, or, as Sir James Paget puts it, the patient might truly say, "I cannot will."

In many cases of hysteria the psychological features are of such a nature and predominate to such an extent as to suggest insanity as a possible element in the case, and undoubtedly, as Osler says, "The disease occupies the ill-defined territory between sanity and insanity."

It is in many cases impossible to draw the line between these two conditions, many hysterics exhibiting a condition of moral degradation and a tendency to deceive and lie to an extent that can only be accounted for by their having crossed the border line. Again, these resemblances are not infrequently reinforced by various hallucinations and delusions on the part of the neurotic patient. The mental symptoms of course vary widely in different cases, but I believe that a psychological element is or has been present in every case of hysteria even when the manifestations are apparently purely physical.

Hysteria is almost unknown among the barbarous races, and seems to be a product of the higher cerebral development of civilization. The most severe types are probably seen in France, though Guiteras states that the severe forms with mental and motor symptoms are extraordinarily frequent among the Cubans.

Hysteria is much more frequent in females than in males, Briquet's figures being 20 to 1 but inasmuch as many of the cases of so-called hypochondriasis in men are hysteria, these figures probably indicate too great a disproportion. The disease may in men be characterized by any of the forms common to women, and some of the most severe and intractable cases are met with in members of the male sex.

No age is exempt from this disease. It has occurred in a child of three years and again in extreme old age, but it is especially frequent at certain periods of life. In the following table Briquet and Landouzy give the percentage number of cases in each decade.

the ages given being those where the symptoms first appeared :

Age . . .	10	20	30	40	50	60
No. of cases	8	50	28	10	3	1

From this it will be observed that fifty per cent. of all cases first presented symptoms between the ages of ten and twenty, more than seventy-five per cent. between the ages of ten and thirty and only one percent. over fifty. Savill of London relates a case of hysterical aphonia in a woman of 71.

Heredity plays an important part in the etiology of this affection. There may or may not be a direct history, but in the great majority of all hysterical cases there can be discovered some inherited neurotic tendency which may have manifested itself in such diseases as epilepsy, chorea, insanity, alcoholism, etc. Of the causes in the individual these may be mental or physical.

Severe mental strain, injudicious management of growing girls, and especially vicious moral influences, may increase the inherent predisposition and excite the disease: an attack is frequently precipitated by some emotional influence, as a sudden alarm or fright or some dire calamity, many people exhibiting some of the minor manifestations of the disease when laboring under strong emotion.

In many cases there is present some defect in the general health, as anemia, disturbed functions in various organs or debility incident to some exhausting disease. Disease of the generative organs is present in perhaps half the cases, but this serves only to depress the nervous system and cannot be said to be the cause, as the organic defects are often but trifling and the hysterical symptoms frequently persist after the removal of the local trouble. Ovarian tenderness is frequently but not always present, and is not confined to hysterics.

Hysterical symptoms are frequently much more marked during menstruation and the menopause, owing to the disturbing influences of these conditions upon the nervous system. Sexual excitement acts in a similar manner. Hysterical symptoms not uncommonly appear in the predisposed during the course of some general or local disease, and,

simulating some grave organic disease of the nervous system, give rise to considerable anxiety on the part of the physician until he is able to thoroughly satisfy himself as to the true nature of the case.

Local diseases may set up hysterical symptoms, as, for example, an acute laryngeal catarrh may excite an attack of hysterical aphonia of great obstancy and persistence.

Neurotic symptoms frequently follow an injury producing a clinical picture that calls for all the skill of the surgeon to enable him to read correctly. Again, what is perhaps the most perplexing of all is the very frequent association of hysterical symptoms with other nervous diseases, both functional and organic, such as epilepsy, cerebral tumor, hemiplegia and various diseases of the spinal cord, giving rise to a condition so complicated as perhaps to render a diagnosis impossible. As Weir Mitchell says, "The symptoms of real disease are painted on a hysterical background." It is interesting to note that this disorder may be spread by irritation, producing the so-called hysterical epidemic, the disease usually in these cases taking on the convulsive type. Numerous instances of such epidemics have been recorded, the outbreaks generally occurring in schools, workshops and certain religious conventions where emotional excitement is at a premium.

Many and variable as are the symptoms of hysteria, they will be found to fall within one of the following groupes, viz.: psychic, sensory, motor, secretory and vaso-motor.

Even in the earliest stages of the disease patients usually exhibit a marked degree of irritability, are sensitive to little troubles, and trifles cause great annoyance. They lose their self-control and are unable to free themselves from a condition of depression that may almost amount to melancholia. Self consciousness rules the patient's thoughts and actions, and her description of even her slightest ailments is greatly exaggerated: she is always seriously ill. A hysterical patient loves an appreciative companion or audience, and sympathy serves only to encourage her to yield to, rather than resist her morbid tendencies, until she ac-

tually induces symptoms and simulates disease, the symptoms getting beyond the patient's control. Such a patient, already emotional, conceives the idea of pain or stiffness, and in time the pain is actually felt or contracture really appears.

How frequently do we see patients, who having experienced a slight neuralgia pain in the left inframammary region, at first feared that it might be due to disease of the heart and later persuaded themselves that they were victims of incurable cardiac disease, suffering constant misery and apprehension, even though assured by their physician that the suspected organ was perfectly normal. Perhaps you will say this is hypochondriasis, but where do you draw the line between the two conditions? Hysterical patients are not only irritable, but they are very emotional, now breaking out into immoderate laughter, again crying and sobbing bitterly, often passing from one state to the other in a few moments. These emotional disturbances may be paroxysmal and are usually induced by the most trifling causes.

Another symptom which is very common and is really psychic is the "globus hystericus," which is felt as a ball or lump rising from the sternal region into the throat, or as if something were gripping the throat. This may be experienced even in the non-hysterical when suddenly frightened, and is often described as the heart leaping into the mouth.

Another remarkable condition occasionally seen is that known as "trance," which usually follows convulsive attacks and is due to inhibition of function of the higher centres. Even cataleptic conditions are sometimes met with in which there is a peculiar plastic rigidity of the muscles, the limbs retaining the position in which they are placed. Some cases approach, others cross the border line of insanity, many writers recognizing hysterical insanity as a distinct mental disease. Spitzka speaks of chronic hysterical insanity as an intensified hysteria. It may take the form of hysterical melancholia, mania or mono-mania, some cases resembling the latter very closely in

the fixity of their ideas regarding themselves and in their developing suspicion regarding others. In a severe hysterical fit with frenzy the patient is temporarily insane. Delusions and hallucinations may even be present.

There may be derangement of all the sensations, general and special. This may be manifested in exaggeration which is sometimes real, as when sounds are heard which are inaudible to others and objects seen which are invisible to others, or disagreeable odors perceived by the hyper-acute sense of smell. Morbid taste is also a frequent symptom. Hyperæsthesia is sometimes general, but is often limited to certain spots or areas which may be clearly defined. It is often unilateral and superficial, but may again be deep-seated, as over the ovaries, and sometimes over the tender spots causes pain and often a sense of faintness and globus hystericus or even convulsions. These spots are Richer's "hystero-genetic zones," and the localities in which they are most frequently seen are the left ovarian region, the spines, and of these especially the dorsal, the left inframammary region and various spots on the abdomen. This extreme sensitiveness is occasionally felt all over the abdomen, simulating peritonitis, and may even be present all over the body. Pain in the left inframammary region is a common symptom, while more frequent still is pain in the vertical region of the head, often severe like a nail being driven in—the "clavus hystericus."

Vague sensations of numbness are among the commonest sensory manifestations. These are usually unilateral and are very frequent in the tongue, especially at the menopause. The so-called nervous chills or shiverings are very common. Pain is sometimes felt in the joints with vasomotor swelling simulating actual arthritic disease.

Anesthesia is very common, though often unnoticed by the patient, and is one of the most interesting and diagnostic features of the disease. It is usually unilateral and may affect the mucous membranes of the nose, mouth and palate, the latter being of

especial diagnostic significance. The patient may not feel a touch, not even a needle sunk into the skin, and even cold and heat may not be perceived, but peculiarly, the tender spots usually remain on the same side. This loss of sensation may be partial, affecting small areas, and is often here to-day and gone to-morrow, and while it usually affects the left side it may move from one side to the other. Charcot has shown that this transfer of the anesthesia can sometimes be produced by stimulating the skin with blisters or faradism. A peculiar feature of the loss of sensation in hysterical paralysis is that it has the distribution of a sock or stocking, affecting the skin below a horizontal line drawn around the limb.

The special senses upon the anesthetic side are frequently diminished: for example, there may be temporary blindness.

The motor disturbances in hysteria may affect almost any part of the motor apparatus, the commonest manifestation being paralysis, which may appear suddenly or gradually. It may follow a hysterical convulsion and is sometimes unilateral, producing a hysterical hemiplegia, or affects both lower limbs—a paraplegia. Perhaps the larynx is more frequently affected than any other part, with paralysis of the adductor muscles, resulting in hysterical aphonia in which the patient speaks only in a whisper or is perfectly mute. These patients can sometimes sing well, but can only whisper when speaking, and cases of this kind have been known to speak quite clearly when asleep. Faradism to the larynx may lead to the sudden recovery of the voice, as in a case of a woman of 71, reported by Saville. This hysterical aphonia follows a slight laryngeal catarrh. In recovery the speech usually returns quite suddenly.

When the paralysis affects the limbs either as a hemiplegia or a paraplegia, the onset is usually sudden, but at first moderate and gradually increased, though rarely absolute. Even when persisting for a long time there is little or no muscular atrophy, and the electric irritability remains normal. It is often induced by emotion, appearing suddenly as a "giving away of the legs," and

is sometimes accompanied by pain.

In hemiplegia the left side is usually affected, and a diagnostic feature of the disease is seen in the fact that the face always escapes entirely. The organic and skin reflexes are normal, while the knee jerks are excessive, sometimes to a marked degree, and an irregular ankle clonus is rarely observed.

Next to paralysis, the commonest motor symptoms are the muscular contractions, which may be persistent, with clonic spasms or paroxysmal, as convulsions. In contracture we have a tonic spasm of the affected muscles, which is increased by an attempt on the part of the physician or attendant to overcome it, and this intensifying of the contraction under such circumstances is an important diagnostic feature. It usually persists during sleep, but relaxes under complete anesthesia, after which it may not return. It is seen sometimes in a spasmodic closure of the jaws, hysterical trismus, and is very common in the limbs, especially in the arm, in which it is always the flexor muscles that are affected, the arm being flexed and rigid, and the fingers flexed with the thumb often outside the fingers or between the first and second. Contracture may follow a convulsive seizure and frequently follows an injury. If this spasmodic contraction which succeeds an injury should, as it is likely to do, spread to muscles which could not be affected by the injury, the nature of the case is clear. In the leg these contractions usually fix it in extension instead of flexion as in the arms. Anesthesia usually accompanies this condition, affecting a stocking-like area below a horizontal line as before remarked. These contractures may persist for years, but often disappear suddenly under the influence of some powerful emotional or mental impression, and are among the cases which give such a reputation to faith curists, divine healers, Christian scientists, etc.

Of all individual symptoms the globus hystericus is the most common, and while in the majority of cases it is purely psychical, in some there is undoubtedly a convulsive spasm of the pharyngeal muscles. In

the hysteroid or hystero-epileptic convulsions, rigidity of the trunk and limbs, often opisthotonos, alternate with wild movements in which the limbs are thrown about with great force, the arms striking out and the legs kicking as though the patient were struggling or fighting, consciousness being apparently lost. The spasms vary, sometimes tonic and again clonic, but usually lacking the regular order observed in true epilepsy, last for a variable length of time and terminate in a state of emotional disturbance in which the patient talks irrationally, with fits of laughing or crying. Tenderness is nearly always present in the ovarian region, and pressure thereon may precipitate a fit, or if exerted during an attack may check one. Warnings are usually present, as giddiness, globus hystericus, etc., and though these patients often fall to the ground, they do so with a sliding motion and never injure themselves as in epilepsy.

Among the interesting features of hysterical convulsions are the frequency of opisthotonos and tonic spasms generally, the struggling character and violence of the movements which are increased by an effort to restrain them and the duration of the fit, which is usually prolonged. The tongue is not bitten as in true epilepsy and the eyelids are usually closed.

Visceral and vaso-motor symptoms. Difficulty of swallowing may be present owing to pharyngeal or œsophageal spasms. Vomiting or regurgitation of food, usually immediately or within fifteen minutes after it is taken, is a very common symptom and one of distressing persistence. Usually it is painless and without nausea, but at times is accompanied by severe and long continued retching. It may follow an acute gastric disturbance, becoming involuntary, but it frequently appears without such a cause and even in some cases may be induced by the will. As a rule, nutrition does not materially suffer, as some food is retained. The most remarkable digestive derangement in hysteria is complete anorexia, or Gull's anorexia nervosa. In these cases the patients really do not take food, and in consequence become reduced to such a marked

degree of emaciation as is rarely seen in any other condition. Though these cases usually recover death may result in extreme cases. Various forms of dyspepsia are common, as also is constipation.

Retention of the urine is a not infrequent symptom, while frequent micturition with an abundant secretion of pale, limpid urine is common, especially in emotional and convulsive cases. Hysterical cough and palpitation of the heart are of course every day symptoms, while tachycardia is occasionally seen.

The most common manifestations of vaso-motor disturbances are flushings of the face often alternating with cold feet, local perspirations and swellings about the joints, especially of the hands and feet. In severe cases of hysteria the temperature is sometimes slightly elevated, but though cases have been recorded with a temperature of 110 deg. to 120 deg., which must be accepted, still the great majority of such cases are evidently fraudulent. The so-called phantom tumors occasionally observed in the abdomen, breast, thigh and calf are probably due to vaso-motor disturbances associated with muscular spasm.

Time does not permit of consideration of the treatment of this interesting disease. Suffice it to say that the chief therapeutical indications are to improve the physical strength and to elevate the moral tone by restoring confidence and resolution and by cultivating self help and self reliance. The confidence of the patient must be won, and this cannot be secured by harsh treatment, but rather by a liberal diet of the milk of human kindness. Complete confidence once gained offers the best prospects for a successful issue to any line of treatment that may be adopted, especially when the intelligent co-operation of the patient's friends is secured.—Medical and Surgical Bulletin.

Dr. Hingston Fox is of the opinion that excessive use of tobacco leads to inebriety. In the case of those who expectorate freely, it may have the effect, and they are the people who should leave it alone.

THE SOLDIER AND THE SURGEON.

By Surgeon Lt.-Col. G. Ryerson, D. S. G.

It may not be out of place to say that my mind has long been directed to military medical affairs, and that I ascribe this fact as being due in no small degree to the influence of a great painting which adorned, and still adorns, the walls of the auditorium of the Faculty of Medicine of Paris. The picture represents a sixteenth century battle-scene. In the distance are groupes of men engaged in combat. In the fore-ground is an operating table, on which is strapped and held by the blood-stained assistants, a powerful man who has just had his leg lopped off by the old circular method. To the right of the picture is a brazier filled with glowing charcoal, in which repose several cautery irons, one of which is being handed to the king, who offers it to the surgeon, Pare. Beneath the picture in letters of gold runs the legend, "The King aids their efforts and rewards their zeal." Gazing upon this painting day after day as I followed the lectures, the idea came to me that I would like to become an army doctor. It was not my fate to enter the service of the Imperial army, but I made what haste I could to enter the militia medical service of my native country, on my return to Canada, on the completion of my education abroad.

Military surgery has kept pace with the scientific advance of the century, and the field surgery of to-day differs as greatly from the septic senses of horror of the sixteenth century as the telegraph does from pony express.

During the bloody civil war in the time of King Charles I. some attempt was made to organize the English medical service, for we read of regimental mates, hospital mates, regimental surgeon, surgeon to a general hospital and a surgeon-general, as being recognized ranks in the army of that unhappy monarch. But it was during the wars of Marlborough that the British army medical service took form and increased efficiency. Previous to that time soldiers who were so seriously maimed as to be rendered ineffective were simply discharged, the State believing that it was cheaper to

hire whole men than to restore the sick and the maimed to health. It declined to be held responsible for those who suffered in its service, and let them shift for themselves as best they could. The morality of the proceeding did not seem to enter into the question. There was no clear distinction between the land and sea service, though there was between physicians and surgeons, and it was no uncommon thing to hold double commission, combatant and non-combatant, the holders serving in either capacity as suited their interests or convenience. The services were separated in 1796. In Marlborough's time it was considered effeminate to be sick, and there are lusty yokels who hold that view still, but the bloody and exhaustive battles of the time, and especially in the low countries, where malaria stalked its prey unchecked brought the strongest to a sense of their fallibility.

As in all stressful periods of British history there arises the man for the emergency, so at this trying period, Marlborough's principal medical officer, Sir John Pringle, proved himself an able administrator, a man of courage, of indomitable energy, with the service of his country and the honor of his profession ever uppermost in his mind. Under circumstances of the greatest difficulty and under every disadvantage, he rose to the needs of the occasion and organized a system of regimental, field, and general hospitals. The first general hospital was opened at Ath, May 11th, 1745, and, after the battle of Fontenoy cared for 600 wounded. It was not, however, until many years later, during the Peninsular war, that surgeons were first assigned to regiments in the field. Sir J. McGrigor, the P.M.O. under Wellington, a man of energy and ability, devised the regimental system of medical officers which has held sway until recently in the Imperial army, and which holds good to-day in Canada. That the medical officers were active and efficient will be admitted when it is stated that in ten months from the siege of Burgos up to the battle of Vittoria, the total number

of sick and wounded admitted to hospital was 95,348; yet on the eve of the battle there were only 5,000 sick in hospital, the vast majority of the 95,000 having returned to duty.

In 1812 a corps called the Royal Waggon Corps was organized, special waggons with springs being constructed for the conveyance of sick and wounded. This corps was disbanded in 1833.

In 1854, on the outbreak of the Crimean war, the Hospital Conveyance Corps was called into existence. That it was not a success was chiefly owing to the total want of special training of the men for their duties, and because the medical officers had no authority over the men.

It was followed by the Land Transport Corps. This corps also came to grief because there was no cohesion or organization which would work, and because it fulfilled but one function required of it, viz., the conveyance of the wounded. The important duties of attending to wounded on the field and in hospital were not provided for. In consequence of all these failures the first Medical Staff Corps was organized in 1855. It consisted of nine companies of seventy-eight men each, "to be employed in any way that may be required in the performance of hospital duties." There were scarcely any military features in this corps, and it also collapsed in about three months. The chief cause of failure was the doubtful and anomalous relations of the medical officers to the combatant authorities. The medical officer had no military authority, hence no power of enforcing discipline.

On September 15th of the same year, this corps gave place to the Army Hospital Corps, which possessed full military organization. The ranks were chiefly recruited by transfer from the combatant ranks of men of good character. Each man spent three months on probation in a military hospital before being finally enrolled in the corps. It was under the command of captains and lieutenants, of orderlies and quarter-masters.

In 1858 a Royal Commission, under the presidency of Right Hon. Sidney Herbert, brought in a report which remodelled the department and established the army medical school.

In 1873 Mr. Cardwell, Secretary of State for War, the author of so many army reforms, abolished the regimental system by Royal Warrant and placed all medical officers on a staff. Regimental hospitals disappeared under this warrant, and became part of station or general hospitals, as the case might be.

In 1877 medical officers were given authority over the A. H. Corps, non-commissioned officers and men, as well as patients in hospital and soldiers attached for duty.

In 1883 Lord Morley's committee made recommendations, which were adopted, the principal ones being the vesting of the control of hospitals in the medical officer in charge, and the assimilation of the A. H. C. and A. M. Department, both to wear the same uniform (blue with black facings.)

In 1889 a committee, under Lord Camperdown, was appointed to make inquiries into the pay, status, and condition of the medical service. One of the committee's recommendations was the adoption of military titles, prefixed by the word "surgeon," as, for instance, "surgeon-lieutenant-colonel," etc. These titles carried precedence and other advantages, but a limited executive power, hence they were found unsatisfactory.

By Royal Warrant of July 1st, 1898, the medical staff corps became the Royal Army Medical Corps, and medical officers were given full military titles. The duty of supplying transport to the R. A. M. C. devolves upon the Army Service Corps, the officer commanding the detachment taking his orders from the senior officer of the R. A. M. C.

Regiments which have served in the great battles of history are justly proud of the deeds of their predecessors, and emblazon the names of the regiment's battles in golden letters on their colors,

while *esprit de corps* runs high. Should we not also be proud of the medical corps of the Imperial army, which has served with distinction and fidelity in every battle since Marlborough's time? Soldiers have their heroes. We also have ours. The names of Ambroise Pare, Peter Lowe, Richard Wiseman, Larrey and Longmore are emblazoned on the annals of military medicine. Nor have medical officers been lacking in military courage. "Have you ever heard of Surgeon Thomson, who, during the Crimean war, when the army marched off after the terrible battle of the Alma, volunteered with his servant to remain behind on the open field with 500 wounded Russians, and passed three awful nights, these two Englishmen alone, among foreign foes, none able to raise a hand to help himself? Have you heard of Assistant Surgeon Wolsley, of the 20th regiment, who, at the battle of Inkerman, had quietly established his dressing station in that awful place, the Sandbag Battery? When the 150 men were forced to desert it, they fell back and found in their path a Russian battalion. There was not a combatant officer left, so the assistant surgeon took command. He had not even a sword, but laying hold of a musket with a fixed bayonet, he gave the word of command, 'Fix bayonets. Charge.' The soldiers answered with a British cheer and sprang forward to the attack. The next instant they were they were breaking their way through the Russians. Only one-half got through alive, and among them our hero. Have you ever heard of Surgeon Landon, who was shot through the spine while attending to the wounded on Majuba Hill? His legs were paralyzed, but he caused himself to be propped up, and continued his merciful work until his strength ebbed away. You may recall the more recent case of Surgeon-Captain Whitechurch, who gained the Victoria Cross at the siege of Chitral for the most determined courage in saving the life of Major Baird.

"There died a short time ago a certain Surgeon-General Reade, C. B., V. C.

During the siege of Delhi, while attending to the wounded at the end of one of the streets of the city, a party of rebels advanced from the direction of the bank, and having established themselves in the houses of the street, commenced firing from the roofs. The wounded were thus in very great danger, and would have fallen into the hands of the enemy had not Surgeon Reade drawn his sword, and calling on a few men near him to follow, succeeded, under a very heavy fire, in dislodging the rebels from their position. Surgeon Reade's party consisted of ten in all, of whom two were killed and six wounded." Surgeon Reade was a Canadian, and one of the two sons of a colonel in the militia, both of whom greatly distinguished themselves. I might add that of 118 wearers of the Victoria Cross fourteen are surgeons, nearly 12 per cent. of the whole number, or 9½ per cent. of all the officers of the army, a record of which we may be justly proud.

Knowing the brilliant and meritorious services of army medical officers it gives one a shock to learn that it was only after many failures, many struggles and much heart-burning, after a prolonged period of unjust treatment, which, to the colonial mind is incomprehensible, that the medical service of the Imperial army has reached the present point of high efficiency and excellent organization—a state of things largely due to the tenacity with which the leaders in the struggle have stuck to the text, and the cordial and active support which they have received from the medical profession throughout the empire, chiefly through the medium of the British Medical Association. We, in Canada, have all the advantage which comes from the experience of others without the trials and anxieties which attend the gaining of experience, and I am happy to think that nothing but the best feeling has always existed between the different branches of the service. No better proof of this can be adduced than that we have as the responsible Minister of Militia and Defence, an able, open-minded and progressive medi-

cal officer, Surgeon Lieut.-Colonel the Hon. F. W. Borden, M.P., who has the very great advantage of the assistance of one of the ablest and most tactful general officers by whom the Canadian militia has ever been commanded. Under the united guidance of the soldier and the surgeon, I look forward with confidence to the future.

Having thus sketched the historical and evolutionary side of my subject, let me ask your attention to the practical work of the medical service in so far as organized relief and transport of the wounded are concerned. In order to understand the way in which a wounded soldier is brought from the fighting line to the base hospital, it is necessary to refer to the composition of a British army corps in the field. Such an army corps would consist of about 40,000 men, about the strength of our militia, under the command of Lieutenant-General. It would be composed of 3 divisions of infantry, and each infantry division would contain about 10,000 men in 2 brigades. The medical detail for each division would be, besides the regimental bearers, 2 bearer companies, 3 field hospitals of 100 beds each, and one divisional field hospital in reserve. The corps troops have also one field hospital. The cavalry division would number about 6,500 men, and would have attached to it 2 bearer companies and 3 field hospitals of 100 beds each. The whole medical detail for the division, exclusive of regimental bearers, would be 8 bearer companies, 10 field hospitals, 2 station hospitals and 2 general hospitals, the latter being on the line of communication at any distance up to 100 miles from the front. The supreme command of the medical arrangements is vested in a surgeon-general, who is the P.M.O. of the force. In many instances he is assisted by Deputy P.M.O., who is a colonel. The duties of the P. M. O. are to advise the G.O.C. on all matters concerning the health of the troops. This would include such important matters as food and clothing, and any special precautions rendered necessary by the climate, also the oversight of his department. The

importance of his functions can hardly be overestimated, for his business is to direct the measures for keeping the men in health, which is the main business of the army surgeon, so that at the critical time they be available.

The last Ashanti campaign was, you will remember, a "doctor's war." Nor would Khartoum have fallen, nor would Omdurman have been successfully fought but for the skilful foresight of the men who kept the troops in health in the trying climate of Upper Egypt. Thanks to the excellent medical arrangements, a tour of service in India is no longer a thing to be dreaded. The P. M. O. has also to arrange for the transport of the sick and wounded, no small matter in a difficult country, and to fix the sites of the field, stationary and general hospitals. Each division has also its P. M. O.

The first line of assistance to the wounded consists of the M.O. attached to the unit and his regimental medical staff, which is composed of one corporal, whose duties are to take charge of the panniers, which are usually carried on a mule: one orderly who carries the field companion and the surgical haversac. Four men per squadron, or two men per company, constitute the stretcher section. The medical equipment of the unit consists of one surgical haversac, one field companion, one water-bottle and a pair of panniers. The duties of the stretcher-bearers, when an action is pending, are, after placing their rifles in the regimental transport, to take the stretchers, and when occasion arises to render first aid, and carry the wounded man and his kit to the collecting station, beyond which they do not go, but at once rejoin their companies. Lord Wolseley says that when a man falls wounded there are ten men always ready to take him to the rear. I have found this to extend to dead bodies. The solicitude of men in action to get to the rear on a fair excuse is remarkable. The first aid dressing, which every man carries in the field, is done up in a waterproof cover, and is sewn up inside the man's tunic pocket. It consists (1896) of two safety pins, gauze bandage and piece of gauze, and a compress of charpie saturated

with an antiseptic (bichloride of mercury.) During the late Spanish-American war these first aid dressings are said to have saved many lives. At the collecting station the man is seen by the medical officer, who arrests hemorrhages and attaches a tally on which is stated the man's name, number, rank, regiment, wound, treatment, and any special instructions required, such as, "look out for bleeding," or to place the patient in a particular position. In the Italian army tallies of different colors are used for severe or slight injuries.

Now come to the second line of assistance, the Bearer Companies. They are departmental, and are formed by the Royal Army Medical Corps. They are divided in action as follows: In front (that is, in rear of the fighting-line), 38 of all ranks; at the collecting station, or in charge of the waggons, 12; at the dressing station, 10, including three medical officers; and in rear, 10. The front division of the bearer company does similar work to that of the regimental stretcher-bearers, *i.e.*, they render first aid and carry wounded to the collecting station. As they arrive at this point they are placed in one of the ten ambulance waggons in waiting and taken to the dressing station. Each wagon is in charge of a non-commissioned officer of the R.A.M.C. On arrival at the dressing station the wounded are unloaded and placed in two groupes—on the right the severely wounded, and on the left the slightly wounded. The site of the dressing station is always sheltered, if possible near a good road and water, and not far from the collecting station. Here it is that the wounded receive proper treatment and primary operations are performed. At the close of the action the bearer companies search the woods and ditches for wounded. In Germany this work, at night, is done with the aid of dogs, on whose backs are first aid panniers and lamps.

From the dressing station the wounded are passed on to the third line of assistance, the Field Hospital. A Field Hospital is attached to each brigade, and on the line of march follows the bearer companies. These hospitals are mobile, and keep in close touch with the troops. After or during an action

the site of a field hospital should be out of range of artillery fire and well sheltered. Buildings may be used, but churches should be avoided, as they are apt to be damp, cold and ill-ventilated. Their only advantage is their proximity to the graveyard. Collecting and dressing stations, field hospitals and bearer companies are under the Red Cross, but regimental bearers are not, for they carry arms and are available in case of necessity as combatants. In wars on savage peoples all ranks may have to fight, as, for instance, at Rorke's Drift. Hospitals fly the Geneva Red Cross flag by day, and show two white and one red lantern at night.

As soon as possible the wounded are passed out of the Field Hospital into the fourth line of assistance, the Stationary Hospital. They are gradually drafted out of this into the fifth line of assistance, the General Hospital, a large hospital containing 400 beds, and in charge of a Colonel, R.A.M.C.

The sixth line of assistance is the hospital ship; and the seventh and last is the Royal Victoria Hospital, Netley. The principal object in view, after treatment, is to "clear the front of wounded men," who impede the movement of the army.

Having said so much on the historical and other aspects of the Imperial Medical Service, permit me to add a little about the past and future of our own militia medical arrangements. It is strictly within the facts that our medical service is in a lamentable and unorganized condition. If we were suddenly plunged into war, we would suffer as serious disasters as befell the Army of the United States during the late Spanish-American war. This war has clearly demonstrated that trained army surgeons and trained ambulance men and transports cannot be improvised with success. The result of such a course is untold suffering to the troops, great loss of life, which might have been avoided, and discredit upon a department which did its best, but had a numerically insufficient staff to work with. Let us take the lesson of this war to heart and profit by the painful and costly experience of others, rather than wait to learn the lesson for ourselves at a great price of

blood and treasure.

Up to 1862 the supplies to camps of instruction left much to be desired, to put it mildly. The surroundings of the sick in many camps of instruction could hardly have been worse. I am not claiming too much for the Association of Medical Officers when I state that to that association belongs the credit of drawing professional and public attention to much-needed reforms. Let us hope that the reforms and improvements which have already been made merely precede a complete reorganization of the Medical Department, under our able Director-General.

I would respectfully submit that the following are among the changes which might properly be made to place the department on an efficient basis:

1. Abolition of the regimental system of medical officers, and the formation of a Royal Canadian Militia Medical Corps, to which all medical officers would belong; those not serving with units or on the reserve would be attached to bearer companies. I believe more efficient work would be done by officers whose interests were identified with departmental rather than regimental affairs. I would not advocate a sudden and violent change in this regard, but rather would suggest that all present medical officers be permitted to continue to wear the uniform of the corps to which they are attached, but I think that all new appointees might be required to adopt medical staff uniform. Medical officers attached to battalions would command the regimental medical staff. The departmental establishment would include at least five bearer companies—one each at Halifax, Montreal, Toronto, London and Winnipeg. From the bearer companies field hospitals could be developed in time of war.

The grades in the medical service, in my humble opinion, should be: Surgeon-Colonel, Surgeon Lieutenant-Colonel, Surgeon-Major, Surgeon-Captain, and Surgeon-Lieutenant. Honorary rank should be abolished. It is as unsatisfactory as relative rank.

These bearer companies would be educational, because at the centres named a

certain proportion of the strength could be recruited from medical students, who might be trained for the medical service. I might add that all Canadian militia is "royal" since 1814; therefore, the proposed title of the corps is in accordance with fact.

2. I think it is essential to good work, by the medical officers, that they shall receive instruction in their special duties, and that they shall be proficient in company and ambulance drill. The same remark applies to the non-commissioned officers and men of the regimental medical staff. For this purpose I would advocate the establishment of ambulance schools of instruction on the plan of those in operation in London and in New South Wales.

3. Medical officers, like combatant officers, should pass a qualifying examination within twelve months of their appointment, which should be provisional, and not to a higher rank than that of a lieutenant, and upon promotion to field rank.

4. Each military district should have a principal medical officer, in most cases a permanent officer, but not necessarily in all.

5. Medical officers should be given control of transport and supplies for hospital purposes, food and medicines, and authority over all connected with the hospitals in camps of instruction or during other service in the field.

6. On all field days the medical department should be exercised in their special duties, a certain proportion of men being supplied with tallies describing the nature of their supposed injuries, and ordered to fall out from their companies to be properly dealt with by the medical officers and bearers. Collecting and dressing stations should be formed in the proper manner and instruction given by the p.m.o. of contending forces.

7. A reserve of medical officers might be formed, to include those who have served, but who for various reasons have been obliged to drop out of active connection with the force, and of medical men of established reputation, who would be willing to serve in time of war. This arrangement would give them seniority and would assure the department of the best surgical skill.

8. The Red Cross Society proposes to keep a register of nurses who would be willing to serve in time of war. Their names might be noted by the Militia Department.

9. A knowledge of the first aid to the sick and injured might be diffused by the medical officers, by means of lectures, under the auspices of the St. John Ambulance Association among the officers and men of the force.

These are some of the suggestions I desire to make. Some will meet with approval and some with dissent. They are offered with my most earnest wish for the welfare of the soldiers and surgeons of my beloved native land.—Canadian Practitioner.

EDITORIAL.

Last Issue Volume 6 No. 12.

The endemic of diphtheria in the General Hospital is to be regretted, but all institutions of a similar character are liable to contract contagious influences of various kinds, which have to be dealt with in the manner which the professional staff of the Winnipeg General Hospital have recommended. If the newspaper reports speak truly it is evident that the medical staff of the hospital are somewhat ignored in its management. This should not be. The professional staff should be as such, ex-officio members authorized to attend all Directors' meetings, and in all matters pertaining to their work should have a voice. It must be remembered that the work of the hospital could go on quite as well under a capable head, minus a board of directors. But without a medical attending staff the doors would close. One representative on the board for the whole medical and surgical staff of a Hospital with the capacity which the Winnipeg General Hospital will shortly afford, is entirely inadequate.

The Winnipeg Street Railway Co. is keeping up its record. A monthly victim is duly offered up. Will this content them, or will

they endeavor still further to deplete Winnipeg's population.

A CARD.

We, the undersigned, do hereby agree to refund the money on a twenty-five cent bottle of Dr. Willis' English Pills, if, after using three-fourths of contents of bottle, they do not relieve Constipation and Headache. We also warrant that four bottles will permanently cure the most obstinate case of Constipation. Satisfaction or no pay when Willis' English Pills are used. W. R. Inman & Co., Central Drug Hall, Winnipeg, Man.; Dixon's Pharmacy, 352 Main St., Winnipeg, Man.; W. R. Austin, chemist, 423 Portage avenue, Winnipeg, Man.; Poyntz & Co., chemists, 506 Main street, Winnipeg, Man.; C. M. Eddington, chemist, 291 Market street, Winnipeg, Man.; F. P. Scale, chemist, Fort Rouge, Winnipeg, Man.

We cut the above paragraph from a daily paper and give it a free ad. It requires no comment. Drs. are multiplying, and find it each year harder to live. Chemists are also multiplying and growing fat on their calling. The time must come, and that shortly when the general practitioner will have to dispense his own medicine. With chemists putting forward the monstrous assertion that they are entitled to keep the prescriptions they compound, and are paid for. A contention as bare faced as it is illegal, and yet, strange to say generally allowed, with acts such as are given above it behooves the medical profession to look to themselves, or the wholesale chemist with his absolute cure for any and every ailment under the sun, and the retail chemist with the knowledge gained by the pamphlets accompanying these wonderful chemical products, will in time wipe the Drs. out and are already working woeful havoc with their incomes. The remedy is dispense your own medicine, as in England, Scotland, Wales and Eastern Canada. The extra cost will be amply repaid you in knowing that your patient gets what you ordered and the patient will not be in terror of receiving a medicine bill, to

which the Dr.'s fee is a mere bagatelle. We are glad to see that many of our well known chemists' names in this city are conspicuous by their absence in this clap-trap advertisement.

There is a foible prevalent in the Dominion which has a ludicrous aspect to comers from the older inhabited lands, that is the assumption of grandiloquent titles to denote various not very important positions. This prevails in professional as well as in civil life. In the older lands we recognize four orders of men entitled to the prefix of Dr., on receiving the respective degrees. The doctors of divinity, doctors of logic and law, doctors of medicine and doctors of music. But dentists in this land call themselves doctors, which they have just as much right to do as the chimney-sweep has to call himself a chimney-doctor. In Great Britain and Ireland a dentist pure and simple calling himself Dr. would render himself liable to prosecution for assuming to be what he is not. But what would be of more importance to him, he would not have the slightest chance of succeeding as a dentist, the public believe in a dentist, or surgeon dentist, but they recognize no such hybrid as a doctor dentist. A dentist should call himself Mr. so and so, dentist, or surgeon dentist, as he may fancy. The calling is an honorable one and requires no borrowed plumage to commend it to the public, so long as the human race have teeth, so long will the dentists' art be eagerly sought after. The same reasoning applies to the veterinary surgeon. He has as little right to the prefix of Dr. as the dentist has, he might legally call himself Dr. of animals, but surely Mr. so and so, Veterinary Surgeon, is a more honest and more desirable description. The most eminent surgeons of the United Kingdom, though they maybe entitled to add LL.D., and M.D. after their names are content so long as they are without the prefix Sir, to be plain Mr.

Paget, Mr. Erickson, Mr. MacCormac etc., they practice surgery, are surgeons, and require to be known as surgeons only. It would be well for the dental and veterinary profession of Canada to follow the custom of the mother-land and on their plates, cards and advertisements leave out the prefix Dr.

MISCELLANEOUS ARTICLES.

FORMALIN FOR SWEATING FEET.

Gerdeck recommends formalin in sweating feet. The sole, but not the dorsum, should be painted with pure formalin three times a day, and the region between the toes once a day. Four or five drops of the drug may also be applied to the sole, as it serves to disguise the foetid odor, as well as to preserve the leather. When the pure formalin cannot be tolerated a 30-per-cent. solution may be employed. The good effects last three or four weeks, when the treatment may be repeated. Under the applications the skin becomes dry, and leathery.—University Medical Magazine.

A NEW EXPERIMENTAL LABORATORY.

Baron Iveagh, who was formerly the head of a brewing firm in Dublin, has presented \$1,250,000 to the Jenner Institute of Preventive Medicine, a body which includes the leading men of medicine and the allied sciences in Great Britain. The purpose of the gift is to promote the highest research in bacteriology and other forms of biology as bearing on the causes, nature, prevention and treatment of disease.

Baron Lister, the distinguished surgeon, and Sir Henry Roscoe, a well known chemist in announcing the gift on behalf of the institute, declare that it will enable the institution to compare favorably with any similar establishment in the world, and will remove from the British Isles the reproach that their opportunities for research directed toward prevention of disease are not equal to those of other nations.

Kinahan's L L Whisky

IMPORTANT

Extract from "The Lancet" of 28th March, 1896.

This is a spirit of exceptional softness and mellowness of character, due to thorough ripening by storage. It is, therefore, peculiarly well adapted for medicinal purposes. It possesses the delicate 'peaty' aroma and is which distinguish Irish Whisky * * * It will be seen that it contains practically no extractives, and that its acidity is almost nil."

Sold at Hudson's Bay Stores.



AMMONOL

In Malarial Fevers

behaves as a stimulant as well as an **Antipyretic**
and **Analgesic** thus differing from other Coal-tar

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