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VOL. I.]

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[No. 8.

Original Communications.

SOME PRACTICAL POINTS IN THE TREATMENT OF GRANULAR LIDS.

BY G. STERLING RYERSON, M.D., C.M., L.R.C.S.E.

Professor of Ophthalmology and Otology in Trinity Medical College.

Of all the diseases of the eye which present themselves for treatment, the one which is most common, and which forces itself on the attention of the general practitioner most annoyingly, is trachoma. Cohin* has shown that 30 per cent. of all eye diseases are affections of the conjunctiva, and that 9 per cent. of blindness is caused by trachoma. In Canada it is a very prevalent disease, especially among the lumbermen, navvies, and the poorer class of farmers. The reason it is so often met with in these classes of the population is, that these people are herded together in small space: the washing utensils and towels are used in common; the air of the sleeping and eating room is laden with tobacco fumes and smoke from an open fire-place or from a defective flue. The food is unvarying in character, with too great a predominance of fat pork and an almost entire absence of vegetables in winter. Under these influences the general health declines, predisposing the individual to contagion. This disease origin-

ates exclusively from contagion from another eye affected with trachoma. Contagion takes place from the secretions: infection by the atmosphere, formerly accepted, is no longer regarded as sound doctrine. The secretion from the eye probably owes its contagious character to the existence of a micrococcus, which has not as yet been very definitely defined.

In the treatment, three objects have to be kept in view: firstly, to allay the inflammatory complications and diminish secretion; secondly, to diminish and remove the conjunctival hypertrophy; and, thirdly, to restore the general health, which is almost invariably impaired.

To accomplish the first two objects, antiseptics and astringent caustics are to be used. The mode of use is illustrated by the following case: J. Y., *æt.* 29, farmer, applied for treatment, April 30, 1891. He stated that his eyes had been troubling him for about a year, but that they had been much worse since a long drive he had been obliged to take in March. Examination showed the conjunctiva to be marked hyperæmic, looking much like a ripe raspberry; cornea normal; secretion very considerable: a good deal of irritation, but no pain about the eye. Ordered—Acid boric ʒi, to be dissolved in very warm water and then applied freely to the eye with an eye-cup three times a day. After three days of this treatment the irritation had greatly subsided: vascularization had lessened, as had also the secretion. It being evident that it was a case of true trachoma, I proceeded to

* Eulenberg's *Real Encyclopædia der Hist Kirde*, 1880.

express the trachomatous material from the conjunctiva with Knapp's roller forceps—after instillation of cocaine. The boric acid was continued, but in addition the conjunctiva was lightly painted with a solution of nitrate of silver gr. xxx. ad ʒi. I might remark, in passing, that in my opinion five and ten grain solutions of nitrate of silver are useless in these cases. At the end of two weeks this man was able to go home in a very much improved state. The treatment given for home use was—Boric acid solution, hot, every morning, and the following oxide at night :

R Hydrg ox. flav. gr. iv.
 Zinci oxide gr. ii.
 Thymol m. ii.
 Camphor gr. ʒ½.
 Cocaine mur. gr. ii.
 Vaseline. ʒi.

Rub up thoroughly. This is a very useful combination, and is a great improvement on the old so-called "plasma." Mild astringent washes are useful after the acute stage has passed. The best substance for this purpose I believe to be iodide of zinc, gr. v. ad ʒi. It is inadvisable to use astringents when the eye is acutely or sub-acutely inflamed : heat and emollients are then indicated. Fluid extract of belladonna ʒi. ad Ogr. aq. fervent, is most soothing. Don't use atropine. It tends to aggravate the granular process in many cases. Cocaine is almost indispensable in the treatment of acute and sub-acute granular ophthalmia. It should always be instilled before using the nitrate of silver. It can also be used to allay pain. It has a marked influence on the granulations, rendering them almost ex-sanguine and more readily acted on by astringents. Don't put it in the patient's hands. He will certainly use it to excess, and, as well known, such use promotes rather than retards the downward progress of these cases.

In using solutions of nitrate of silver, wash off the excess with plain warm water. Don't use salt and water ; there is always more reaction after its use.

(To be continued.)

A sentence of two and a half years confinement in a fortress has been passed upon a German medical student for killing a physician in a duel.

A CASE OF TOXIC AMBLYOPIA, WITH REMARKS.

BY ALFRED J. HORSEY, M.D., M.R.C.S. ENG., L.R.C.P. ED., ETC.

Mr. President and Gentlemen,—I have much pleasure in presenting to your notice the case of the patient before you, kindly referred to me by Dr. Prevost just one month ago, on account of gradually failing vision in both eyes for several months past, the onset of which was so insidious that he is unable to say definitely when it commenced. For three months he has been unable to read or write, or to follow his avocation of parliamentary translator.

He is fifty-five years of age, of swarthy complexion, with no special diathetical bent : and as far as his feelings go, and as near as can be judged, excepting a general muscular tremor, is otherwise in good health and possesses more than average vigour of mind and body. He has never had any previous eye trouble, and comes of a long-lived family, having good vision. He has no pain or local discomfort, but complains that objects appear as in a fog, and that he is growing blind.

He sees better in a dull than in a bright light, better morning and evening than in the middle of the day.

On external examination his eyes present nothing unusual, excepting that the pupils are slightly dilated and the conjunctivæ are somewhat dark and muddy, as is sometimes seen after excessive use of nitrate of silver drops—which he has not been using, however. The pupillary reflexes, both to light and convergence, are normal.

His vision equals $\frac{20}{60}$ ($\frac{10}{60}$) in the right for distance, and for near work, Jæger 19 at 20 cent., while in his left, his better eye, $\frac{4}{60}$ ($\frac{14}{60}$) and Jæger 10 at 20 cent.

Glasses do not improve vision. The ophthalmoscope showed marked pallor of the temporal sides of both discs. There was not any visible atrophy of the discs or other apparent changes in the fundus of either eye. That the pupillary reflexes were active, I would recall to your attention as the absence of another reflex, which, taken with the

* Read before the Ottawa Medico-Chirurgical Society, Oct. 14th, 1892.

falling vision, introduced a factor which demands its full significance in both diagnosis and prognosis. I refer to his patellar reflexes which were wholly wanting (which suggested locomotor ataxia), and are not usually absent in tobacco amblyopia.

He could stand with closed eyes with his feet together without swaying, and walk without the characteristic gait of locomotor ataxia, though there was some hesitancy in his steps which could not with certainty be attributed to its most probable cause, imperfect vision making them uncertain. Neither had he lightening pains nor gastric crises, nor had he ever had syphilis.

His colour sense was tested and found imperfect, as amblyopia was marked. But where the interest of the case hinges is, that for small pieces of colour $\frac{1}{8}$ (one-eighth) of an inch square, he was blind—not positively blind, for he could imperfectly see the piece held directly before either eye at about three feet, the opposite eye being closed.

But when moved a few inches peripherally in any direction, while his eye maintained its fixed position towards the front, colours could at once be recognized. This was more particularly the case for green and red, which appeared black. The extent of the field for white being unbridged.

For many years he has been a great smoker, and also drank spirits freely—the form of smoking being the pipe, the kind of tobacco, our own Canadian grown, home cured, in which he continuously indulged while at work, many hours both by day and night. The case is undoubtedly one of tobacco amblyopia, in which alcohol perhaps has a share.

Another similar case of a milder form has been met with during the past year in my own practice, and others have been seen at hospital clinics abroad, one of which I took notes of in the Royal Ophthalmic Hospital last summer.

A man aged sixty-two, whose sight had gradually failed so that when he came under observation his vision was reduced to $\frac{1}{80}$ ($\frac{2}{200}$) in either eye, having also well defined amblyopia for colours (colour scotomata). He had smoked one ounce of Cavendish daily, after leaving off which for three months it improved, simply from abstinence from tobacco, to the astonishing degree of $\frac{1}{5}$ and $\frac{1}{4}$ for right and left eyes respectively; or from the top of

Snellens' wall type to the bottom, the colour scotomata having disappeared.

The patient under consideration has faithfully abstained from tobacco since he came under observation (exactly one month ago), though he has continued his whiskey which, he says, averages five or six glasses a day—the only medicinal treatment being moderate doses *tr. nucis vomicæ*, and also Donovan's solution, which have not been regularly taken. The improvement of vision was very marked, increasing from $\frac{1}{80}$ ($\frac{2}{200}$) to $\frac{5}{8}$ or $\frac{1}{16}$ in his right eye, and from $\frac{1}{80}$ to $\frac{1}{8}$ in his left eye.

His near vision from Jæger 19 at 20 cent. to Jæger 16 at 30 cent. in his right, and from Jæger 10 at 20 cent to Jæger 12 at 30 cent.

His patellar reflexes are still absent, excepting to a slight degree on the right side. The scotomata for blue have disappeared, those for red have diminished, while green still remains.

Jan. 30th, 1893—Later notes "up to date," showing patient's condition.

He has written me a very legible letter, expressing his gratitude for his marked improvement, saying he resumed his duties two months after coming under treatment.

Yesterday he presented himself to me for the first time since his case was reported to the society three and a half months ago, when I found that, though he had vastly improved, so that he could write and read ordinary print for any reasonable time, he had not wholly recovered.

His vision now equalled $\frac{1}{4}$ ($\frac{5}{20}$) in either eye, a little clearer in the left. With - 1.50 spherical glasses one more line could be read, and Jæger 6, for near vision without glasses. His perception for small pieces of colour is much improved, green and red being still imperfect, especially for the former: red, though it is distinguished centrally, is done so more readily peripherally. The ophthalmoscope still reveals marked pallor of the temporal sides of the disc, apparently little changed since last examination. There is no thinning of the lamina cribrosa or stippling to indicate atrophy. The patellar reflexes have only slightly returned.

Central colour scotomata may be produced by several poisons, tobacco and alcohol being the

chief agents. Tobacco amblyopia was first described by McKenzie in 1854, and since has been carefully investigated by such men as Hutchinson, Forster, Hershberg, and others, and their conclusions in the main agree, so that central toxic amblyopia is amongst the best established facts in ophthalmology.

It is always symmetrical, and usually to the same degree in either eye. In the case we are considering, the vision in the right is more affected than the left, or was so at the first examination which has since become equalized, the right, the worse eye, having recovered more rapidly than the left, the better eye.

In considering this central loss of colour sense, it is necessary to remember that the normal eye has not the power to distinguish colours over its entire fundus, that is, over the whole area of expansion of the optic nerve; but that colour perception is divided into concentric circular areas, having for their centre the fixation point.

The smallest circle is for green, outside this a larger one for red, then yellow and blue. All colours normally can be perceived within the area for green, but green cannot be perceived beyond its own narrow boundary; and so on outwards for red, yellow and blue, and lastly, white, which includes the whole field where no colour can be seen.

The explanation of the central loss of colour perception lies in the fact that there is in these cases a retrobulbar neuritis of the optic nerve before it reaches the globe, and that all fibres of the optic nerve do not extend into the retina equally far; but those from the outer temporal side extend only a short distance from the disc, while its central axial fibres extend more peripherally. Pathology has verified these conditions. Central colour blindness must not be confounded with congenital colour blindness or Daltonism, where there is inability to distinguish one or more shades of colour. The prognosis is usually good, provided tobacco be given up, and that neuritis has not given place to atrophy.

In the present case, amblyopia being extreme, together with the absence of patellar reflex, made the prognosis more guarded. I mention the kind of tobacco which is excessively strong, thinking it may be more potent in its influence than other sorts, though the kind and amount is generally

thought to have little influence. As he still has imperfect vision, I have advised him to give up alcohol as well as tobacco, which I have confidence he will do, hoping a further improvement will take place should any of his trouble be due to it and not to atrophy following interstitial neuritis.

That the case is one of toxæmia due to tobacco, is, I think, sufficiently proven by the very great improvement in so short a time after giving up tobacco while he continued to drink, as he says, five or six glasses of whiskey a day. As he is still under observation, I hope at another time to have the pleasure, with your permission, of presenting to this Society further notes of this instructive case.

CLINICAL NOTES ON A CASE OF SYPHILIS OF THE SPINAL CORD.*

BY D. CAMPBELL MEYERS, M.D., M.R.C.S. ENG.,
L.R.C.P. LOND.,

Neurologist to St. Michael's Hospital.

Thinking the following case might be of some interest to the Society, from a physiological as well as a clinical point of view, I take the opportunity of laying it before you. The case, let me add, I owe to the kindness of our President, Dr. Temple, to whom I am much indebted for it.

The history taken from my case-book is briefly as follows:—

S.I.V., aged twenty-seven, married three years, no children.

Family History.—Father alive and healthy. Mother died eight years ago of heart disease. He has three brothers and one sister, all healthy. No consumption or nervous disease in family.

Precious History.—Patient was never ill until the present. About two years ago he contracted a hard chancre. His mouth was affected and his skin covered with a rash. He underwent treatment for about six months, when, thinking himself cured, he discontinued it and was quite well until present trouble appeared.

Present Illness.—Began about four months ago, when he noticed a twitching of the muscles of right

* Read at a meeting of the Toronto Clinical Society.

leg. About two months ago this leg became suddenly weak, and his foot began to drag when he walked, and in two or three days he could walk only with great difficulty. The twitching of the muscles increased with the paralysis. He had no pain, nor had he any abnormal sensations in skin. With the paralysis urinary trouble came on, and also constipation. On August 11th last, he consulted Dr. Temple who prescribed a mixture containing iodide of potash, 10 grains three times daily, and since this time he says he has somewhat improved.

Present Condition, August 24th.—Patient is a well-built, muscular man of about 5 ft. 10 in. in height. As he stands there is marked tremor of muscles of right thigh, that of the quadriceps being most marked, but the flexor muscles and those of the gluteal region are also affected. This tremor reminds one forcibly of that of multiple sclerosis, and like the tremor of this disease occurs only on voluntary movement, the tremor being absent when the limb is at rest. There is also a tremor of muscles of leg when foot rests lightly on the floor. He can stand quite well on right leg only when he has something with which to steady himself, but while so doing the tremor becomes much worse. When he lies down the tremor is no longer present, but returns if he changes his position in bed or makes any movement with the leg, when it lasts about one minute after ceasing the effort. On sitting, tremor is violent throughout limb for a few seconds. He can walk a few steps without stick, but with difficulty. When patient is lying down passive motion can be performed without resistance, but a tap on the patella tendon at once causes an extensive tremor of thigh muscles. Knee jerk markedly increased, and ankle clonus present. No wasting of limb. The power of flexing and extending knee is much diminished, and the same may be said of ankle. He can move great and second toes slightly. His sensibility to pain and touch is normal throughout limb, but that to cold quite lost below knee. On the application of ice to this region, he says he only feels something wet touching him. (It was impossible to obtain any hot water at the time, so test for sensibility to heat was deferred.) Passive motion in right leg well imitated by the left, and he can recognize quite

well any change of position of his right leg (his eyes being covered). Examination of left lower limb shows the muscular power to be good, except as regards flexion of foot, which is perhaps slightly diminished in force. He complains of feeling of numbness in sole of foot, which sometimes feels as though it were being tickled, which causes the leg to give way when walking on it. He has an occasional tremor in the extensor muscles of the thigh, when he goes to do anything suddenly, but none in any other part of the limb. There is no wasting of any of the muscles, nor any ataxia. Knee jerk increased and ankle clonus present, but not so marked as on right side. He states he has a feeling of oppression on left side below costal cartilages on level with umbilicus. There is no abdominal or cremasteric reflex on either side. He notices right ankle swollen every night on removing his shoes. His urine, which hitherto he was unable to retain an instant after the desire to micturate was felt, is now improved, but he is obliged to go immediately the desire comes on. Micturition is very frequent. The pupils of normal size, equal, and contract to light. No deformity, pain, or tenderness along spine.

September 1—Sensibility to heat on right leg is markedly diminished, extending from line of knee joint downwards. On left leg sensibility to heat is slightly diminished. Sensibility to pain markedly diminished on right leg, normal in left. He complains of more twitching in left thigh. Otherwise as last day, except urine which continues to improve.

September 9—Sensibility to pain has much improved on right leg and foot. On the foot he says he feels a prick of a pin quite well, but the middle third of the leg is still decidedly analgesic. The same may be said in regard to his sense of temperature. On left leg and foot sensibility to touch and pain are normal; also to temperature, except in middle third of leg where it is lessened. There is less tremor on standing than last day, and right leg is somewhat stronger. Feet, cold and blue. Urinary symptoms continue to improve.

The notes of September 16th and 24th show a gradual improvement in all the symptoms. Soon after the latter date patient moved away and was lost sight of.

The treatment given was that for syphilis, to

gether with a pill of belladonna and cannabis indica for his urinary trouble.

The diagnosis made was that of a small syphilitic growth, in the right half of the cord, in the lower dorsal region, occupying the lateral pyramidal tract and part of the auto-lateral ascending tract, but a growth not sufficiently advanced to entirely prevent conduction in some of the fibres of these tracts. The derangement of sensibility in this case is interesting, since the path for the conduction of pain and temperature in the cord has of late been much discussed. That the path for the conduction of both these is quite different to that for the conduction of tactile sensation is quite well shown in this case, since, in it, tactile sensation was never at any time impaired, although the derangement of the sense of pain and temperature was very marked. The majority of evidence points to the auto-lateral ascending tract, as the path for the conduction of both these latter senses upwards, and consequently I have believed this tract implicated in the growth. Since neither the tactile nor the muscular senses were affected in the case, I think we may assume that the posterior columns were not invaded by the disease. That the sensory loss was greater on the more paralyzed side, instead of the opposite, is also interesting, and is explained by the fact that the sensory fibres in the lower part of the cord do not cross at once, but ascend some distance before doing so.

In regard to the motor symptoms, we know that the lateral pyramidal tract is the chief path for the conduction of voluntary impulses from the brain to the periphery, and consequently it can be easily understood that a lesion of this tract must cause a derangement of voluntary motion, even when the strength of the muscles themselves is unimpaired. This would explain the patient's power of standing on the right leg alone (which was the more affected), even when he could control the limb only with difficulty in walking. The slight affection of the left limb might be explained by the recrossing of the motor fibres in the cord, as has been shown by Turner and others.

The increased knee jerk and ankle clonus are explained by the loss of inhibitory influence from the brain, from implication of the lateral pyramidal

tract, the reflex centre in the cord being preserved. That the incontinence of urine was intermittent was shown by the passage of a catheter, when only a couple of ounces of urine were found. The control of the sphincter was deficient, owing to the interference in the conduction of the voluntary fibres for the bladder which probably descend in the pyramidal tract. The sensation of the bladder was normal, since he was at once aware of the desire to micturate, but the bladder acted automatically, expelling the urine as soon as a sufficient amount had collected, the restraining influence of the brain having been withdrawn. The absence of wasting of the muscles was due to integrity of ganglion cells of the anterior horn. In regard to the vaso motor symptoms, experiments on animals suggest that the lateral columns conduct the impressions which act on the vaso motor centre, a suggestion quite in harmony with the facts of this case.

Meetings of Medical Societies.

TORONTO CLINICAL SOCIETY.

(We are indebted to Dr. Brown, of the Toronto General Hospital, for the report of this meeting.)

The regular meeting of this Society was held March 8th, the President, Dr. Temple, in the chair. After the usual routine business was transacted, the following gentlemen were elected Fellows of the Society: Drs. N. A. Powell, W. Canniff and W. B. Thistle.

Dr. D. C. Meyers read his clinical notes on a case of syphilis of the spinal cord (see page 318).

Dr. J. E. Graham said he was very much interested in the very lucid description Dr. Meyers had given of the case. It resembled very closely a case he (Dr. Graham) had had in the General Hospital during the past few weeks, a case of syphilitic disease of the cord in which both limbs were affected, the one side more than the other. It exhibited about all the symptoms Dr. Meyers had stated, increased reflexes on both sides, inability to walk with any degree of comfort, and partial paralysis. Tactile sensation was perfect, but the sensation of heat and cold was absent in both limbs. There was also some urinary trouble. The lesion, therefore, in

this case must have been nearly identical with that of the case presented. Continuing, Dr. Graham said he would like to ask Dr. Meyers' opinion on two points. In his paper he had stated that the action of the bladder was automatic, that was, that the bladder would fill up, and when it had arrived at a certain degree of distension, the patient would urinate involuntarily. Of course, that indicated a cutting off of the cerebral influence to the bladder. In this case the influence was apparently cut off only on the one side, and the question was whether or not the cerebral impressions passed down both sides of the cord. The other point was in reference to the loss of sensation of heat and cold. Dr. Meyers had stated that the fibres which convey the sensation of heat and cold passed up the antero-lateral portion of the cord. The idea given by a good many was that it passed up the centre of the cord close to the spinal canal. According to this theory of Dr. Meyers, he would like to know how he explained the symptoms in syringomyelia. In this affection there was destruction of the central fibres, and one of the most marked symptoms was the absence of the ability to distinguish heat from cold. He (the speaker) had a case in the hospital nearly a year ago, which seemed to confirm this view. The patient was suffering from central myelitis. It was the result of the pressure of a tumour upon the spinal cord, somewhere in the lower part of the dorsal region. In this case, one of the most marked symptoms was the absence of sensation to heat and cold, while the tactile sensation was unimpaired. In the post mortem a central myelitis was found; the outer portion of the cord was healthy, the inflammation seeming to have attacked principally the grey matter of the central part of the cord. In the first case the treatment consisted of the administration of iodide of potash in doses amounting to one and a half drams in the twenty-four hours. There was an improvement in the bladder symptoms at once. There seemed to be paralysis of the bladder to some extent, which led me to believe that the bladder centre was involved in the disease. When he left the hospital there was some improvement in the legs as well. It was curious to note in this case that, although this patient had been under treatment in an American sanitarium for some four months, and had received treatment by douches,

baths, etc., he had not taken any iodide of potash although it was an undoubted case of syphilitic disease.

Dr. Temple then cited an interesting case he had been treating, a case of syphilitic disease he took it to be. The patient was a man who was strictly temperate. Twenty years before, he had had a bad attack of syphilis, resulting in the loss of part of the septum of the nose and the palate. Was treated by a city physician and helped. For the past few years he had been under Dr. Temple's care. About two months ago he was taken ill suddenly, early in the morning. Dr. Temple was summoned. The patient had gone to bed perfectly well. In the morning on attempting to get up, he experienced a great deal of stiffness. As he had been riding the day before, he thought that the condition might have been due to that. He got out of bed with difficulty, and upon trying to put on his clothes, he suddenly lost power of both the right leg and the right arm. He was very much alarmed. On arrival, Dr. Temple found complete paralysis of the right side. His hands and feet were very cold. There was no sensation on the affected side. It appeared a very serious case indeed. Iodide of potash was prescribed with the idea that the condition was the result of the syphilis. In the evening there was no improvement. The patient was still unable to move or do anything. Next morning when the Doctor called, the patient was up, dressed, and apparently as well as ever. The speaker thought the case was not one of hysteria.

Dr. Meyers, in closing the discussion, said he believed cerebral impulses to the bladder passed down both sides of the cord. As those impulses probably descend in the pyramidal tract, a lesion in the dorsal region would cut off the cerebral impulses to the bladder in the same manner as a lesion in one internal capsule, causing hemiplegia, in which disease urinary disturbances are also present; hence the inhibition of one cortical centre is sufficient to cause the bladder symptoms alone mentioned. In that case the sensation of heat and cold had been entirely lost while tactile sensation had remained perfect. The post mortem shewed the rest of the cord to be quite normal.

I expressed the opinion at the meeting of the Ontario Medical Association, in May last, that

syringomyelia was due to an interruption in the crossing of the sensory fibres of heat and cold in the cord.

I have had a case like the one referred to by Dr. Temple. The patient was a woman: her first symptom was inability to pronounce very well. In a few moments her hand began to get stiff, her tongue deviated to one side, and one side of her face became flushed. She also complained of giddiness. These symptoms rapidly disappeared and the patient has had no return of them since. What the lesion was I do not know.

Dr. Temple asked if it might be an embolism that induced these conditions. Dr. Meyers said that it might be: he had never heard of an explanation of these cases.

DR. GRAHAM—I would like to ask Dr. Meyers why it is in syringomyelia that the fibres which conduct tactile sensation are not effected in the same way as those which conduct heat and cold.

It occurred to me that it might be explained in this way: the fibres pass up for some distance in the neighbourhood of the central canal, and then pass out. The case I had last spring was so marked that it impressed me very much. The outside was perfectly normal, while there was a marked central myelitis.

Dr. Meyers said that the tracts through the centre of the cord had not been well marked out yet, so that it was difficult to answer the question regarding tactile sensation.

The next part of the programme was to have been "Clinical Notes on a case of Purpura Fulminans," by Dr. R. B. Nevitt, but as he was absent, Dr. W. H. B. Aikins suggested that the members should report cases in practice.

DISCUSSION UPON THE EPIDEMIC OF SPECIFIC DIARRHŒA.

Dr. Burns thought that, since the members of the Society had been asked by the Provincial Board of Health to express their views on the epidemic that has prevailed in the city during the past few months, he would like to hear the opinions of those present regarding the cause of this so-called cholera. Did it exist elsewhere, or was it confined to the city only? He would like to hear any special points members had observed in connection with such cases. What were the prin-

cipal characteristics of the disease, and what the pathological conditions? I have no doubt, the speaker went on to say, that all have seen many cases of this trouble, varying from the mild form of diarrhœa to the more serious condition resembling cholera morbus. I had two cases as bad as any case of cholera morbus I have ever seen, associated with cramps, rice-water stools, and vomiting, and collapse. In one case I nearly lost my patient. Is the cause of this the Toronto water, or does it exist elsewhere in the Province as an epidemic of grippe with gastro-intestinal symptoms most prominent?

Dr. JOHNSON—I have only to note one point. I have had some cases outside the city, where, of course, the city water is not used, and have found them exactly similar to those inside the city. There is no doubt that the city water is in a very polluted condition, containing much animal matter, such as dead fish, etc., but I think this condition of the water would be more likely to produce typhoid fever than cholera. The disease appears to be choleraic; it comes on suddenly, runs a limited time, and then ends.

Dr. Hynman, of Exeter, who was present, stated that they had had no such epidemic in his district.

Dr. A. A. MACDONALD—The points I have observed with reference to these cases are: First, with reference to the city water. I have taken a good deal of pains to make inquiries as to whether the city water had been used as it comes from the tap by patients I have been attending. In almost all cases the water, if used at all, had been boiled, and I would think if the water had been sufficiently boiled, that it would be harmless. In giving my opinion that the water is not the cause of the disease, I would not wish to take any responsibility off the city authorities for not supplying us with good water. In a number of my cases I have noticed, in addition to the points already mentioned, that the period of convalescence has been prolonged. Patients have been reduced in strength out of proportion to the severity of the disease. I have noticed, too, that pains of a semi-neuralgic character have, in some cases, manifested themselves, pains in the head and neck, limbs and other parts of the body. I am inclined to regard this as a form of la grippe. I think that it yields to the same general plan of treatment.

Dr. ALLEN BAINES—My friend, Dr. M., had an attack of this form of disease—a very bad attack. He had not been taking any water but what had been boiled. He went to the trouble of analyzing the water. He found out after it had been boiled that there was no organic matter, but there was an excessive amount of chlorides. He attributed the attack to this condition of the water. I would like to say that in two of my cases the patients had recovered from the attack, and after three weeks they had it again. One had three attacks. This would seem to lend weight to the view that the cause might be due to the excessive chlorides: for, in each case, the patients resumed the drinking of the boiled water.

Dr. Graham thought that, although the boiling might destroy the bacteria, it did not destroy the toxines. These in the boiled water might have something to do in the causation of the disease. There was one point in this connection interesting to note, and that was, in many cases he had heard of, as soon as the families ceased to use the city water, the disease diminished very much. This would show that the city water was an element in its causation. A good many of the cases were simply cases of winter diarrhoea. They were like those cases which one sees after a prolonged period of hot weather. The speaker had seen a post mortem on one of these cases a short time ago. The conditions were different from any that he had ever seen before. The contents of the intestines were found in the peritoneal cavity. There was a marked enteritis. There were a number of ulcerations of the solitary glands, but no disease of "Peyer's patches." It was not, therefore, a case of ordinary typhoid. The mesenteric glands were somewhat enlarged.

Dr. KING—I had a letter from a patient of mine who suffered from cholera before leaving the city. She had had another attack when in Picton. She said the disease was prevalent in that region. The trouble appeared to me to be due to the condition of the water. The treatment that gave me the best results has been calomel and salol.

Dr. W. H. B. AIKINS—Dr. Macdonald says that the disease may be a manifestation of la grippe, and I am rather inclined to take a similar view. In three of my cases the symptoms were:

chills, headache, elevation of temperature, with a certain amount of coryza and bronchial disturbance, followed in a day or two by vomiting and violent purging. Prior to seeing these cases, I was under the impression that the epidemic was due to the city water alone, but as none of these patients had taken any of the city water, I came to the conclusion that these, at all events, were genuine cases of la grippe.

Dr. TEMPLE—I had not attributed the cause to the city water. I think it is atmospheric. I have one lady convalescing from a very severe attack. I made inquiries about the water. She very rarely drank any, usually taking milk, wine or porter. I have called it catarrhal diarrhoea. In treatment, I have used large doses of camphor and small doses of opium, and had very good results.

In closing the discussion, Dr. Burns said: The reason I asked the questions I did were—first, on account of the new word cholera. I took the trouble to look up the subject of cholera in the hand-book of medical science. There are three varieties: first, the simple cholera; second, cholera acuta or grave; third, cholera foudroyant. Cholera is cholera of a mild type, appearing especially at the beginning of an epidemic. The French writers lay a great deal of stress on this form, because it is often the precursor of the more malignant variety; and as we know that epidemics travel in cycles, and that cholera exists in Europe at the present time, I would like to have elicited from the members whether they thought this is significant of what we may look for hereafter. My own experience accords with that expressed, that in the majority of instances patients did not drink city water, or, if so, only after it was filtered and boiled.

LONDON MEDICAL SOCIETY.

A meeting of the London Medical Society was held in the Lecture Hall of the Medical College on Monday evening, February 13, 1893, the President, Dr. Hodge, in the chair.

Applications for membership were made for Drs. McLaren and Eede.

Dr. Gardiner was then called on to read his paper on the

TREATMENT OF TYPHOID FEVER.

What is typhoid fever? Is it simply an inflammation of "Peyer's patches" with an increase of temperature on account of the tissue changes in and around these glands, or rather is it not an increase of temperature caused by an effort of nature to eliminate a poison from the system, and are the glands not affected in the process of this elimination, and are not all the symptoms caused by a ptomaine poison produced by germs or bacilli introduced through the alimentary canal in the general system and in the different tissues forming the poison, and the fever is really the result of the increased chemico-vital action set up by these tissue changes and the efforts of nature to eliminate the poison from the system? Or is the poison a leucomaine and are the symptoms caused by its action on the different organs? An intelligent answer to these questions is necessary before we can scientifically treat the disease. For if the disease is simply local, the local treatment is the proper method, but if it is chemico-vital, then we must endeavour by our treatment to assist nature to eliminate the germs from the tissues, or to administer some antidote against the poison produced by the tissue changes. Are the tissue changes in some cases due to the elevation of temperature, or are they in all cases due to the chemico-vital action of the system in its efforts to eliminate the ptomaine from the body. I believe that the temperature with its peculiar class of symptoms is caused by the chemico-vital action, not only at the seat of the apparent lesion but also through the greater part of the body, and the tissue changes in the heart and muscles are caused as a rule by the poison acting on these muscles or tissues, and only occasionally is the extreme heat of the body a cause of serious trouble in softening the tissues, but is itself, like the softening, a result of the large quantity of poison taken into the system or found in it.

Now, if we take this view of fever, and I think it is the correct one, then what is the proper method of treatment to follow, *i.e.*, of the three systems now in common use, *viz.*: Expectant, antipyretic, antiseptic.

I. Antipyretic. Brand's method, which has for its object the reduction of the body heat by immersion in cold water, is, in my opinion, useful in adding to the comfort of the patient, and it may in

a few cases where the heat elevation is a source of danger to the heart and other organs even arrest a threatened disaster, but as a routine practice with the intention of curing the patient by the reduction of the body temperature and the removal of the disease by such a reduction, I do not think either experience or logic will bear us out; and a bath or sponging once or twice daily will accomplish all that is required in this line and with far less trouble. The same may be said of antipyretic medicines, only that they may do a great deal of harm as well as good, and after their administration the seeming improvement is often followed by great weakness and a return in a more aggravated form of all the symptoms for which the drug was given. Of the internal use of cold water I have had some personal knowledge, and with all due deference to Prof. Meigs, I must say that, used as he states it should be used, in many cases it will do no good and often may do harm by increasing diarrhoea and vomiting.

II. Antiseptic. If the disease were simply a local one, then surely some antiseptic could be found to render aseptic the parts affected by its presence, but unfortunately before it comes under your notice it has become both local and systemic, and so far I do not think even the most sanguine eclectic will claim that a drug has been found, which is so far reaching in its antiseptic qualities that it will, with its keen scent and powerful germicidal properties, hunt up and destroy all the miserable little bacteria whose presence in our system, in this disease as well as others, gives so many pangs. I fear that such a drug would be apt to destroy the patient in its search for the disease. Of the drugs so used, and whose efficacy has been very much vaunted, each in their turn as *tae* specifics, I will mention a few, but only to say that in my own experience, and I think in that of many others, failure to do what their ardent admirers have claimed for them is the rule rather than the exception.

Calomel is among the first, and as a drug to be given in the early stages of the disease, I think that it answers admirably. It cleanses the intestines of accumulated matters hurtful in themselves, and may for the time at least render the alimentary tract antiseptic. It also gives us a chance to start fair in our dietetic treatment, but this is all the distance I am inclined to follow with it, and would

not care to use it through the entire course of a fever case.

Thymol is a very useful remedy, and in those cases where the stools are offensive and frequent, will both check their frequency and remove the bad odour and generally put the patient in a better condition to withstand the disease, but here its efficacy ends. I usually give it in doses of grs. ii.—grs. v. every three hours.

Sulphocarbolate of zinc, too, is very useful in cases with an offensive diarrhœa, but the greatest care must be observed in its use, as failure of the heart is very apt to cut short your experiments with this drug, and I fear that the deaths it has caused are more than the lives it has saved.

Of naphthaline I cannot speak, as I have not used it enough to give an opinion as to its efficiency, although, in doses of grs. xv. —grs. lx. daily, it has many powerful advocates.

Nitrate of silver, too, has been vaunted, and with it a host of other remedies, such as salol, creasote, iodoform, etc., etc. I have not used them. They may be good or bad. I do not believe they are specifics nor continued intestinal antiseptics. Mineral acids are useful and I employ them, but rather as tonics than as antiseptics.

Turpentine, too, still holds a favoured place with many, whether it be as an antiseptic or a carminative, but I think that thymol is better for the latter purpose. But why prolong the list. You have all tried these remedies and most of you have for a time thought, for this disease at least, at last the Elixir of Life has been discovered, when alas, for your dream, the grim monster, Death, has claimed its victim and you try some other remedy.

Now we come to the third and last system. A year ago I stated that this was the method I was most in favour of, and since then I have not changed my views. Specifics for typhoid fever have not been found. A large percentage of fever cases will get well under proper dietetic treatment and without medicine; a small percentage will die under any and all forms of treatment; and with these considerations before, as I believe that a proper treatment of the various symptoms and conditions as they arise will best conduce to the comfort of the patient, and as good if not better results will be attained than any so-called specific treatment for the disease. The first symptom which we meet is

in connection with the bowels, and in order to start fair and with a clear stool, I usually give a calomel purge and place the patient on a mixture of quinine with an acid vehicle, usually sulphuric or sulphurous, and this I continue for a few days, reducing the amount of quinine from time to time until it is more as a placebo than anything else. If the meteorism is severe, thymol in grs. ii.—grs. v. is what I now use. If the diarrhœa is severe and stools offensive, sulphocarbolate of zinc is useful, but I would advise it to be given with the greatest of caution on account of its tendency to produce heart failure. Opiates, bismuth, lactopepsine or a combination of these, I often use for the same purpose. In hæmorrhage I use ergot hypodermically, with plumbi acetatis and opium. Ice, too, I think, helps, but my experience in this complication is limited to a few cases. The question of using partially digested foods, of over-feeding and under-feeding, of bathing and feeding at regular intervals even through the night, and of wakening the patient for food when weak, have all to be considered, and I hope in the discussion to get an expression of opinion on them. How, when, and in what quantities should we use alcoholic or other stimulants will, I hope, be settled once for all by this meeting. What is best to be done for a case of heart failure or of perforation of the intestines will require your careful attention, and I hope will be freely discussed for me as each is here to learn from the other; and as our profession is one in which there are no secrets allowed, we hope to hear of some cure for these alarming complications.

In conclusion, I would ask the meeting what is the best method of treating the constipation which in quite a number of cases is very obstinate. I believe that in not a few cases an elevation of temperature is caused by the above condition. Most of us have personal knowledge of the miserable feeling which constipation causes; and if discomfort and malaise is set up in the healthy by this condition, much worse symptoms are likely to result in the sick by the absorption of the ptomaine of the fæces. I do not like to leave the bowels more than three days without having them moved either by injection, suppository or mild purgative. How the rest of you treat these cases will, I hope, come out in the discussion.

In the discussion which followed, Dr. Graham

thought that the application of ice externally had little effect in controlling the hæmorrhages. The symptoms should be treated on general principles as they arise. If the temperature rise to 103°-104° sponging with warm water has the effect of reducing it.

Dr. Drake recommended the ice in the treatment of hæmorrhage. Cold sponging he had found most efficient in reducing the temperature. He would not wake the patient for food unless very weak.

Dr. Butler thought the cold sponging very grateful to patients.

Dr. Meek recommended laparotomy and washing out of the peritoneal cavity in those cases of perforations when the shock was not too great. He had found in some cases an accumulation of fecal material to be the cause of a high temperature.

Dr. Eede thought the fever was due to the implication of "Peyer's patches." The sulphocarbonate of zinc he had used with not much caution, and had never noticed any of the bad symptoms mentioned by Dr. Gardiner.

Dr. Gowan asked if the patient was sleepless when no other symptom was marked. what course would be pursued? In a case of perforation, what would be done to make the patient most comfortable in his last hours?

Dr. Campbell thought the treatment appeared to be to protect the patient against the effects of a poison. Few cases could be treated on the same plan. Calomel he used in some cases, but not where diarrhœa was marked. As antiseptics he used the sulphocarbolates of zinc or soda. Cold sponging and antipyretics he had found not very satisfactory. They reduced the temperature at the expense of the patient's strength. When the diarrhœa was troublesome, gallic acid, opium and turpentine had given best results. In the last stage, when the patient was weak and heart failure impending, alcohol, ammonia and digitalis were indicated. For sleeplessness full doses of alcohol often had the desired effect; when delirium was active, opium and atropine or hyoscine. The coal tar products he considered dangerous remedies. In cases of hæmorrhage he used ergot and turpentine; in cases with constipation, warm water injections every day, unless the patient was too irritable. When perforation had taken place, make the patient as comfortable as possible by the use of hypnotics.

Dr. English in regard to food would give milk \bar{z} i. every hour at least. He would not allow the patient to sleep over two hours without nourishment. Alcohol he used early in every case, the quantity varying with the condition of the pulse. Antifebrin he had used as an antipyretic in grs. v. doses, repeated in two hours if necessary, together with tepid sponging. He had good results from the sulphocarbonate of zinc. He thought it shortened the duration of some cases.

Dr. Hodge thought absolute rest together with good ventilation essential in all cases. Cold baths he had not used. Tepid sponging and an ice-bag to the head, he had found an excellent thing to quiet the patient. Cold water he allowed *ad libitum*, and never saw it produce diarrhœa or vomiting. As to antiseptics, thymol appeared to be one of the best. A case of heart failure dependent on the use of zinc sulphocarbonate he had never seen. In one particular case, its use in grs. ii. dose every second hour with tepid sponging had reduced the temperature. When the pulse became rapid and weak, alcohol, \bar{z} ii.— \bar{z} iv. in the twenty-four hours, was allowed. As the quantity was increased the case improved. Opium as a hypnotic had not in this case any good effects. The meteorism was often due to the diet. He used milk \bar{z} vi. aq. calcis \bar{z} ii. every three hours during the day and every four hours during the night.

In reply, Dr. Gardiner said he had used ice and hypodermics of ergot in cases of hæmorrhage, with apparent success. In regard to laparotomy, he would not suggest it in low cases. In cases of sleeplessness, pot. brom., in the early stages, and full doses of alcohol in the later stages. Alcohol gave good results, especially in cases with hypostatic congestion. He would not disturb the patient for food every hour, but would agree in giving it during the night. He thought cases with bad hygienic surroundings should be placed in a more favourable position, and would advise removal, at the same time observing great care in so doing.

In regard to the sulphocarbonate of zinc, he stated, several hospitals had given up its use: and cited a case in his own practice where heart-failure was apparently the result of the administration of that drug. The bowels, he thought, should be moved every three days by enemata or small doses of calomel.

Dr. Butler reported five cases of hyperæsthesia of the nasal passages, with results of treatment. The treatment was chiefly the application of the electric cautery. In some cases there was obstruction of the nasal chambers, while in others they were quite free. In some cases the symptoms occurred only during the hay-fever season, with and without asthmatic seizures. In others, the trouble existed during the whole year, but was aggravated during the hay fever period.

Case 1. J.B., age, thirty-eight years; occupation, veterinary surgeon. Family history, good; no history of asthma in the family; had excellent health up to 1880, when he had some symptoms of nasal catarrh. He had had the diseases incident to childhood, as measles, scarlet fever, whooping cough, but there were no apparent ill effects resultant. I mention these points in connection with the family history, as most authors attach great importance to them in developing the neurotic habit, so commonly found in persons suffering from hyperæsthetic rhinitis. In 1881, asthmatic attacks came on, while living at Grand Rapids. He was obliged to leave Grand Rapids, and removed to Ohio; was comparatively free from asthma for one year, but subsequently it returned, and during the hay-fever season it was very violent. I may say that the State of Ohio is notorious for hay-fever. The day he left Ohio to come to London, he was suffering from an asthmatic attack, but when he reached London his breathing was perfectly free; but he was sneezing freely. There was tingling in the nose, and profuse lachrymation, palpebral pruritus, a feeling of depression over the frontal sinuses, and itching over the roof of the mouth.

Examination of nasal passages. On *right side* the anterior end of the inferior turbinate hypertrophied, so as to touch the septum, and extremely irritable. *Left side*: Middle turbinate enlarged, and in contact with septum. Posterior end of inferior turbinate so hypertrophied that it pressed firmly against the septum, and nearly touched the floor of the mouth. Sajou's area, on both sides, extremely sensitive to the probe in spots.

In attempting to manipulate the growth at the posterior end of the inferior turbinate with a probe, I brought on tightness of breathing. I could repeat this at will. I cauterized the hyperæsthetic spots in the anterior part of the nose, and com-

pletely relieved the lachrymation, sneezing, etc. In a few days I attempted to snare the posterior hypertrophy, but did not succeed. I then buried the cautery point in it, cauterizing it pretty freely. This was in the evening. Towards morning a furious attack of asthma came on. The application of cocaine, full doses of iodide of potash (20-30 grs.) and hypodermics of morphia and atropia, had very little effect on it. The attack lasted for three days. In about a week, or ten days, I applied the cautery again, and repeated it at intervals of a week or so until the growth was removed. He was under treatment for three months, and never had asthma while he was with me. He returned to Ohio in April, remained there three or four weeks; had no asthma. He then removed to Minneapolis; went through the hay-fever period without a symptom. About the following Christmas, while in Wisconsin, he had some tightness of breathing, but it soon passed off. He was free then until last fall, during the hay-fever season, when he had considerable trouble; but it passed off, and he has been in pretty good condition since, so that he was able to attend to a large practice. As palliative treatment, I found that the application of two per cent. solution of cocaine to the nasal passages, followed by a two per cent. solution of menthal, gave best results. When his asthmatic attacks came on, grindelia gave good results, but finally pot. iodide with hypodermics of morphia did him most good. Now it is only fair to state that hay-fever, or hay-asthma, is nothing like so prevalent in Minnesota as in Ohio; so it is difficult to say how much of the benefit received in this case is due to the change of climate, and how much to the treatment. Whether the results will be permanent, time alone can decide.

Case 2. Mr. D., grocer: age, about fifty; has had hay-fever, with slight tightness of breath, for twenty years. He is frequently obliged to go on the lakes during the hay-fever season. At other seasons of the year he gets on very well, except that he cannot handle seeds. Nothing special in the family or personal history.

Examination: Nasal passages perfectly free and roomy; no evidence of any hypertrophic changes, except three knot-like enlargements on the right side of the septum (cartilaginous part), which were very sensitive to the probe. Several very sensitive spots were found at the front, well up towards the

ridge of the nose. These were cauterized in five sittings, extending over a period of two months, followed by the application of albolene. He received no internal treatment, except some cascara and glycerine for his bowels. The following hay-fever season he was perfectly free, and during last season, '92, he had slight trouble, but nothing to prevent him doing his work.

Case 3. A.J., farmer; age, thirty-five years; was a powerful man, weighing about two hundred pounds, a perfect picture of health in appearance. His voice was husky from slight laryngeal congestion; slight pharyngeal catarrh. Considerable hypertrophy of the inferior turbinates on both sides. Breathing, comparatively free, except that he was unable to groom his horses. As soon as he attempted this, his nose became completely blocked and violent sneezing came on, with some tightness of breathing. I used an alkaline spray to the larynx and pharynx. After having opened the bowels freely with calomel, I gave him Coca wine. The cautery was applied to the turbinates. Now, perhaps, it may be thought that the laryngeal congestion was the cause of the obstructed breathing. I should be inclined to think so, but I asked him to plug his nose with cotton while cleaning his horses. This had the effect of relieving him. This was done a few times as an experiment. When he left me he was decidedly better, and he told me if the trouble returned he would come back. I have not seen him since, and I will allow you to come to your own conclusions as to the permanency of the result.

Case 4. Mrs. B., age, forty-five; has never had asthma, but for twenty years has been troubled, more or less, with violent sneezing and lachrymation, and intense itching and tingling sensations in the nasal passages. She states that as soon as she went into a crowded room the trouble was increased.

Examination: Left side. The inferior turbinated at the anterior end in contact with the septum. Hypertrophy of the soft tissues over the middle turbinate. Sajou's area, on both sides, extremely sensitive. The cautery was applied to the sensitive spot, as well as to the enlargements. Solutions of cocaine, menthol and camphor menthol were also used locally. Valerianate of zinc, asafœtida and strychnia, were given internally. I began the treat-

ment in the fall of 1889. She was much improved. During the next hay-fever season she visited a sister who lived in Illinois, north of Chicago, on the lake shore. During former visits, she was always worse than when at home in London; but this time she prolonged her visit to six weeks, and was perfectly free, except about an hour on one day, when she had slight symptoms of her previous trouble. Since that time (during 1891-92) she has been troubled more or less. She is much better than before the treatment, but not cured by any means.

Case 5. Mr. B., chemist. Is affected only during the hay-fever season. He came to me, last year, after the attack had begun. Was treated during the hay-fever period of '91, by Dr. Price-Brown, of Toronto, by cautery and local applications of cocaine and menthol. I gave him the same treatment last year. Great improvement followed, and he states he got through the period quite comfortably.

I have treated quite a number of other cases, but it is not necessary to take up any more of your time, as the ones reported are fair samples of them. I may state that I tried in several cases the application of a solution of atropine, one per cent., to follow the cocaine solution. Dr. Glück, of Omaha, recommends it highly. He states that it prolongs the effect of the cocaine. I gave it up as useless. It produced dryness of the throat even when reduced to one-quarter per cent. solution.

In the discussion which followed, Dr. Gowan inquired if internal treatment alone ever completely relieved the symptoms.

Dr. Eede asked, at what period of life did hay-asthma usually attack persons.

Dr. Campbell asked if irritation of the nose was a cause of all cases of hay-fever.

Dr. Hodge reported a case.

In replying Dr. Butler stated that the use of zinc Valerianate, asafœtida and zinc phosphide may help to relieve, but he had never seen any striking results follow their administration. As to period of life, his cases were all between twenty-five and fifty years; none had been below twenty-five years. He had never seen a case of hay-fever in which the nose was not extremely sensitive.

Owing to the unavoidable absence of Dr. MacArthur, the report of his case was laid over until the next meeting.

Dr. Meek was asked for a paper on "*Puerperal Septicæmia, its Causation and Treatment*," for the next meeting.

Dr. English will report a case.

British Columbia.

Under control of the Medical Council of the Province of British Columbia.

DR. MCGUIGAN, Associate Editor for British Columbia.

Owing to the small-pox having broken out, Dr. McGuigan's time has been fully occupied as health officer and he has been unable to furnish editorial material for this issue.

The report of the Commissioner appointed to enquire into the late epidemic outbreak of small-pox in this Province contains matter of much interest, as it traces to its source the origin of the outbreak. The concluding portion of the report is as follows :

PROTECTION AGAINST CONTAGION FROM ABROAD.— SMALL-POX AND VACCINATION.

The best protection against all invasions of contagion seems to reside, not in the first line of defence, viz., quarantine: Through any quarantine, isolated cases, it is shown by experience, will find their way; but in the second line, isolation and sanitation. Any case which penetrates through quarantine must be immediately taken up, isolated, and treated in such a manner as to prevent its propagation. It seems to be universally admitted that all these contagions are propagated by means of germs: whether carried in the air, or by water, or in solid fish of any description may be disputed. But this further is everywhere admitted, that cleanliness, both of the person and of the man's surroundings, diminishes the *nidus* in which such germs flourish, and also diminishes the susceptibility of individuals to yield to their attacks. And as a principal means of cleanliness a copious supply of pure water is essential. With these precautions it is tolerably certain that no contagion will ever become epidemic.

As against all other contagions these are the only provisions which can be made, viz., isolation and sanitation. But as against the particular disease of

small-pox there is the well-known and approved prophylactic vaccination, to the supereminent value of which all the professional men examined before us testified quite unanimously. There were differences of opinion as to the mode of operating, some preferring calf lymph provided from vaccine farms, some preferring arm to arm vaccination; but all agreeing as to the great value of the operation. The experience of the Province in the recent epidemic shows, however, that vaccination and re-vaccination, by no means affords the perfect protection against contagion which has been sometimes supposed. The experience here, however, may to some extent be due to the inert points used. Yet there can be no doubt that vaccination very greatly lessens the chances of infection, and still more frequently disarms small-pox of its virulence. In the recent epidemic, out of one hundred cases treated by Dr. Richardson, fifty-three had been vaccinated, but only six showed four scars, *i.e.*, fully vaccinated. And out of thirteen deaths only one vaccinated person died, and he was suffering from a complication of disorders. That is, one vaccinated person died out of fifty-three attacked, and twelve unvaccinated persons out of forty-seven attacks. This is certain, that although doctors and professional nurses are obviously more exposed to contagion than any other classes of the community, not a single doctor or professional nurse was attacked during the whole course of the epidemic here. They all believed and trusted in vaccination. There are no statistics to show the numbers of vaccinated and unvaccinated persons here; but probably the vaccinated are far more numerous—far more than the ratio of fifty-three to forty-seven; in which case the percentage of attacks, as well as of deaths, is largely in favour of vaccination. In fact, only six out of one hundred attacks had been fully vaccinated.

Against this universal consent of all who had made a professional study of the question, we offered to take the evidence of all who professed the contrary opinion. Two champions presented themselves. One, who appeared much the stronger in his views, had confessedly not studied the question at all, and the mere vehemence of the expression of his opinions of course entitled them to no weight, but rather detracted from their impressiveness. The other, Mr. Greig, had devoted a great

deal of time and study to the subject of vaccination ; and adduced a vast quantity of figures in support of his propositions, which were chiefly that (1) vaccinia is in no degree a protection against small-pox, but rather predisposes to the disease ; (2) the Austrian statistics show that the mortality per cent. in vaccinated cases is nearly double that of the unvaccinated ; (3) small-pox in the eighteenth century was not usually fatal, nor an object of dread, except among infants ; it was in fact a merely infantile disorder ; (4) vaccinia in itself was a highly dangerous disease, though perhaps not so immediately fatal as small-pox, but with a high probability of conveying into the vaccinated persons various deadly poisons : erysipelas, syphilitic, and scorbutic disorders, consumption, etc., more to be dreaded than small-pox itself.

These propositions are so utterly contrary to all the accepted ideas of educated persons, and to all common knowledge, that we examined a little into the tables and figures adduced. But we found that they were all (with one exception) merely one-sided, extracted, or constructed, in order to support a foregone conclusion (though we are quite sure that Mr. Greig did not think so, and, in fact, that it would be impossible to persuade him to that effect) and utterly unworthy of any reliance.

The extreme and unjust vehemence of the anti-vaccinationist mind may be perceived by the degrading prejudice exhibited against the entire medical profession by Mr. Greig, who we are quite convinced would be most fair and temperate upon any other topic. As to all public vaccinators in England, he over and over again referred to the necessary bias in their minds by reason of the fee (3 shillings). And he greatly preferred private vaccinators, because, he insinuated, any of them might, to please the parents, vaccinate the infant with milk instead of vaccine lymph and then gave a vaccination certificate. And although repeatedly pressed, whether he really and seriously thought that the latter would be guilty of such a fraud, or that the former would be willing to out-Herod Herod by poisoning innocent infants at six bits a head, he still smilingly adhered to his views : that if these motives were not always put in practice, they were always present : nor was it possible to make him perceive that he was ascribing the basest conduct to the entire muster-roll of the profession :

since doctors who are public vaccinators, and doctors who are not, necessarily exhaust the whole category.

In our opinion, though vaccination is not infallible—probably there is no infallible remedy or prophylactic against any disorder in the world—yet it is so potent that, if universally adopted, small-pox might be eliminated from the nomenclature of existing diseases. The evidence of Mr. Kito, the Japanese Consul at Vancouver city, is valuable as illustrating the high degree of appreciative intelligence possessed by his fellow countrymen.

We think that vaccination should be compulsory on all children before attaining the age of three months, followed by re-vaccination at the age of puberty.

To insure the due performance of the operation, we recommend the appointment of public vaccinators by Government, who alone should be authorized to issue certificates of successful vaccination, of insusceptibility, and of unfitness for submitting to the operation. They should keep a register of all cases and results, and be subject to a supervision of a superior officer.

When the disease is prevalent, or threatens to become so, extra provision should be made for vaccination and re-vaccination, and the routes of travel should be properly guarded to prevent the departure from an infected place of any person capable of carrying the infection elsewhere.

But these and all other measures of a like nature are best left to the discretion of a Provincial Health Officer, who should, we think, be appointed by the Government and responsible to the Executive : and to whom all health officers should report on any matters connected with disease or sanitation as he may from time to time specify.

We strongly recommend that the various municipalities should, so soon as such officer is appointed, be deprived of the right to legislate in any way upon matters relating to the public health, but that to ensure uniformity these should be regulated either by Parliament, or by the Provincial Health Officer, so far as Parliament may think fit ; and that the several municipalities should be confined to administrative powers only. And in this view we suggest that the entire Province be mapped out into health districts as large as may be, with a health officer in each, to whom

all reports from medical men in such districts are to be made in the first instance.

AS TO QUARANTINE GENERALLY.

The old notion, perhaps founded on the number of days of Lent, had in view the detention of vessels, etc., for forty days, as the word itself clearly expresses. This interval was probably fixed long before any notion had been formed of the period of incubation of various infectious diseases. In view of our present knowledge, and of the necessities of commerce and personal intercourse, no such detention could be sanctioned in any civilized communities. In 1891 there were 52,000 passengers landed at Victoria from steamers alone, exclusive of those who proceeded further, and exclusive of sealing vessels. In 1892 the steamers arriving here were seventy-five per month. Indeed, it may be said that there is nothing to justify the detention here (except for the purposes of inspection) of any vessel arriving from a port which has no epidemic, and where the vessel herself has been free from contagious sickness on the voyage, these matters being certified by the commander and medical officer (if any) of the vessel, and by the inspecting medical officers or health officers of the ports of arrival and departure respectively.

But it is to be remembered that disease may be developed at any time, immediately after as well as immediately before arrival, and inspection of a newly arrived ship should be repeated from day to day.

The disinfection of cargoes extending to several hundreds or thousands of tons presents great difficulty. Evidently, infection may be conveyed in the wrappings of a bale of goods as readily as in the clothes of a passenger. The newly provided dioxide blast would probably furnish a method of dealing with cargo far superior to any heretofore in use.

Where passenger steamers, such as the China and Japan lines, carry regular medical officers, it might be well that these should in some degree be recognized by and made responsible to the Department at Ottawa, just as much as the officers at the quarantine ports of the Dominion.

The inspection of a newly arrived ship should

take place in daylight, unless there are portable electric lights on board.

The real protection of the community lies, however, on shore. Every case of contagious disease should be at once carried to a contagious hospital and treated there—and all berths, bedding, etc., disinfected, or destroyed, where that is possible.

Seaports being the outposts of the whole Dominion, and the health of the whole Dominion to its centre, so far as imported contagious disease is concerned, being entirely dependent on the vigilance in detecting and treating such cases at the seaports, and the commerce of the whole Dominion being also concerned in seeing to it that such protection should offer as little inconvenience as may be compatible with effectiveness, the expense of isolation and disinfection of such cases at the port of entry, of separate hospitals, etc., should not be thrown entirely on the respective municipalities at such seaports; but a proportion, at least, of such expense should be borne by the Dominion. Not the whole expense: for such hospitals are also extremely necessary in these municipalities for dealing with non-imported cases: scarlet fever, diphtheria, etc. The Dominion, in return, should be invested with an authoritative voice in their management.

In the case of persons dying of contagious disease, cholera, etc., in an isolation hospital, there can be no doubt but that cremation is the only really correct and proper method of disposing of the body. The objections to this method seem to be of the purest sentimentality: for the process is in its ultimate results absolutely identical with that which goes on after earth to earth burial, but without its disgusting features. Cremation is a certain preventive against contagion from the body, especially against any contamination of water springs from the corruption of the corpse. If it were once properly understood that the results of combustion and of decay are, as to the products, precisely identical, and that only the phenomena vary: that after a lapse of (say) fifty years, a corpse is resolved into precisely the same gases as in a few minutes of combustion, but that in the one process a sensible heat is exhibited, not perceptible in decay—and that a decaying body exhibits odours and appearances not perceptible in combustion—perhaps the sentimental

objections would be overcome. At any rate, if it should be impossible to compel cremation, the bodies of deceased patients should not be allowed to leave the grounds of the isolation hospital: they should be buried there and means taken to destroy their injurious properties.

Mr. Moore's evidence is worthy of consideration. It suggests a great desirability of legislation in Canada similar to that which in England regulates the importation of rags from Russia.

The sanitation of all localities is secured and maintained by keeping in repair all public ways and drains: by the early and complete removal of filth: by the rigid inspection and regulation of all unhealthy trades and establishments, especially by the prevention of over-crowded tenement houses and lodging houses: by ensuring a constant and abundant supply of pure water. With respect to this last, it is very important, especially when the source of supply is a lake, that it should be removed from human habitations, so that none such be permitted to drain into the area of its watershed.

At the commencement of any epidemic general directions should be published by the Government, with information as to the measures to be adopted, until the Health Officer shall intervene.

With respect to cholera, it may be useful to point out that the theories accepted by the best authorities of the day seem to be as follows:—

1. Asiatic cholera is an infectious disease, resulting from the entrance into the alimentary canal of a poison, probably a specific bacterium, whose history has not yet been clearly determined, *i.e.*, the poison must be swallowed, not inhaled, etc.

2. The disease is endemic in India only. Elsewhere it is imported. It may be imported by any vehicle, liquid or solid, which has derived, mediate or immediately, any of the specific poison from the alimentary canal of a patient. There is a divergence of opinion as to the degree of dryness, and the length of time necessary to destroy the bacterium. That a certain degree of desiccation and a certain lapse of time will destroy it, seems admitted; but the only admitted degree of desiccation seems to be that attained in a furnace.

3. No amount of filth or moisture will generate the poison; but filth and moisture furnish the very best conditions for maintaining, invigorating

and propagating the bacterium, if once introduced.

4. The disease is not contagious in the sense of being communicable by contact.

MATT. BAILLIE BEGIE,
E. A. PRAEGER.

Ontario Medical Journal

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.

TORONTO, MARCH 1893.

THE CIRCULAR OF THE SO-CALLED MEDICAL DEFENCE ASSOCIATION.

As limitation of space in our last issue precluded an exhaustive criticism of the circular recently issued by the Defence Association, we have something further to say on the subject; and, owing to its hydra-headed nature, we must invoke the patience of the reader. At the outset we would lay down the axiom that no deliberative body exists in the wide world invulnerable to assault or faultless in judgment. Debate enlightens, and controversy paves the way for wisely concerted action. No two men ever yet have held identical views on all subjects, and within the Medical Council there always has been, and always will be, a minority unable to see eye to eye with the ruling majority. It is, therefore, not to be expected that every member of the profession shall, on all occasions, unreservedly accept its policy.

The Medical Council does not claim for itself the quality of perfection; on the contrary, it has courted the advice of those to whom it is responsible. In ordering a full stenographic report of its proceedings, and thus letting the full light of day illuminate the Council chamber, it has manifested a spirit not averse to fair criticism, and, virtually, has said to every member of the profession, "Come, let us reason together"; and it is only fair to assume that any reasonable suggestion from outside would be taken into consideration. In proof of our assertion we may instance the invita-

tion extended to the Defence Association to appoint a committee for conference with one nominated by the Council for the purpose of harmonizing views diametrically opposed.

As is known, the meeting occurred in September last; and, after considerable discussion, the Association's committee was requested to formulate its grievances. This was done, and the memorandum is here reproduced, together with the reply, as it appeared in the next issue of the press:

"Dr. McLaughlin then set forth the demands of the Defence Association, which were as follows:—

"1. That Section 41 A be repealed.

"2. That the matter of annual fees be held in abeyance until the medical profession are properly represented in the Council.

"3. That the teaching bodies, viz., the universities of Queen's, Toronto, Trinity and the Western University, have one representative each, and the profession seventeen."

The Legislative Committee met immediately afterwards, and agreed to the following propositions, which virtually leave the Defence Association the masters of the situation:—

"1. We consent to 41 A remaining in abeyance until after the next election, and the electorate pronounce upon it.

"2. We do not consent to suspend Section 27 (the levying clause), but will still rely on the honour of the profession to pay the fee.

"3. We will favour adding five additional territorial representatives.

"4. We will not object to institutions which neither teach nor grant degrees being deprived of representation.

"5. We are in favour of protested elections being referred to the senior county judge in the division in which the election took place."

Unfortunately for the good name of the profession the overtures of the Council were not accepted; and we think we were credibly informed that the only impediment consisted in the fact that, while almost every request was granted, it was only on condition that the honour of the profession might be relied on for the payment of the paltry two dollars a year. We cannot imagine why the Defence Committee declined a settlement on this basis unless it was actuated by motives which

cannot harmonize with a conciliatory spirit; it was evidently determined to take all or nothing, and accordingly has gone on in battle array. Hence the circular over the names of Drs. Sangster, Armour, Hillier and Coburn; and we take it as the crystallized argument and supreme appeal for the support of the profession. Coarse reproach and innuendo will carry conviction to no fair-minded man; and we dismiss the vocabulary employed in the drafting of the circular with the suggestion that it would have been improved in decency had a few superlatives in Anglo-Saxon been eliminated to make room for more moderate phraseology. Verily, if the language is warranted by facts indisputable, the Council must be a sink of corruption, and nothing short of annihilation of the Medical Act would adequately purge its iniquity.

Dr. Sangster and his coadjutors claim that the Council is not representative in character, and present a host of reasons which we shall endeavour to deal with in detail: That the ten school representatives (eight only attend council meetings) have as their constituents a handful of but forty or fifty, comprising the medical faculties, is a statement utterly without foundation. We will take a solitary example, that of the University of Toronto. Would any sane person for a moment assume that the gentlemen who are senators of that or any other Canadian university, would so belittle the dignity they possess as to obey the mandates of their servants, the Medical Faculty, and sink their right of judgment in the appointment of a representative? We think not. As a matter of fact, before the present incumbent received his credentials there were no less than three nominees for the position, and the medical members of the Senate were pretty well divided in the voting. We take it for granted that the Senate of each of the other universities professes to understand its own business, and makes all appointments on its own responsibility.

Note the contrast: Dr. Sangster says that forty or fifty members of medical faculties elect ten representatives. Our position is this: Every graduate has a voice in the Constitution of the Senate (few practitioners in Ontario are not graduates of one or the other university); the Senate makes the appointment and is responsible to its

constituents; the conclusion is evident that the university representative indirectly owes his badge of office to his fellow-graduates; a pretty large constituency, and one by which he is watched pretty closely.

The members of the medical faculties are charged with interfering in territorial elections. This may be perfectly true; but how many instances can be cited of rights abused? We venture to say they are few and far between. Can any good reason be adduced why a member of a medical faculty should be gagged by process of law any more than any other constituent? He is, or should be, just as anxious that the best man secure the position; and, while we would deprecate any unfair use of the privileges pertaining to his public position, we would just as strongly oppose his disfranchisement.

No greater slur could have been cast upon the twelve territorial representatives than appears in sub-section 2, page 1, of the circular. The Secretary of the Defence Association evidently holds in unbounded estimation the magnetic influence and persuasive powers of the eight school men; for, according to his statement, "they inspire and determine the whole legislation of the Council," and the inane territorial representatives, or a sufficient number of them for all practical purposes, are such ninnyhammers as submissively to place themselves in the hands of the school men, and, like so many puppets, dance whatever sort of jig may be required; it must be so, for Dr. Sangster says, "the university and school representatives have succeeded in attaching to them a string." We wonder what those gentlemen think of the left-handed compliment they have received from the Doctor?

The Doctor's memory must have played him false when he penned sub-section 7, page 2; otherwise, having uttered the statement just referred to, he scarcely would have affirmed so positively that "the two elements in the Council—territorial and university—are essentially antagonistic in character."

In order to whip the Homœopaths into line, and lead by the nose as many territorial representatives as their sinister purposes demand, one would think that the first step in this direction would be a complete unification of the school

men; and it would have been wise on the Doctor's part, before making so grave a charge against men esteemed in the community, to have made some inquiry as to whether or not such unification can be shown to have been effected. We have carefully searched the reports of every Council meeting, from 1879 up to the present date, and have found but one solitary instance amongst the recorded yeas and nays in which there was unanimity amongst those terrible school men, and that was on the motion to erase from the register the name of Dr. Washington. One would imagine that at some time a question might have possibly presented itself of such a nature as to consolidate the vote of the school men, but, as there is no reference to such in the minutes of the past thirteen years, how dare anyone stigmatize, as recreant to their trust and opposed in principle to the best interests of their profession, twelve gentlemen esteemed at least as highly as the writer of the circular? The same paragraph goes on to say that by such scheming and combination "the matriculation standard was degraded."

The matriculation clause, adopted the preceding year, was found to be out of harmony with the departmental examinations, and hence the change which is anathematized so vigorously. To prove our assertion, it is only necessary to quote from a letter written by the Deputy Minister of Education, also one over the signature of Mr. J. E. Hodgson, a high school inspector:—

"I might suggest it would, perhaps, be better to have your requirements worded somewhat differently, say 'the departmental matriculation in arts, and in addition, if not included, physics and chemistry.'

"J. MILLAR,

"Deputy Minister of Education."

"Referring to the subject of our conversation this morning, I have to say that unless the matriculation examination of the Medical Council is made to harmonize with the arts matriculation in universities, the workings of high schools will be materially interfered with by the necessity of providing extra classes for a relatively small number of pupils.

"J. E. HODGSON."

Some will recollect the battle that for years was waged between certain universities as to which had

the higher matriculation standard ; and, to give a sufficient guarantee, the Government suggested that the Education Department establish another examination called the "Departmental Arts Matriculation." This having been accepted by the universities, it was natural and right that the Council should seek to have its requirements harmonize with the regulations of the Department; and reference to page 179, Annual Announcement of 1892, will show that the proposition adopted by the Council is framed in the words of the suggestion made by the Deputy Minister. Surely a standard sufficiently advanced for our best universities cannot be called low for matriculation in medicine; and, more than this, in 1891 the Hon. G. W. Ross expressed the opinion that the standard of this examination is likely to be elevated.

Dr. Sangster may say in reply, "why did not the Council fix it at honour instead of pass matriculation?" He may not be aware that when asked for legislative power to fix a higher standard for matriculation, the Government acceded on the condition that rights should not be abused or employed for the purpose of unjustly limiting the number of students; and, had too advanced a step been taken, we are quite confident that the Legislature would have politely said: "Gentlemen, you have abused a prerogative granted in good faith, and have sought to erect a barricade too lofty for any poor man's son to scale; this being against the interest of the public, we propose to clip your wings and take once more into our own hands the prescribing of what we think is a satisfactory matriculation."

The Doctor, in this connection, studiously avoids reference to the addition of a fifth year devoted to practical work; he does not relish the idea of bringing the whole truth under the notice of the profession; naturally he would not dampen the ardour of the Defence Association by telling them that the Council, in introducing this radical change, afforded the profession a surety that its ranks would not be crowded to suffocation by inferior accessions, and gave the public at large an increased confidence in the fact that it is difficult to find, either on this continent or abroad, a profession as thoroughly equipped for its responsibilities.

Sub-section 3, page 1, says that the schools and universities never surrendered any rights, that they have all the rights and privileges that pertain to

British universities, and that they never possessed any others. The statement is more than a suppression of truth, it is absolutely without foundation.

The schools took the initiative in asking for the incorporation of the profession partly in their own interest, but chiefly that in fixing a uniform standard a sufficient guarantee should be afforded the public. The law had recognized their degrees as equivalent to a license to practise; and this licensing power they voluntarily relinquished, knowing full well that, in so doing, they degraded their diplomas to the rank of a decoration, and rendered them in the eye of the law worth but their weight in second-hand parchment. Was this not a surrender of rights long in their possession? At that period the great majority of practitioners were graduates of one or the other university. It is to be hoped that their love of Alma Mater grows no colder as the years go by--their thoughts turn homeward now as then. We cannot separate a university from its alumni, and if the compromise effected between graduates and non-graduates in 1866 was fair then, how can it be said that those mutual concessions should be repudiated now?

Next, as to the comparison instituted between our own and British universities. We are asked to believe that ours have as many prerogatives as those in the United Kingdom; and the circular flatly contradicts itself in the next paragraph by giving the information that the British Medical Council "confines its functions to matters of curriculum and registration."

We have the facts: The British Council fixes the curriculum; and, should any of the graduating bodies conform, the Council does not interfere; the graduate of such institution receives his license and is registered on production of his diploma and the payment of a fee of five guineas; while, on condition that the graduating body does not include in its curriculum all the subjects prescribed by the Council, it, the Council, appoints examiners, in the subjects omitted, to act in conjunction with those appointed by the university. Is it right then to say that our universities, whose examinations are virtually not recognized by the Council, have all the rights that pertain to British universities, whose functions are, in certain instances only, circumscribed by the Council, and whose diplomas, in other cases,

are accepted by the British Council as sufficient credentials for registration?

For years the British Council has sought to obtain the powers which ours possesses, and hitherto has failed on account of the antagonism of the schools in declining to relinquish the rights which ours once enjoyed.

The complaint is made that our Council is arrogant, and imposes penalties, which the British Council dare not. The British Council has authority to erase from the register the names of any guilty of misdemeanour or felony; also to strike out the name of anyone who neglects to reply to the registrar as to his location, and it was on this precedent that a similar clause was introduced by our amendments of 1891.

To argue from Dr. Sangster's premises: the Doctor admits that the British universities surrendered scarcely any rights, and still they have representation; ours surrendered all the rights they ever had, so far as license is concerned; then the conviction must be so much the stronger that ours, in all fairness, should be represented. Even the Doctor himself, being somewhat of a logician, must surely admit it.

So far as paragraph 6, page 1, is concerned, we hope we are not of the dirty species of birds that foul their own nests; we have possibly as exalted an opinion of the profession as the writers of the circular; and would long hesitate before concluding that the profession would not have advanced without the aid of the schools; but which is better qualified to know the requirements of a capable and cultured practitioner: a council composed exclusively of men in actual practice, and, necessarily, not in close touch with medical educationists, or a body in which both classes are represented? We leave the reader to judge.

This brings us to the medical tax, the great stumbling-block of two dollars a year, that on which hinges all the outcry about irresponsibility. Prior to the enforcing of its collection, no murmurs disturbed the air, nor were columns of the daily press invoked, in season and out of season, to champion the cause of the outraged and down-trodden. The Doctor must have spent many a weary hour, over the midnight oil, in penning the grievances of one who had never contributed a solitary cent to the funds of the College; but, for eighteen long years

prior to the edict, "pay up like your chums, or quit," he lay in a state of hibernation, well protected by a thick epidermis, and with eyes serenely shut to the injustice which he says was being meted out to his fellows; and at last, like Bruin, he awakes, sore in the head for having slept so long. Or, to throw aside simile, why did he forget his honour and capability in standing idly by and permitting his fellow-practitioners to be robbed by a body of men whom he now denounces as non-representative, and "full of menace and pregnant with peril to the profession"? He knew perfectly well that many were paying their dues, without a murmur, year after year; and, although he now parades his righteous indignation, through many years he was silent as an oyster concerning all the bad deeds of the Council, and opened his mouth only when the penalty clause was about to force open his own purse strings. Complacently, and with a thankful heart, he accepted all the benefits he could get—his brothers paid the shot—and all went merry as a marriage bell. We impute no motives; but he who reads may draw his own conclusions. Remorse cannot be a stranger to him, who, knowingly, has allowed his brethren to be trodden to the ground under the iron heel of tyranny without having lifted his strong right arm in protection, and squeals at last when someone chances to touch an old corn of his that should have been pared sixteen or seventeen years ago.

Contradiction is becoming monotonous; out we cannot pass over paragraph 7, page 2, without pointing out its attempt to hide the truth. The writer affirms that the Council has, on more than one occasion, applied for power to increase the assessment, that once it asked for a \$10 limit, and expresses the fear that it may eventually grow to \$50 a year, to be sunken in Toronto real estate. Back again to the records: it applied but once, and that was for the privilege of making it \$5, not \$10 as stated; and, if the Doctor knew the whole truth, he should, in all fairness, have laid it before his readers. Had he been so inclined, he might have added the commutation clause, which provided for a life payment of twenty dollars as an alternative, from which sum were to be deducted all fees that had ever been received. The Council has again and again expressed the desire that the time should come when fees would be no longer

required; but we cannot see, if a fee is necessary, that two dollars a year is a heart-rending amount. Pharmacists have to pay four; and, in default, are debarred from conducting business, under a penalty of twenty dollars for each infringement of the Pharmacy Act. The College of Dentistry has power to levy \$3 per annum, recoverable in court of law, and while in arrears the delinquent cannot legally collect for services performed.

The Doctor takes exception to our using the penalties enforced by the Law Society as a precedent, on the grounds that lawyers are self-governed; that they receive back, in term fees and valuable literature, a sum which, every year, amounts to many times their annual assessment, and that they have access to a valuable library. That they are self-governed is not strictly true; at present there are six *ex officio* benchers; and, as this class embraces all the attorneys-general of the Province and Dominion who may be Ontario barristers, as well as all retired Superior Court judges, the number may at any time be largely augmented. Does the doctor know that, by Section 18, of the Judicature Act of 1881, term fees were abolished? And concerning the immense amount of literature received in return each year, we are informed by a prominent bencher that the cost of its publication falls at least three or four dollars short of the annual tax of seventeen dollars. Moreover, the same gentleman expresses his conviction that the said thirteen or fourteen dollars' worth of literature is a forced purchase in the eyes of probably one-half of the profession, whose business is of such a character as not to require it.

Whether or not they like it, they must pay; and yet we do not hear of a Legal Defence Association. Their library, not being easily accessible to those outside of Toronto, they cannot consider it a great boon personally, and yet they make no great outcry about the heavy fees being sunken in Toronto real estate. By way of contrast with our own, we refer to the penalties incurred by lawyers who neglect to pay. The fee is seventeen dollars; a fine of six dollars is imposed if three months in arrears, nine dollars if six months, and twelve dollars if nine months. While behind in his dues he is disqualified to practise; and, should he take the first step in litigation, he is liable to a further fine of forty dollars which must be paid together

with all arrears before being restored. The one-sided story in the circular is plausibly worded and has been touched up by a master hand; but its unfairness will be manifest to any casual observer. The Doctor would have his readers infer that lawyers' fees, in part, go to the support of the library; but, here again, we catch him napping. If, as he avers, they receive back annually, in literature, more than they pay in, where is the surplus to come from for the library? He used to have a reputation for mathematical ability; but, now, he is struggling hard to subtract the greater from the less and still have a positive quantity remaining. *Tempora mutantur!*

At first view there is some show of reason in the contention that a license to practise should exempt the recipient from all further financial obligations; but let us look at it as educated men, whose minds and hearts have been enlarged by the discipline of mental training. To become a member of the medical profession of Ontario is to enter a brotherhood for mutual protection and for the sake of such immunities as may be conferred. There is, or should be, something of a generous motive prompting the step; we do not ardently desire additions to our members in the shape of horse-leeches, who ever cry "give, give"; initiation fees, the world over, are but the stepping-stones to liberality when exigency occurs. When the medical practitioners of Ontario banded themselves together, in 1866, for purposes offensive and defensive, they virtually proclaimed an intention to stand shoulder to shoulder and in solid phalanx move forward, although it might at some future time mean a financial outlay of one or two dollars a year. But the Doctor says that the profession were hoodwinked by the schools, and out of the bad bargain has grown the iniquitous assessment. We believe that at that very time he was a member of the faculty of Victoria school; and, if so, why, as an honourable man, did he remain tongue-tied while a fraud was being perpetuated on the outside profession? He says it was not consulted in the framing of the compact, and that this injustice again occurred when the amendments of 1874 were obtained. We believe that, prior to the passing of the original Act, circulars were issued setting forth the provisions of the intended bill; and Dr. H. H. Wright, out of his private purse, paid the postage

on those circulars. The same course was adopted prior to the legislation of 1874; and on file is an account furnished the Council in 1875, for circulars printed by the *Globe* Publishing Co. for that purpose. More than this, at least two of the Doctor's doughty adjutants in this campaign against cruel despotism were drawing their indemnity as members of the Council in 1874, when power to levy fees was acquired, and when the constitution of the Council was the same as now; still we find no record that, by word or act, they took exception to either the one or the other. Eighteen winters have come and gone, and it is only recently that they have ventured to open their mouths in impeachment. Tonguetie appears to be prevalent but not serious, for it needed but the enforcement of the assessment clause to snip the frenum. It is but just to say, that one leading member of the Defence Committee has regularly paid his dues; but those who have contributed financially towards the advancement of the profession, would do well to ponder the thought that the large majority of the leaders in the Association have withheld their mites, and, as serenely, have pocketed the profits.

Sub-section 1, page 2, of the circular is worded rather forcibly for nice usage amongst gentlemen—the Council of 1874 is accused of having secured the amendments “by fraud and misrepresentation”; and as already said, Drs. Coburn and Eastwood were members when the initiative was taken. It did nothing of the kind; although there was a surplus in the treasury at the time, the Council acted in good faith with the Legislature when it represented that the only available source of revenue—the students' fees—would be inadequate to meet the necessary liabilities, which were expected to largely increase, and for the following reasons: Borrowed rooms, without proper appliances, had been employed for examination purposes which could not be otherwise than imperfect, and such a thing as a practical examination was unknown to students. This could not longer be tolerated. We respect our own diploma and the ability of those who put us through the mill at that very time; but, in the light of after years, we cannot refrain from contrasting occasionally the curriculum of those days with that now in existence. The extension of the curriculum, by the

addition of clinical and other practical examinations, meant that the membership of the Examining Board would have to be supplemented, and each member would have much more work to do in order to fulfil the intended requirements. It was also stated to the Legislature that the time had come to think about securing a college building suitable for the purpose; and all this meant a great increase in outlay without any assurance of increased revenue. On these grounds the Council asked a government grant, and, in reply, was told that a profession incorporated for its own good, just as much as for the public welfare, ought to be self-supporting, and, therefore, should contribute. Hence came the amendment commanding the levying of an annual fee of not less than one dollar and not more than two. Does this look like a proceeding worthy of the epithet, “fraud and misrepresentation”?

Paragraph 3, page 2, is an ingenious appeal to the electorate against centralization and monopoly. It is an appeal to a jealousy which we hope is not entertained by any medical man, no matter how retired he be, or rural his place of abode. We shall dismiss it with one short question: If the college building were not in Toronto, the educational centre, where should it be?

The next paragraph of the circular enunciates the cardinal principle that all who contribute to the support of a government should be adequately represented in its administration. To this we heartily subscribe. We have already shown that at any election the Council can be held responsible for its acts; that twelve good and true men are a guarantee that the electorate shall not suffer; and have referred to the fact that, in the conference with the Defence Association, the Legislative Committee expressed a willingness that five more territorial representatives be added, the only objection being on the ground of extra expense.

Do medical men honestly accept sub-section 5, page 2? Does the Doctor seriously wish us to believe that the profession has received from the Council, since 1874, absolutely nothing in the shape of protection or anything else in return for the fees paid? So far as this journal is concerned, our modesty forbids an expression of opinion as to either its merits or intrinsic worth; but we may say that as its columns are open to

the profession, it would have been in better taste for those who do not coincide with the Council to utilize its pages, instead of airing dirty linen in public by sending communications innumerable to the daily press. The profession at large is a capable jury, and to it, and it only, an appeal should have been made.

The Doctor trots out the same old hobby, unfair use of school influence, as a reason why elections should be triennial. Would the electorate desire the Council to be transformed into a novitiate by the innovation? The present members can have no personal ends to gain by being conservative in this matter; therefore, to them it is only a question of right or wrong. But, while disclaiming any intention to reflect on the profession, we think that, as a rule, practitioners are too much occupied to make a special study of collegiate details; and, therefore, it is not unwise to assume that a representative is much more capable in his fifth than in his first year of office.

Some years ago the Legislative Committee was twice instructed to ask for an amendment to the Act, whereby the senior county judge should be the final arbiter in protested election cases; the matter dropped out of sight until recently, when a case, coming up for disposition, revived it. There is no doubt that, when next approaching the Legislature, it will not be forgotten; the members of the Council would be only too glad to be rid of the unpleasant responsibility of pronouncing upon the credentials of a fellow-representative.

In seeking to transfer to the Legislature the function of arranging the time, place and manner of holding elections, the Doctor has omitted to state, in Section V., any specific instances as proof that injustice has been perpetrated, or that the Government erred in allowing the Council to mind its own affairs.

We have already denominated the penalty clause the *bête noir* of the Association; we have fairly met the objections; but as Section V. is devoted exclusively to its condemnation, we have to take exception to certain statements contained therein, points upon which we have not yet touched. Sad is the Doctor's wailing on account of the retroactive character of the penal clause. We have tried to show that the power of assessment was acquired by fair means; if so, the tax has ever been

a just debt; and clause 41 A of the amendment was framed purposely to meet the cases of those who had defied the law, and sheltered themselves behind the knowledge of the fact that recovery by process of law was abhorrent and too expensive to be profitable. Does the Doctor desire to degrade himself by pleading the statute of limitations in order to escape payment of all his indebtedness prior to the last six years; or would he wish us to accept as an argument such twaddle as, that a measure framed for a set purpose—that of collecting from delinquent debtors—is deplorable because it is directed towards those who have failed to fulfil their obligations? That erasure for non payment is equivalent to the punishment meted out to a felon is manifestly absurd; plenty of grace is allowed and sufficient notice given, and reinstatement is forthwith made by the Registrar on the payment of arrearages; the proceedings are unknown to the general public; and therefore, in this respect, should be much preferred to the indignity of appearing in a public court, and in the eyes of the community being forced by legal mandate to pay a small debt. We have already contrasted the penalty with that inflicted by the Law Society, and might have said further that the original Judicature Act fixed the maximum annual assessment, while a later amendment removed such restriction, so that now that body may put the fee at any figure it chooses.

It was an oversight in the drafting of the bill of 1891, that no provision was made for temporary absence from the country; no doubt, this will be rectified when next the Council asks for legislation; and, in the meantime the displeasure of no practitioner would be incurred by exonerating any of that class from indebtedness upon their return to the province.

The great majority of the profession cannot swallow Section VII., being satisfied that their interests are safe in the hands of the twelve territorial representatives. Studious care is taken that not a syllable shall appear in the circular concerning the offer made the Association that five additional members be added, on condition that the word of the Defence Committee were given that the honour of their supporters might be relied upon for the payment of the fees. To suppress the truth for the sake of making a point is sometimes called deception.

The Council is accused of the following acts of extravagance :—

1st. Excessive allowance to the members, and salaries of college officials out of proportion to their duties.

2nd. Reckless prodigality in conducting examinations.

3rd. A suspicion in the mind of Dr. Sangster that if he were to audit the accounts gross irregularities would be found.

We shall deal with the last first, and inform the profession that each year the Finance Committee spend many an hour in closely scrutinizing the accounts, and verifying them by vouchers which have never been found wanting.

In our last issue, we showed that on account of the increased functions of our Council, when compared with that of Quebec, the duties of the respective Registrars are not analogous, and that, therefore, the salary paid in Ontario must be fixed independently. Paragraph 4, page 4, of the circular, again suppresses the truth. It is correct that the Registrar's salary is fixed by statute in Quebec at \$150, but a bonus of a like sum is granted, making it \$300; he has two secretaries at \$100 each, and in addition there are assessors who cost a good deal of money.

The assessors in Quebec have functions similar to those performed by the assessors appointed by the British Medical Council. In Quebec they are eight in number; their duty is to act as supervisors of the university examinations. There are four Quebec universities—two for each—and each receives ten dollars a day during the whole time of the examinations, and travelling expenses. The expense incurred is necessarily not a constant quantity, for the duration of such examinations will vary from year to year. We have not been able to ascertain the total cost for last year, but will assume that each examination lasts for ten days—a reasonable average. Eight assessors for ten days at ten dollars each per diem, total \$800; in addition to this sum will be the expenses, say, \$100, or in all, \$900. Dr. Sangster has deliberately founded an argument on the false premises laid down in paragraph 4, page 4, of the circular. Total expenses of College officials in Quebec, as above shown: Registrar, allowed by statute, \$150, bonus, \$150; Treasurer, \$100; two secretaries, at

\$100 each, \$200; eight assessors, \$900; total, \$1,500.

In our February number we contrasted the respective functions of the Quebec Council and ours, demonstrating beyond question that the duties discharged in our office are at least three times as great as those in Quebec, and notwithstanding this, our total expenses are but \$2,500, while theirs amount to the tidy sum of \$1,500, not \$250. The Doctor, either wilfully or in ignorance, has deliberately stated that which investigation of the truth demonstrates as not in accordance with the facts. We must here speak of motives: in either case, whether he spoke without having endeavoured to get the full facts, or having known them, was guilty of suppression, he intentionally strove to mislead the profession. What does the profession think of it?

It is utter nonsense to talk of employing a clerk to discharge such duties as at times must tax the capacity of a capable medical man. None but those who are intimate with the details can form any approximate estimate of the time consumed, or the benefits that accrue to the profession through having its affairs in the hands of one well trained in the work, and careful in the discharge of his duties, and therefore the Council is best qualified to know what his salary should be. Is it any proof that the Treasurer's honorarium is out of proportion, to refer to his gratuitous services in the early years of the Council? This Dr. Sangster has done. The office is no sinecure, and its onerous character is patent only to those who audit the accounts.

The Treasurer, for eight long years, did this work gratuitously; and Doctor Sangster now taunts him with being a sort of parasite in accepting what is but a very moderate salary for the duties performed. The Courts, for similar services rendered by executors, allow according to the nature of the particular estate administered, from one and one-half to five per cent. on the amount involved.

In twenty seven years, up to June, 1892, Dr. Aikins carefully handled for the Council \$339,156.32; in all, the expenses of the Treasurer's office were \$4,837.50; or less than one and a quarter per cent. More than this, after the College building was erected, additional funds were required for its equipment—elevator, lighting, exam-

ination hall, etc., and to meet these liabilities Dr. Aiken's discounted for years his private paper in the Bank of Commerce. At one time this amounted to \$16,000; we make no parade of incurring such serious responsibility for the good of the profession; and now, for his pains, is hounded by one who never put his hand in his pocket to lessen the indebtedness by a single cent.

Would the electorate desire their interests to be served at a financial loss to those who occupy seats at the Council Board? Is it likely that representatives shall be chosen from amongst those whose income is less than the sessional indemnity? Economy is a good thing; but the profession does not ask for charity.

It is claimed, and truthfully, that the cost of examinations is increasing; and it may be taken for granted that according as students multiply, and examinations grow more comprehensive and searching, this will naturally follow. What would the profession think of a policy of retrenchment at the expense of having perfunctory examinations? In proof of this extravagance the Doctor compares the examination outlay of 1880 with that of 1890, stating that in 1880 it was only \$1,120, while in the latter year it was \$3,748, and lifts his hands in holy horror. The comparison, without assigning true reasons for the increase, is unfair, and another endeavour to mislead the profession, and indirectly the Legislature. Here are the facts:—

In 1880 the primary was oral, not written.

In 1880 the final was written, not oral.

In 1890 primary and final were both oral and written, thus largely increasing the examiner's work, probably one-half; and, in addition to this, there were no hospital clinics in 1880. These clinical examinations existed in 1890, and none but those who conduct them can form a correct idea of the amount of time and energy consumed.

In 1880 the numbers examined were 95 final and 80 primary students, or 175 in all.

In 1890 there were examined 256 primary and 232 final students, a total of 488.

In 1880 there were 9 examiners.

In 1890 the additional work incurred by having hospital clinics necessitated the appointing of three more. Now, we shall lay down the data, and a simple arithmetical calculation will demonstrate the truth or falsity of the Doctor's statement—figures don't lie.

If in 1880, 175 students were examined; in 1890, 488 students were examined; in 1880 the labour in examining each student be denoted by 2; in 1890 the labour in examining each student be denoted by 3; in 1880 there were 9 examiners; in 1890 there were 12 examiners; and in 1880 the examinations cost \$1,120, what should they have cost in 1890? Answer, \$6,246.

The actual cost having been only \$3,748, does the above result show that they were not conducted economically?

The Doctor being fond of comparisons, here is another: As is known, Dr. Sangster examined in chemistry (theoretical only) in 1870 and 1871; Dr. Acheson examined in chemistry (practical as well as theoretical) and toxicology in the years 1889 and 1890.

In 1870 Dr. Sangster examined 38 students and received \$35.

In 1871 Dr. Sangster examined 33 students and received \$70; or in all, he examined 71 students and received \$105; an average of almost \$1.50.

In 1889 Dr. Acheson examined 247 candidates, read 494 papers and received \$165.75.

In 1890 Dr. Acheson examined 208 candidates, read 416 papers, and received \$141.25; or in both years he examined 455 candidates, read 910 papers and received \$307, an average of 68 cents for each candidate.

Dr. Acheson received less than one-half of what Dr. Sangster did; had at least twice as much to do with each student; and, in this calculation, no account has been taken of the additional labour involved in conducting the practical examinations in the laboratory. Dr. Sangster, as already said, had no laboratory work. We would advise the Doctor, when he again goes kite flying, to be sure that the toy has a tail sufficiently long.

The Council is assailed for having last year incurred additional expense in reviving the fall examination. Listen to our answer:—

1st. This change was made after petitions had been presented, signed by over two hundred students. The policy of the Council should not be one of antipathy towards embryo doctors.

2nd. The petitions were granted with the provision that those who had failed in a former examination should pay \$20 instead of \$10, which latter sum had previously been exacted for a supplementary examination; and this was in accordance

with a proposal made by the petitioners that, if fall examinations meant a financial loss to the Council, the fees should be sufficiently increased to obviate a deficit.

3rd. The fall examination of 1892 cost, according to the Treasurer's books, \$834.10.

The receipts from candidates were \$1,400, leaving therefore a profit of \$605.90. Does one speak the truth when he says that fall examinations mean a financial loss?

Or to put the matter in another light:—

According to the regulations, a candidate who presents himself at a spring examination after having failed on a former occasion, pays only \$10. Amongst the candidates there were fifty-eight of this class last fall. Each paid \$20 or \$10 more than the Council would have received had he waited until spring. Consequently the receipts from the said fifty-eight students were \$580 over and above what they would have been had there been no supplementary.

Loud complaints are made that disastrous speculation in real estate has been indulged in; the present Council would probably have been no wiser than its predecessors, and, therefore, should not censure; but it is well for the Defence Association to know that one of its prominent leaders had a voice in the measure which bequeathed to us the legacy. A college building was a necessity, to continue borrowing or renting would have been no credit to an independent profession, to provide a suitable place for thorough examinations was imperative, the committee used its best judgment and did not spare time or trouble, the structure was erected at a minimum of cost under closest supervision—our old friend, Dr. H. H. Wright, watched its progress day after day, as though it were his own personal property, and the profession has a great deal for which to thank him; so that now the College of Physicians has a home of which it need not be ashamed, and desirable property well worth the expenditure. We venture the opinion that those who so violently assail the speculating tendency would not, at that time, have done otherwise: almost anybody can, *post factum*, parade wisdom and exclaim, "I told you so." We never heard a note of warning from Dr. Sangster until his fees had to be collected. In our last issue we demonstrated pretty clearly that paragraphs 1 and

2 of the 5th page of the circular are fallacious, that the building almost carries itself, that within a short time it will be more than self-sustaining, that it would be folly to dispose of it; and, even if a sale were contemplated, that it would be worse than madness to think of it now while Toronto real estate is at so low an ebb.

Dr. Burns' letter in our February number is a satisfactory answer to paragraph 7, page 5, and to it we need not further refer.

There is no apology necessary for the personal mention we have made of Dr. Sangster's name; his platform, paraded in the daily papers to catch the eye of the public who are incompetent to judge, has not been repudiated by the Association; and having posed as another Luther and accepted the secretaryship, he should have remembered that consistency is a jewel.

We have striven candidly to compare the contents of the circular with the facts; and knowing now its true intent and aim in garbling some, and suppressing other vital truths, the reader is left to determine whether he will stand up nobly for the welfare of his profession, or, on the other hand, accept what Dr. Sangster says and join the Medical Defence Association.

THE PROPOSED AMENDMENTS TO THE ONTARIO PHARMACY ACT.

A careful perusal of the amendments, which the druggists shall ask from the coming session of the Ontario Legislative Assembly, will make it clear that every physician should bestir himself.

If the druggists obtain their proposed amendments, the physicians throughout the Province will be placed in an extremely unfortunate position. One very important privilege they now enjoy, will be taken from them; and in many cases their livelihood.

By clause 11 of the proposed amendments, a physician shall be allowed, "in places other than incorporated cities or towns," to keep a drug store, provided he employes "a legally qualified pharmaceutical chemist," and in addition "shall himself pass the final examination for the degree of Phm.B. of Toronto University."

This is drawing a pretty tight cord round the neck of every physician who lives outside of incor-

porated cities and towns. But what is to be the lot of those who live in cities and towns?

They are not to be allowed to keep a drug store at all. They shall not be allowed to register "as a chemist and druggist, unless they cease to practise as a physician and surgeon." This is asking too much. Physicians cannot be expected to yield their rights supinely, and we warn them to take a firm stand in this vital issue. It is monstrous to ask medical men, who keep a drug store, and have been doing so for many years, to pass another examination, in addition to the penalty of having to give up their practice. No, this will never do.

But, seriously, we would ask the druggists if they do not at times do a little prescribing, would they object to being made to give up this little habit of putting up mixtures for a goodly number of the ills to which human flesh is heir? People who live in glass houses should not throw stones. We would commend to our confreres, the druggists, the fables of the dog and the shadow, and the boy and the jar of nuts. They are grasping for more than they shall get; and may, in their efforts, lose some of what they have. In behalf of the medical profession of this Province, we enter our unqualified protest against the proposed changes; and we feel sure that the Medical Council will leave no stone unturned to secure the defeat of such legislation, for it would discriminate most unfairly against the doctor.

Since writing the above we have been informed that the Legislative Committee of the Medical Council, through Dr. Williams, has taken action in this matter, and Dr. Williams has been assured by the promoters of the bill that all objectionable clauses affecting the medical profession will be withdrawn.

A RAY OF HOPE.

At last a ray of hope for the medical service of the militia is to be seen struggling through the Cimmerian darkness of officialism. We learn from the public press that the Minister of Militia has consented to investigate the condition of the service. Last week Surgeon-General Bergin and Dr. Ryerson, secretary of the Association of Medical Officers, waited upon the Minister and obtained

this result. We are not over hopeful, but we have faith in the personal integrity of the Hon. J. C. Patterson, and believe that he will redeem his pledges. The question of reorganization is not a political but a professional and a humane one. It is of vital importance to the commonwealth that our citizen soldiers' lives shall not be wasted by the neglect of sanitary conditions in camps. The Government has announced that Dr. Bergin shall visit all camps, and bring in a report. The JOURNAL will also have its representative, who will give the profession the results of his experience.

THE DISCIPLINARY CLAUSES IN THE COLONIES.

Such is the caption of a leading editorial which appeared in the *Medical Press and Circular* of Feb. 8th, and is interesting as showing the superiority of the Ontario Medical Act over the one which obtains in Great Britain. It is regrettable, however, that the writer, though taking his inspiration from this journal, failed to make due acknowledgment, as is customary under such circumstances. He further demonstrates the insularity of his knowledge by using the words, General Medical Council of the Dominion, (though no such body exists) when he no doubt means the Medical Council of Ontario.

"It is of interest to note that certain of the Colonies are bestirring themselves in the matter of medical discipline, and some proceedings which have recently taken place in this regard, unmistakably show that, at all events, the profession in Canada will in future not be allowed to have its honour reflected upon by the disreputable conduct of unprofessional medical men. The manner, however, by which the disciplinary power is vested in the General Medical Council of the Dominion somewhat differs from that which obtains here. As soon as the complaint of unprofessional conduct has been officially made, a committee of the Council is formed, consisting of not less than five members, who hold meetings, take evidence, and thoroughly investigate the case. A report is then drawn up and presented to the Council, and on the reception of such report the Council has the power to strike the name of the offender off the Register. The right of appeal, however, may be

exercised, as is the case in this country. Since the Ontario Medical Act came into force, two practitioners have had their names erased from the Register, and two others are now on their trial, both for 'infamous conduct in a professional respect.' Disgraceful and unmitigated advertising in the public press formed a feature of the charges in one of the latter cases, and advertisements were described by one witness before the committee as a gross slander upon the profession, and as a false and absurd pretence on the part of the advertiser to cure all diseases. It goes without saying that this vigorous and determined effort on the part of the General Medical Council in the Dominion, to purge the profession of medical men who stoop to the wiles of quacks in order to obtain practice, will have a very salutary effect. Upon the whole, we think that the procedure carried out in accordance with the Ontario Medical Act, for the prosecution of professional offenders, is an improvement upon that which is adopted by the General Medical Council here. It would seem that no sooner is the formal complaint lodged by four practitioners than the Council at once takes action, and commences an inquiry, the preliminary facts for which are specially investigated by an officer—so-called a detective—who is in the pay of the Council. The inquiry itself would appear to be as searching and as exhaustive as that which takes place before any legal tribunal. In the case of one inquiry, the report of which has reached us, many medical men were called upon to state their views as to the conduct of the alleged offender, and witnesses were submitted to cross-examination by the counsel representing the defendant. Thus it will be gathered from this that the inquiry conducted by the Council really partakes of the nature of a full legal trial, carried out with great formality, at which evidence on both sides is submitted, with a view to judgment being given. No secrecy is made of any of the proceedings; the court, so to speak, is quite open, and the defendant is at liberty to bring whom he likes to testify to the rectitude of his character and practice. After hearing all the evidence, the committee's labours in public are completed. It adjourns for the time being, and meets later on, when the whole evidence is gone carefully through, and a report thereon prepared and submitted to the Council."

ONTARIO MEDICAL ASSOCIATION.

As will be seen from a reference to the advertising columns, the date of the Thirteenth Annual Meeting has been postponed from the 7th and 8th to the 21st and 22nd of June. The Executive has been led to take this step for the reason that the American Medical Association holds its annual meeting in Milwaukee, on the 6th, 7th, 8th, and 9th of June. Another large gathering of physicians will take place in Omaha during the week previous, in connection with the National Association of Railroad Surgeons. Neither of these meetings would interfere with the annual meeting of the Ontario Medical Association under ordinary circumstances, but this year a special effort is being made to organize a large excursion for medical men to the Chicago Exhibition, in connection with one or both of the above gatherings, and the railroad authorities are offering persuasive inducement in the way of reduced fares. The Executive in consequence deemed that it would best conserve the interests of the Association by postponing the annual meeting two weeks beyond its regular date. The attention of the members is drawn to the change, in order that they may make their plans for the summer in such a way as to allow them to attend this meeting. The following gentlemen are on the Committee on Papers and Business: Dr. Spencer, (chairman); Dr. Atherton, Dr. Birgham, Dr. Smith (Seaforth), Dr. Gibson (Belleville); and on the Committee on Arrangements: Dr. J. H. Burns, (chairman); Dr. A. A. Macdonald, Dr. Millman, Dr. A. Davidson, Dr. Chas. O'Reilly, Dr. F. W. Strange, Dr. A. J. Johnson, Dr. Wilson (Richmond Hill), Dr. J. L. Davison, Dr. E. E. King, Dr. P. Strathy, Dr. G. S. Ryerson, Dr. R. B. Nevitt, Dr. F. W. Cane, Dr. R. M. Hillary (Aurora).

The attention of the readers of this journal is drawn to the number of excellent practices which have been sent in to the office Dr. White opened a few months ago for the convenience of his conferees in disposing of or securing openings for successful practice. Some of the most valuable practices in this Province are for disposal. Those who desire to purchase may well consult Dr. White.

EDITORIAL NOTES.

There are 1,254 medical students this session at the University of Berlin.

Prof. Fredrich Von Esmarch celebrated the completion of his 70th year on the 9th of January.

There were 128 new works published in the United States on medicine and hygiene during the year 1892.

The four official languages at the Pan-American Medical Congress will be English, French, Spanish and Portuguese.

The annual meeting of the American Surgical Association will be held in Buffalo, commencing on the 30th of May.

Dr. Stephen Mackenzie reports the case of a patient suffering from intermittent fever whose temperature was as high as 113.8°F.

A death under chloroform occurred at St. Michael's Hospital in this city, February 27th. Dr. Johnson held an inquest. The facts of the case will be published in next issue.

The German Government has issued an order that the centigrade thermometer shall be used exclusively throughout the empire instead of the Reaumur thermometer as heretofore.

The *N. Y. Medical Record* says there has been in that city of late a shocking prevalence of deaths due to abortions produced in order to prevent the results of pregnancy and conceal the evidence of crime. Nearly twenty cases have been reported within a short time.

CONVOCATION OF TORONTO UNIVERSITY.—A short time ago Principal Sheraton gave notice that he would introduce a statute into the Senate for the purpose of regulating some important matters relating to the election of the representatives of graduates to that body. A special committee was appointed, and reported at last meeting of the Senate. The report of the committee was not adopted; but, on motion of Mr. Houston, was

referred to the convocation of graduates. When the graduates, in the various faculties, are called together, it is hoped that medical graduates shall attend and look after their interests in this matter.

THE TEN-MINUTE PAPER.—The ten-minute paper has recently become (*New York Medical Journal*) a marked feature in the work of the New York Academy of Medicine. The result has been a marked increase in the attendance at the meetings, a large number of concise, pithy, and interesting papers, and a wide publication of the proceedings. The instructions to writers of papers formulated by the chairman contained a number of apt suggestions and were somewhat as follows: 1. Hippocrates and Galen may be passed with very slight notice, as they have been for some time dead and their opinions are somewhat obsolete. 2. Scratch out the formal introduction and begin where the subject matter really begins. 3. Condense the body of the paper. 4. End the paper where the subject matter ends, making its action like that of the piston syringe—begin, spatter, stop. Will gentlemen now preparing papers for the Ontario Medical Association take note of the above?

THE TREATMENT OF ACUTE INFLAMMATION OF THE MIDDLE EAR.—Dr. J. T. Campbell, of Chicago, in the *Annals of Ophthalmology and Otology* for January, goes over the treatment of the above condition. As a prophylactic, he says the douche should never be used, as the fluid may be forced into the middle ear. Local antiseptic treatment should be applied to inflammation of the naso-pharynx, and hypertrophied tissue removed.

The acute inflammation in the middle can be greatly relieved by dropping into the ear five or ten drops of warm five per cent. solution of cocaine and a two per cent. solution of resorcin. The head should be so placed that it will remain in for ten or fifteen minutes. It should then be removed by a small pledget of cotton wool. A compress of gauze, wrung out of hot boracic acid solution, is then placed over the ear, and covered with oiled silk to keep in the heat and moisture. This process may be repeated three or four times.

The middle ear should be inflated, either with a Politzer's bag, or by a rubber tube, with one end

in the patient's nostril. Through this tube air is blown when the person swallows.

If the tension becomes great, the membrana tympani should be punctured in the postero-inferior angle. After this is done, the ear must be kept thoroughly clean. The inflation is to be kept up twice a day.

Much relief is obtained by a saline cathartic and the administration of diuretic and diaphoretic medicines, or local depletion by means of one to three leeches in front of the tragus for a few minutes.

THE TREATMENT OF PURULENT OPHTHALMIA.—A. A. Poucher, of Montreal, in the *Annals of Ophthalmology and Otolaryngology* for January, reviews the main points of the treatment of this affection.

1. With regard to the nitrate of silver, the author uses it in strengths varying from gr. v. to gr. xv. to the ounce once or twice a day, and always to the palpebral conjunctiva. He waits till the inflammation is sufficiently controlled to permit of the lids being easily everted. He says that it would be blameful to use the silver at the outset of the disease. It should always be used with great care, so as not to injure the cornea.

2. The use of antiseptics to cleanse the eye and modify germ development is of much importance. A saturated solution of boracic acid, perchloride of mercury 1 in 5,000, peroxide of hydrogen, etc., are all good. He gives the preference to the saturated solution of boracic acid. This should be instilled into the eye hourly in bad cases.

3. The third point in the treatment is the application of cold. Excellent results are claimed from the proper use of the agent. It may be applied by means of Lister's tubing, by cold compresses, by broken ice in a thin rubber bag, or by pieces of ice laid on the eye. The compresses heat up rapidly, while the tube is difficult to keep in position. For these reasons Dr. Poucher now employs the ice applied directly. Under the influence of the ice the purulency greatly lessens, and in a few hours to twenty-four hours the lids can be everted.

4. The writer strongly objects to incising the eyelids as recommended by Critchett. The proper use of the ice always brings about sufficient reaction to render this mutilation unnecessary. He does not scarify a fleshy chemosis. In addition to the

cold, in very severe cases, local depletion at the temple may be resorted to with advantage.

ANTISEPTIC MANAGEMENT OF WOUNDS.—Sir Joseph Lister delivered an address on the above subject, which appeared in the *Brit. Med. Journal*. The two great principles are: (1) Not to introduce, at the time of operation, material capable of inducing septic changes; and (2) to dress the wound in such a manner as to prevent the entrance of septic mischief. With regard to the first point the spray is not needed. If the hands, sponges, instruments, the part to be operated upon, etc., are rendered thoroughly aseptic, the operation may be performed with the same simplicity as in former days. Lister contends that for surgical purposes corrosive sublimate is much inferior to carbolic acid in germicidal power. The anthrax bacillus, the staphylococcus pyogenes aureus, the tubercle bacillus are all destroyed much more rapidly by carbolic acid 1 in 20 than by perchloride of mercury 1 in 1,000. For the sponges, instruments, hands, and the part exposed for operation, this is the best agent to use. It also has the great advantage of permeating the epithelium freely, a property which the corrosive sublimate does not possess to any great extent; and, if the surface is greasy, does not possess at all. The carbolic acid, on the other hand, acts equally well in such a case. During the operation, sponges should be washed out in carbolic acid solution 1 in 40. Finally, when the operation is over, the wound should be washed with the same strength of carbolic acid solution. The second point is to keep the wound aseptic. An ideal external dressing must contain a reliable antiseptic, stored in the dressing, unirritating and capable of absorbing the blood. The gauze should be first moistened with 1 in 20 carbolic acid. The double cyanide of mercury and zinc is the favourite antiseptic with the author. To this is added some rosolane, or hydrochlorate of mauveine. This dye has the power of fixing the cyanides in the gauze. The dyed powder is added in the strength of grs. xxx. to the pint of carbolic acid solution 1 in 20. The gauze is drawn through this solution and is ready for use. This dressing is both germicidal and inhibitory, and possesses the four requisites mentioned above. Should this gauze become dry before using, it should be moistened in 1 in 20 carbolic acid solution.

NERVOUS AFFECTION CAUSED BY MALARIA.—William Browning (in *Brooklyn Medical Journal* for January, 1893) describes the leading forms of nervous disturbance attributed to specific malaria. He divides them into three classes, cerebral, spinal and neural.

1. Those of the brain are mainly intracranial inflammations of a meningitic type, mental disorders, epilepsy, chorea, aphasic symptoms, hysteria, neurasthenia and hystero-neurasthenia. These various forms merge into one another. They are usually of the paroxysmal type.

2. With regard to the spinal cord, it has not been clearly shown that its diseases are ever of truly malarial origin. It has been held by some that cases of tabes and disseminated sclerosis are sometimes of malarial origin. The malarial poison may cause a pseudo-meningitis, but that the chronic degenerative spinal diseases are thus caused remains as yet unsettled.

3. Among the peripheral nerve disturbances caused by malaria may be mentioned neuralgia, neuritis, contractures and paralyses. The most common form is neuralgia. The neuralgia is usually intermittent. The nerves most frequently affected are those of the brow and the sciatic. Neuritis may be of single nerve, a plexus or multiple. The optic nerve is specially liable to be affected, causing atrophy.

HEART FAILURE.—A. L. Loomis, in the *International Medical Journal* for February, 1893, states that all classes of heart failure fall under one of the following forms :

1. Those in which the heart has for a long time been called upon to perform an abnormal amount of work, as in valvular or arterial disease.

2. Those in which obstructive changes in the coronary vessels markedly diminish the nutritive supply of the cardiac muscles.

3. Those in which toxic influences act directly upon the nutrition of the cardiac muscles, or so interfere with its nerve supply as to lessen cardiac resistance.

A review of such cases makes it evident that the term heart failure is misleading and should be abandoned, for it does not express the true pathological state. "Death by heart failure" is only a cover for the ignorance of the real condition of the heart.

The first form is the most frequent. By careful attention to heart compensation, and the avoidance of heart strain, the fatal day of heart failure can often be long postponed. In this form of heart disease, the question is not the treatment of the heart failure so much as its prevention.

The second form is often very hard to diagnose, especially in its early stage. It is marked by a tendency to cardiac fibrosis. There is a weakness of heart action. On making exertion the person has attacks of palpitation, pain in the region of the heart, shortness of breath, a sense of impending suffocation, cold extremities, pallor of countenance. These symptoms, taken with absence of valvular disease, pretty clearly establish the diagnosis of cardiac fibrosis.

In the third class—diseases of a toxic and infectious nature—Loomis urges the early use of alcohol, strychnia, and heart tonics, and not to wait till the first sound becomes indistinct. In this way patients are often saved from fatal heart failure.

VENESECTION IN PULMONARY HÆMORRHAGE.—Dr. W. R. Huggard (*British Medical Journal*, January 28th, 1893) reports two cases where he employed venesection in pulmonary hæmorrhage. The benefits derived by the patients were marked and immediate. The hæmoptysis ceased, the cough was lessened, the temperature was lowered, and the local irritation in the lungs reduced. The indications for venesection are : a plethoric patient, high tension pulse, the general health good, absence of debility, the presence of inflammatory irritation in the lungs, recurrence of the hæmorrhage, and the disease usually in the early stage. In such cases the pulmonary hæmorrhage is generally preceded by a feeling of oppression, and followed by one of ease and relief.

THE LATEST STAGE OF LEPROSY.—Hallopeau (*Ann. de Dermatologie et de Syph.*) showed at the French Society of Dermatology a patient who had been fourteen months in Martinique. In 1855 he returned to France, and was never afterwards exposed to the contagion of leprosy. He first showed symptoms of this disease in 1887, thirty-two years after he had left a country in which leprosy prevails.—*British Med. Jour.*

FIRST QUARTERLY MEETING OF THE PROVINCIAL BOARD OF HEALTH.

The first quarterly meeting of this Board for 1893 began on March 1st, and continued on the two following days. The Chairman, Dr. Cassidy, in his annual address, after recapitulating the recommendations which the Ottawa Sanitary Congress had made to the Federal Government *re* cholera, and expressing his gratification at the readiness shown by Hon. Mr. Angers in carrying them into effect, dealt in detail with some of the more conspicuous shortcomings of municipal and domestic hygiene. He particularly instanced the foul water supply of Toronto, which had undoubtedly been the cause of so much sickness during the past winter. Regretting the pitiable condition of the citizens who, to escape typhoid fever, were obliged to drink boiled water, he suggested that the City Council should introduce the Hyatt system of filtration, by which a crystal-clear water quite free from pathogenic germs could be obtained. He showed that, in operation, the Hyatt differed from ordinary filters, in as much as provision is made for a thorough cleansing of the filtering material (sand) once every day. He quoted from the observations made at St. Thomas by Mr. McKenzie, of the P.B.H. laboratory, demonstrating that after filtration through these filters, 1,500,000 gallons of the comparatively impure water of Kettle Creek is every day converted into first-class water, the bacteria being reduced from 45,000 per cubic centimeter to 90, in one sample, and from 1,240 to 44 in another. Referring also to cases of illness, which can be readily traced to the use of well water, polluted by household wastes, he indicated the necessity of cleaning suspected wells and protecting them from the drainage of neighbouring pits, vaults, etc. Respecting small-pox, which is prevalent in Ohio, Michigan, Iowa, Connecticut and Pennsylvania, as well as England and Japan, while giving full credit to the beneficial influences of isolation and disinfection, he cordially endorsed vaccination and revaccination as the surest preventatives of this constantly recurring plague. The address was received and discussed, after which it was adopted and ordered to be printed in the annual report.

The Board subsequently considered a report of

the Committee on Legislation, amending the Order-in-Council dated 17th September, 1892, *re* cholera. The report was adopted and is now in the hands of the Government. We expect to be able to submit the text of the new Order-in-Council to our readers in the April number of this journal.

One of the most important reports presented was that of the Committee on Publication *re* "Hints to Local Boards of Health and individuals on methods of dealing with municipal and house wastes." The adoption by municipalities of the recommendations in this report will produce radical changes in the present primitive methods of disposing of excreta and household wastes. Pamphlet No. 1, 1893, which, in its amended form, will replace pamphlet No. 15, known as "Rules for Checking the Spread of Contagious Diseases," will be a very useful publication, particularly to Local Boards of Health and sanitary inspectors.

An application was also made by the Ottawa Board of Health asking for an investigation by the Provincial Board of Health into the condition of the sewers in Ottawa. Dr. Bryce was instructed to take action in the matter and report to the Board at the next meeting.

The Board also considered and approved of a proposition submitted by the city of Windsor for the extension of an intake waterworks pipe to a point in the river above Walkerville, not contaminated with sewage from that town. The proposed source of water supply of Petrolea was also approved of, provided that precautions are taken to protect the source from pollution.

Instructions were given to the Committee on Publication to have a large edition of the cholera circular printed for distribution. Dr. Cassidy presented the report of the special committee on "a sanitary exhibit at the World's Columbian Exhibition." The report was received and adopted. The committee, which consists of Drs Cassidy and Kitchen, is co-operating with Messrs. Awrey and Larke in preparing materials for a Canadian sanitary exhibit at the Chicago Exhibition. The Board then adjourned.

In 1890 the eight physicians of Windsor were grumbling that the profession was crowded, since then nine new ones have hung out their shingles.

Correspondence.

The Editors do not hold themselves in any way responsible for the views expressed by correspondents.

MEDICAL PRIVILEGES IN HOSPITALS.

To the Editor of ONTARIO MEDICAL JOURNAL.

DEAR SIR, — The enclosed appeared as an editorial in the *Evening Journal*, Ottawa, March 4. It will, I am sure, interest your readers, as it shows, to a certain extent, the condition of hospital affairs in this city.

Yours truly,
M. D.

Ottawa, March 6, 1893.

"The question of medical privileges in hospitals is receiving attention in Toronto as well as here. In the Toronto General Hospital, the same rule obtains as in the Protestant Hospital here, forbidding doctors not on the medical staff to attend their own patients, even in the private wards. This exceptional rule—for in other Toronto hospitals there is no such regulation—is the subject of discussion in the ONTARIO MEDICAL JOURNAL, and so far no one has come out to champion the rule.

"In the January number of the MEDICAL JOURNAL, Dr. John Ferguson makes a vigorous plea for the rights of the profession at large. He points out that the Ontario government and the city of Toronto give large subsidies to the hospital as a public institution; that the public subscribes liberally to it; that all the medical men of the city and their clients contribute either directly or through the city and the government to the maintenance of the hospital; that that which the whole public and the whole medical profession support should be for the equal benefit of all members of the public or medical profession, and that therefore it is grossly unjust that a few doctors should not only monopolize the advantages of the hospitals, but actually use the hospital to debar other doctors from their patients, and to deprive paying patients of their own doctors.

"The feeling on the subject among Toronto medical men is made evident in the following or February number of the MEDICAL JOURNAL. Dr. Ferguson's letter having set the ball rolling, four other

doctors take the trouble to write their views backing him up. Dr. C. A. Hodgetts trusts that 'this remnant of ancient exclusivism will be removed by the hospital trustees.' If Dr. Hodgetts lived in Ottawa, he would have learned by this time that here the hospital trustees are mere puppets to register the decrees of the hospital doctors, and have repeatedly been forced by the doctors to swallow their own doings in an abject manner. Probably Dr. Hodgetts justly places more reliance on the courage and sense of justice of Toronto trustees of the public. At any rate, both he and Dr. D. A. Young, Dr. J. A. Todd, and Dr. Hastings, who all write on the subject in the February issue of the MEDICAL JOURNAL, seem to think it is a matter which really rests with the trustees, and they appeal to the trustees to have the injustice removed. There is, as already intimated, little hope of permanent success of such appeals here. If, on more than one occasion, the hospital directors, when left to their own judgment have taken independent action but have subsequently, under the threats of the medical staff, retracted their doings, swallowed their decisions, and adopted a diametrically opposite course, what hope is there that any appeal to them against injustice to either the outside doctors or the public can be worth while, so long as the private interest of the medical staff counts on the side of the wrong?"

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR,—Allow me to say that every disinterested practitioner in the city must have long ago arrived at conclusions similar to those expressed by Dr. Ferguson, in the January number of the JOURNAL, in reference to the injustice done to the public, and the members of the profession outside the hospital staff, by the present plan of management of that institution.

There is a general impression abroad in the community, that the medical men on the staff must be possessed of more than ordinary ability, in order to obtain such an appointment, but with the exception of a very few, such a claim would not be made by themselves, nor accorded by others, except it be in the matter of successful wire-pulling.

Patients come under the care of outside practitioners from time to time, to whom it is important

that they might be able to avail themselves of the superior nursing which the hospital affords, but who refrain from doing so because they are not allowed—even on paying liberally for a private ward—to have their family physician attend them; or if they do consent to enter, how often does it occur, either from the “damning by faint praise,” or something else, that the patient, his family and friends, slip into other hands later on?

Much more might justly be said, but I will not further trespass on your valuable space at present.

Yours sincerely,

JAS. McCULLOUGH.

172 Spadina Avenue.

Toronto, March 9th, 1893.

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR,—I have read with much interest Dr. Ferguson's letter in the January JOURNAL, and also the various communications it has called forth. I have for some time thought that a change in the direction indicated would be a benefit to the hospital and a gratification to the patient. In suggesting to a patient the advantages of the General Hospital, the first question usually put to us is, “Will you attend me there?” “No, but you will have the best of care, and I can go and see you frequently.” “Well, I won't go.” Then our work begins—with ventilation defective, heating imperfect, nurse overworked and without experience, odour of cooking close at hand, children noisy, neighbour's small daughter practising, etc. If, under these difficult and distressing circumstances, the Medical Council considers us competent to take charge of this case, are we any the less capable of managing the very same case in a light, well ventilated, nicely heated ward of the hospital, surrounded by every appliance and contrivance known to medical science, and assisted by a staff of well trained, regularly rested nurses, such as our General Hospital affords? In conclusion, are we getting what we are paying for? Is the suffering public getting what they are paying for? Answer, yes or no. Echo answers, No.

S. M. HAY.

Toronto, March 9th, 1893.

To the Editor of ONTARIO MEDICAL JOURNAL.

DEAR SIR,—I have read with special interest the letters from some of the Toronto physicians favouring the abolition of the monopoly of the exclusive right to attend private patients, which has for years been claimed and practised by the staffs of certain hospitals. As the patient who first successfully protested, last July, against this practice in the city of Ottawa, as a violation of British right and justice, happened to be mine, I would like to say that we have ever since had a sort of professional warfare on the subject, and peace has, by no means, been yet proclaimed.

Without going into details, at present, it may be of interest to the general profession to know, that certain hospital doctors in this city, from whom better things might be expected, fought bitterly against the change, even after the directors of the hospital had passed a by-law allowing any legally qualified physician to attend his patients in private wards.

The arguments were as follows :

1. Precedent is against the practice.
2. The system is not feasible—confusion.
3. Outside doctors would not be responsible.
4. Reputation of the hospital might suffer, as inferior men might have patients in the hospital.
5. The privilege of attending private patients should be reserved for the staff, on account of gratuitous services in the public wards.
6. The public have made no appeal for change.

1. To the first argument I may reply that, although it is true a few hospitals, such as the Toronto General and the Montreal General, do deny their private patients the right of choice in their physician, this does not make the practice right. Slavery was considered right by many long ago, but in this age of progress who would advocate it? Just so, in a few years all the relics of this ancient exclusivism will have ceased to be. There would be some excuse for this practice in the States, where the standards of medical men are so varied, but why in Ontario, where for years the standard has been uniform?

In the Kingston General Hospital the privilege has always been allowed, and although a city less than half our size, and containing another large hospital, it has drawn a revenue of more than our

two hospitals from the Government, thus showing her progress. In Toronto, too, two hospitals have been opened on the principle of "open to all," in the face of the exclusive practice in the old Toronto General Hospital.

All the newer hospitals of Ontario, as well as many of the older ones, allow their patients the right of choice. We may mention as additional examples the London (Ont.) Hospital, Hotel Dieu (Kingston), St. Thomas, Guelph, Brockville and others, but the best way is to treat the question on its merits.

2. To assert that there would be confusion is utter nonsense and born of prejudice. The staff would not be interfered with, discipline would be perfect and the hospitals flourish. Private wards would be filled and the revenue increased. It works well everywhere it is in vogue. Both homœopathic and regular physicians attend even the public wards of the London Hospital, and we have not heard of any calamity.

3. With regard to *Responsibility*, every physician is responsible, first to his patient and second to the hospital, according to its rules and regulations. The fact of a doctor accepting professional work in a private ward makes him amenable to the laws of that institution, precisely the same as the staff, under penalty of being declared ineligible for admittance.

4. The *Reputation* of the hospitals does truly suffer at present from the fact of some of the staffs attending patients in both public and private wards, whom the patients do not wish to have. This cannot be easily remedied with regard to charity wards, unless by a system of change in the personnel of the active staff, but the reputation of our hospitals on the other hand would be much better if every private patient could choose his own family physician to attend him. The staff would thus suffer no wrong, the hospitals interested would be served in many ways, and all pay-patients would be satisfied.

5. The staff have no right to claim a consideration for gratuitous services in public wards. It is truly a cold charity that looks for a remunerative monopoly for a reward. Besides most of the staffs sought the position, and other medical men whose credentials are equally good, are willing to render their services *truly* gratuitously.

Far be it from me to intimate that physicians do not practise charity and self-denial in attending the public wards of a hospital; on the contrary, I doubt if any other class of men are more charitable than physicians, but the monopolists forget about charity towards their professional brethren.

6. It is a stern fact that probably nineteen-twentieths of the public and the supporters of our hospitals feel it is a great injustice to all, and a drawback to the advancement of a hospital.

The public have made an appeal to the directors to open their private wards, through the outside doctors as their representative. We asked nothing selfishly, only our patients' rights are looked for.

In support of our contention also, we may add that it does no injustice to anyone, and we deem it a right any public hospital owes its private patients. The hospitals are supported by the public, municipalities and the Government, therefore private patients should have free choice of physicians, instead of the doors being closed to all but a few doctors.

A physician and his patient should not be separated, except by mutual agreement.

It would also bring physicians together on an equality, and all would share with each other in a knowledge of the latest scientific advances.

We confidently expect that this disgraceful hospital barbarianism will shortly be a thing of the past in our capital city.

Apologizing for the amount of space taken,
I am, Fraternally yours,

R. PRESTON ROBINSON.

Ottawa, March 11th, '93.

INTERNATIONAL MEDICAL CONGRESS.

To the Editor of ONTARIO MEDICAL JOURNAL.

DEAR DOCTOR,—I beg to inform you that through the courtesy of His Honour the Lieutenant-Governor of Ontario, a communication has been received by me as Secretary of the Ontario Medical Association, conveying an invitation from the Central Committee of the Eleventh International Medical Congress, meeting in Rome on the 24th of September, 1893, to the President and members of the Ontario Medical Association, to appoint delegates to this Congress. Will you

kindly insert an item to this effect in the columns of the *ONTARIO MEDICAL JOURNAL*, and request any members of the Association who may find it convenient to attend this Congress to communicate with me.

Yours truly,

D. J. GIBB WISHART.

47 Grosvenor Street, Toronto. *Secretary.*

MEDICAL COUNCIL AFFAIRS.

To the Editor of *ONTARIO MEDICAL JOURNAL.*

SIR,—Doctors differ on some points ; but, after all, it is amazing upon how many points they agree. It is not strange that they differ on matters legislative, but it would be surprising if they did not all agree in complimenting Ontario upon its medical laws. A objects to the fee; B dislikes the manner of collecting it; C insists that the five years' term is too long; D objects to the property, etc.; but all agree that the Council that brought this legislation about could and should secure its repeal, if our elected representatives said so. Suppose the City Council of Toronto should get legislation from the Government, and a number of prominent citizens should combine to ask the Legislative Assembly to repeal obnoxious clauses, we would expect the Government to say:

"Gentlemen, there is apparently a difference of opinion; you have votes, elect a council that agrees with you, and we shall be glad to carry out its desires."

So with the Medical Council. But it is claimed our Council is not elected. Well, some of it is, and if it can be clearly shown that a majority of our representatives desire something that the school men defeat; then let us go to the Government, and not till then. Meanwhile the Defence Association should limit its endeavours to influencing practitioners so that they will return representatives pledged to—no fees, triennial elections, sale of property, etc. Their platform is not so objectionable, but the urging of it upon the Legislature will weaken permanently the influence of our only elected assembly, hence the profession itself.

Two more clauses might be added to their platform:

1. Since private practitioners are not allowed to advertise, medical schools should be prevented

from sending their "hifalutin" announcements to any but their own grads. and to those who ask for them.

2. A student should be allowed to study wherever he pleases, *i.e.*, he should not be compelled to spend one session at a Canadian school, and to pay for one-half of the entire lectures. Compel him to spend so much time, if you will, and to pass all our examinations, but why protect private, money-making, quack-like advertising, profession-crowding medical schools.

M.C.P.S.

Windsor, March 1st, '93.

EPIDEMIC SKIN DISEASE.

To the Editor of *ONTARIO MEDICAL JOURNAL.*

DEAR SIR,—I am obliged by your courteous correction. No doubt, primarily, I was to blame, for there appears a footnote on page 5 of my monograph, "Mr. Hutchinson narrates an interesting epidemic which occurred in the Greenoch Parochial Asylum . . . as far back as 1888," and I ought more explicitly to have stated that this had only been discovered by inquiries set on foot subsequent to November, 1891.

By the courtesy of my professional brethren, several less marked instances of the disease, both epidemic and sporadic, have been made known to me (compare footnote, page 61 and page 64), showing that the malady existed before, although it had been confused with other skin affections and its contagiousness entirely overlooked.

It would be of great assistance in unravelling the complex facts if medical men in other countries would kindly notice small outbreaks of the disease or mild sporadic cases, and I should esteem it a favour to be made aware of any such.

Believe me to be, dear sir, yours faithfully,

THOS. SAVILL, M.D., London.

Upper Berkeley Street,

London, W., Eng., Feb. 22nd, 1893.

The Topsy of an "Uncle Tom's Cabin" troupe died recently, and bequeathed her body to the doctors, autopsy!—*Texas Siftings.*

Personals.

Dr. G. S. Ryerson was elected February 28 to the Provincial Legislature to represent the city of Toronto.

Mr. N. G. Morang, the well-known and popular manager for Canada for D. Appleton & Co., medical publishers, has opened an office at 63 Yonge street, Traders Bank.

Dr. O. R. Avison, of this city, is about to retire from practice, with the intention of going to Korea as a medical missionary to work in conjunction with Dr. Hardy.

Dr. W. Canniff has returned from a prolonged sojourn in the South. He has fully recovered his health and vigour, and has resumed practice, having opened an office on the corner of King and Yonge streets. We believe his intention is to confine himself to office work, consultations, and sanitary matters. We congratulate the Doctor on his restoration to health, and wish him every success.

Book Notices.

The Canadian Magazine.—The March number, which is the first number of the *Canadian Magazine*, is to hand. The prospectus gives Hon. J. C. Patterson, Hon. T. Ballantyne, T. Mulvey, B.A., John Ferguson, M.A., M.D., G. F. Frankland, T. H. Best, J. G. Mowat, E. Stewart, C.E., and L. Bentley, M.D., as the directors. The matter and make-up of the *Magazine* are excellent. We wish it success. It should find a place on every physician's table.

Hand-Book of Massage. By EMIL KLEEN, M.D., Ph.D., of Bohemia. Translated by E. M. Hartwell, M.D., Ph.D., of Boston. Philadelphia: P. Blakiston, Son & Co.

Probably there are few agencies at the command of the physician of greater power for good or evil than massage. In the book before us, the subject of massage is treated in a most thorough manner. It is not going beyond the truth to say that it is the most complete treatise on the question in any

language. The work covers the ground fully. The explanations of the physiological action of massage are very valuable and suggestive. To all who wish to study this subject, no better book can be found than Dr. Kleen's. It is worthy of note that the author is only a practising physician. He is not on several hospitals. Something good can therefore come from the man who does a private practice. The translation is free, and the paper and type good. J. F.

A Treatise on Diseases of the Rectum, Anus and Sigmoid Flexure. By JOSEPH M. MATTHEWS, M.D., Professor of Principles and Practice of Surgery, Kentucky School of Medicine. With six chromo-lithographs and numerous illustrations. New York: D. Appleton & Co., 1892. Canadian Branch, 63 Yonge St., Toronto

Dr. Matthews, having had a fifteen years' practice as a rectal specialist, gives the profession the benefit of his rich clinical experience in this handsome volume of about six hundred pages. Several chapters, which are new to books on this subject, are introduced, and prove to be of considerable value. They are, Disease of the Sigmoid Flexure, The Nervous Rectum, Anatomy of the Rectum in Relation to Reflexes, Antiseptics in Rectal Surgery, and A New Operation for Fistula in Ano. There is a thorough exposure of the methods of the quack rectal specialists; upon this subject the author is quite pronounced. He also quotes freely from Dr. E. Andrews, who published the origin of the carbolic acid injection treatment in 1888. This work is not a compilation; it is true the author quotes freely from others, but he always gives credit, and does not plagiarize. There is evidence of strong original work, and any physician who is not posted in rectal matters can safely put down his cash for this book, and after fully mastering the teaching, make an examination of the rectum with a degree of confidence if not with pleasure.

International Clinics. A quarterly of clinical lectures by professors and lecturers in the leading medical colleges of the United States, Great Britain and Canada. Volume IV., second series. 1893. Philadelphia: J. B. Lippincott Co., 1893.

This volume opens with an obituary of the late Henry I. Bowditch, who died Jan. 14th, 1893, at the advanced age of 84. "Dr. Bowditch's life

was a very full one, distinguished, whether we consider him as a physician, teacher, citizen, or simply as a man by his courage, simplicity, zeal, industry, and an intense interest in progress. There never was a man who more completely disregarded consequences when he felt that duty dictated action. . . . He indignantly repelled for himself and the medical profession the charge of atheism so often made against it. . . . He was always a reader and lover of the Psalms and other books of the Bible, but he 'did not believe in creeds made by men.'" Dr. James Tyson has an able lecture on "The Relation between Renal Disease and Disease of the Circulatory System." Following this is a lecture by Dr. A. L. Loomis, on "Cirrhosis of the Liver and Kidneys." The other contributors to this most excellent volume are Drs. Bristowe, T. J. Mays, W. B. Hadden, C. G. Stockton, J. M. Anders, N. Bridge, W. H. Porter, I. E. Atkinson, C. Cary, Wm. Pepper, J. P. Putnam, G. A. Gibson, C. L. Dana, W. Howard, J. W. Putnam, I. N. Danforth, L. C. Gray, Graeme M. Hammond, R. J. Godlee, G. Carpenter, J. Ashhurst, jr., W. W. Keen, R. Park, R. Able, H. R. Wharton, A. P. Gerster, V. P. Gibney, J. B. Hamilton, H. H. Mudd, F. S. Watson, J. H. Brinton, E. P. Davis, A. Routh, W. E. Ashton, A. J. C. Skene, H. C. Coe, M. D. Mann, Paul F. Mundé, W. O. Moore, T. R. Pooley, B. Robinson, G. M. Lefferts, E. F. Ingals, A. H. Ohmann-Dumesnil, and others equally well known;

Obituary.

DR. C. S. GRAFTON.

The death of Dr. C. Stewart Grafton, of Toronto, will be deeply regretted by all who knew him. During his college days he was a bright, active and industrious student. He took the degree of M.D., C.M. from the Univ. Vict. College in 1883, and the same year the L.R.C.P., Edinburgh. After spending some time in the hospitals on the continent and in London, he returned to Canada and started practice in partnership with Dr. Douglas, Port Elgin. While there he was united in marriage to Miss Douglas, his partner's daughter. He then came to Toronto and located on Spadina avenue, where he built a handsome residence and had secured a comfortable practice when he fell a vic-

tim to tuberculosis, which, despite the best medical aid and climatic treatment, proved rapidly fatal. He was highly esteemed by all who knew him, both in and out of the profession. He entered peacefully into rest on Tuesday, the 7th of March, 1893.

DR. ADDISON WORTHINGTON.

The subject of this notice was born in the county of Prescott, Ont., on the 3rd of June, 1818. He received his general education at the Academy of Plainesville, Ohio, to which state his father moved in 1824. He spent a few of his early years in school teaching, and subsequently returned to Canada to pursue his medical studies, under the late Dr. Alexander Wylie, of Dundas county, and at McGill College, Montreal. He received his license in 1851, and at once commenced practice in the county of Dundas, where he soon attained a large practice. In 1862, he moved to the county of Huron, and for nearly a quarter of a century practised in the town of Clinton. He was a man of high Christian character, and was greatly beloved by his patients in every class of society, and to the poor and distressed, he was ever a generous and sympathizing friend. He took an active interest in everything pertaining to the profession, and by his unceasing efforts and support he contributed largely to the success of the Huron Medical Association. He was elected President of the Ontario Medical Association in 1885. Aside from his profession, Dr. Worthington proved himself a highly useful citizen. He was an active promoter of the railway facilities of the county of Huron, and took a leading part in securing the construction of the Toronto, Grey and Bruce, and also the London, Huron and Bruce railways. Educational institutions found in him a warm supporter, and he was for many years a trustee of the Clinton High School. He was held in high honour in the Masonic Order, having been first master in three different lodges, and was also a member of the Royal Arch. His health began to seriously fail early in the winter, with indications of a valvular heart lesion; he, however, heroically continued in active practice until within ten days of his death, which took place on the 7th of February, precipitated by an attack of bronchitis.

He was three times married, and leaves a widow and several children to mourn their loss.

Births, Marriages, Deaths.

BIRTH.

ELLIS.—At Norwich, Ont., on Feb. 20th, the wife of Austin D. Ellis, M.B. (Aberd), of a son.

DEATH.

GRAFTON.—At the residence of his father, Jas. B. Grafton, Esq., "The Maples," Dundas, March 7th, Chas. Stewart Grafton, M.D., formerly of Toronto, aged 32.

Selections.

ANTIPYRINE IN HEADACHES.—Græme M. Hammond (*New England Medical Magazine*, February, 1893) enumerates the indications and contraindications for this drug in migraine.

1. In the angio-spastic form of the disease, antipyrine either affords no relief, or makes the condition worse. In these cases use glonoin, quinine, amyl, or alcohol.

2. In cases of migraine with vaso-motor dilatation the antipyrine is very valuable, indeed is the best agent. It should be given early in the attack.

3. In those cases of migraine, due to digestive derangements, toxic agents in the blood, or uric acid from errors in diet, this is a very effective remedy.

4. Before administering antipyrine in these cases, the heart should be carefully examined. If found weak, some stimulant and heart tonic ought to be combined with it. Digitalis and caffeine are both good. Alcohol should not be used in this connection.

5. In migraine and neuralgia of malarial origin, antipyrine is very serviceable. It has no curative action in these cases similar to quinine. It relieves the pain, but does not cure the malaria.

SURGERY OF THE GALL BLADDER.—Czerny (*Deuts. med. Woch.*) sums up in the following conclusions his views on the present position of the surgery of the gall bladder: (1) gall stones indicate operative interference when they cause repeated or persistent disturbance; (2) an operation is necessary in every case of em-

pyema of the gall bladder, and whenever troublesome symptoms are caused by simple hydrops; (3) the typical procedure in cases of calculi in the gall bladder consists in incision, emptying, and suture of this viscus, the abdominal cavity being drained for a brief period after the operation; (4) a temporary biliary fistula should be established in cases in which, with obstructed cystic duct, the gall bladder is inflamed, and its fluid contents altered in character; (5) extirpation of the gall bladder is indicated only in cases of inflammatory and of carcinomatous degeneration; (6) in cases of obstruction of the ductus choledochus, operative interference is indicated only when the patient's general condition is favourable to such treatment; if the surgeon cannot remove the obstructing body, he should establish a fistula between the gall bladder and the duodenum; (7) the best incision in operations on the gall bladder is a rectangular one, the vertical limb lying along the linea alba, the horizontal one being carried directly outwards on the right side at the level of the umbilicus; (8) the dangers of operations for gall stones are much less serious than those for the removal of stone from the urinary bladder.—*British Med. Jour.*

FATAL RUPTURE OF PYOSALPINX—SUSPECTED ABORTION.—Rochet (*Journale d'Accouchements*) recently described a case of rupture of a pyosalpinx from rough handling during the application of the curette to the uterine cavity. He adds a yet more instructive case. A female servant, aged twenty-six, was admitted into hospital, losing blood. She fancied this might be due to a miscarriage at the first month, which she believed to have occurred on the previous evening. The uterus seemed normal. A tender mass, of the size of a small egg, lay in Douglas's pouch. A few days later the patient insisted on leaving the hospital. She was therefore examined first; the mass was found smaller and less tender; at the time the examination caused no pain. Pyosalpinx was diagnosed, and the patient, instead of leaving the hospital, remained, and an enema with a dose of castor-oil was given in view of an operation. In the evening the patient became very ill. Next morning an exploratory operation was performed. Pus escaped freely when the abdomen was opened. Douglas's

pouch was laid open and drained. The patient died in a few hours. There was a judicial inquiry owing to a suspicion that she had died from attempted abortion. There was no doubt that the cause of her death was rupture of a pyosalpinx. The uterus showed signs of recent early pregnancy. There was no evidence of criminal abortion. Rupture of a pyosalpinx is no doubt the cause of many mysterious deaths after curetting, dilatation of the uterus, etc., when the uterus is dragged downwards or pushed upwards with violence.—*British Med. Jour.*

MISSED ABORTION.—Liebmann, of Buda-Pesth (*Centralbl. f. Gynak.*, from the *Arzosi Hctilap*), relates a case in which the remains of a fetus which had died *in utero* were discharged piecemeal. A 3-para suffered at the fourth month of pregnancy from a foetid sanious discharge, which lasted for two weeks; then pieces of foetal bone began to come away. The process took about seven months, with intervals corresponding to the greater or less strength of the uterine contractions. Some of the bones were discharged singly; some remained articulated and required forceps for their removal. The placenta came away four and a half months after the beginning of the abortion. The number of bones that were thus gradually delivered amounted to over seventy, and indicated that the foetus had reached the third month.—*British Med. Jour.*

PATHOLOGY OF CARCINOMA.—Dr. H. C. Coe read a paper on this subject before the New York State Medical Society. The reader introduced his paper by a reference to the great interest which had been aroused in cancer within the past five years, and the hope that its mystery would be solved by the aid of bacteriology.

Various theories have been advanced regarding its nature, many of which were fanciful, others quite suggestive. These were viewed in turn down to the latest investigations on the parasitic origin of the disease. They all contained the central idea that the disease was in the nucleus of the cell itself, the cell being really infectious. Under certain degenerative conditions the normal epithelial cell might be susceptible to external infection, perhaps by the entrance of coecydia and thus assume a

new malignant character. Metastasis was simply infection in distant localities by cells carried through the lymphatics from the parent growth. It should be carefully distinguished from direct extension of cancer to the tissues surrounding the neoplasm; this distinction was important from a surgical standpoint. Cancer was formerly regarded as a "cachexia," but this term was now rejected, the condition being simply a depreciated condition of the general system such as was present in all wasting diseases. Cancer, like tuberculosis, might be local or general.

Heredity was a factor of minor importance. Even persistent local irritation must be supplemented by some degenerative process in the epithelial cells at the point of irritation. The same applied to the cancerous transformation of benign neoplasms. The inflammatory changes *within* a cancerous tumour were essentially destructive, while those *around* it might be conservative, limiting the extension of the disease. It had been shown that outlying groups of cancer cells might be destroyed by an acute inflammatory process. The following practical deductions were made: The possibility of general or constitutional prophylaxis was purely theoretical. "Local" prophylaxis consisted in the prompt removal of a suspicious growth or tissue in the pre-cancerous stage, *i.e.*, while it was still merely suspicious—as in the case of the eroded cervix uteri. It was possible that a specific might yet be found, such as had been sought for tuberculosis, etc.

Surgically the only rule to follow was *early and complete removal* of the cancerous neoplasm, even at the risk of subsequent deformity. Since it had been demonstrated that inflammatory processes might actually destroy groups of cancer cells within adjacent healthy tissue, union by first intention might not be so desirable as has been thought. The ultimate condition of the patient was the first consideration, not the rapid and non-suppurative healing of the wound. Patients must be educated to the necessity of radical removal of the growth at its incipient stage if a radical cure is to be expected. Reference was made to Robinson's and Byrnes' results with caustics and the galvano-cautery. With regard to the palliative treatment of cancer by operations, enough praise could not be bestowed upon the results of modern surgery. With greater knowledge, increased skill and im-

proved technique, these would continue to improve. We were not justified in holding altogether pessimistic views with regard to the surgical treatment of cancer.—*Medical and Surgical Reporter.*

ICHTHYOL IN SORE NIPPLES.—Dr. Oehren (*Therapeutische Monatshefte*) recommends ichthyol in the treatment of sore nipples. He uses the following formula :

R Ichthyol.....öj.
Lanolin,
Glycerinää öj ¼.
Olive oil.....öjss.

He claims that the advantages of this salve are as follows : One application causes the pain to disappear, the fissures quickly heal without it being necessary to wean the child, or to use a protective cap. The consistence of the ointment is such that it is easily washed off after being applied, and at the same time the salve contains nothing that will harm the child.—*Medical Record.*

THE INTERNAL USE OF RESORCIN.—Menche (*Jahrb. f. Kinderh.*) reports favourably upon the use of resorcin in diarrhoea of children. It is

chiefly indicated to arrest fermentation. In this disease its use should be preceded by calomel in divided doses. If the child is in collapse or is very feeble, calomel should be omitted. Its effect in checking fermentation has, in his experience, been decided. The stools have become less frequent. In gastritis his results have been favourable.—*N. Y. Med. Journal.*

EXALGINE IN THE TREATMENT OF CHOREA.—Lowenthal (*Berlin. klinisch. Wochenschr.*) reports thirty-five cases of chorea treated by exalgine. The dose was usually about three grains a day. Occasionally fifteen grains a day were taken. The shortest duration of disease was eight days. The effect of the drug was much more distinct and favourable when its administration was begun early in the disease. In most cases the disease continued five or six weeks, but the symptoms were reduced in severity. The unpleasant symptoms were chiefly nausea, vomiting, headache, vertigo, and cyanosis. Jaundice appeared in three cases. The author does not regard exalgine as a specific in chorea.—*N. Y. Med. Journal.*

[OVER.

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The Corporation is accepted by the High Court of Justice as a TRUSTS COMPANY, under the approval of the Ontario Government, and is authorized to act as Executor, Administrator in case of Intestacy, or with Will Annexed, Trustee under Deed, Will, Court Appointment or Substitution, Receiver, Committee of Lunatics, and Custodian of the Estates and Properties of Lunatics, Guardian of Children, also as Agent for Executors, Trustees and others, thus relieving them from onerous, and oftentimes disagreeable duties.
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APPENDICITIS VERSUS TYPHILITIS.—At a recent meeting of the London Clinical Society (*New York Medical Journal*) Sir Dyce Duckworth protested against the use of the term appendicitis by one of the speakers, stating that the term was of American origin, and had not been accepted in England. He believed that inflammation of the vermiform appendix should be designated by the term typhilitis, and stated that appendicitis would not figure in the next edition of the *Nomenclature* of the Royal College of Physicians. The word appendicitis is a hybrid, and therefore objectionable. Eephyaditis is to be preferred, but appendicitis has become popular, and, with all the objection that can lie against it, it is to be preferred to typhilitis, because the latter does not mean disease of the vermiform appendix, but of the cæcum.

THE USE OF CREASOTE IN SCROFULA.—Sommerbodt (*Berlin. klinisch. Wochenschr.*) has written favourably concerning the use of creasote in tuberculosis. In this paper he speaks of its favourable action in scrofula. Full doses are necessary, small doses being of no avail. To a child of seven

years he gives one gramme per day. It may be given in capsules, if the child can take it in that form. Otherwise it is given in wine or milk. The initial dose should be very much smaller than this, the amount being increased gradually during a period of about ten days to the maximum. It is sometimes poorly tolerated by the stomach. To avoid this it should be administered immediately after meals.—*N. Y. Med. Journal.*

TREATMENT OF POST-PARTUM HÆMORRHAGE.—Tarnier (*Journ. des Sages Femmes*) strongly insists on the recognized modern treatment, namely, clearing out clots by the introduction of the hand into the uterine cavity, followed by hot water injections. At the same time he advises that a small dose of alcohol be given. Should these means fail, ergot must be administered; 7 or 8 minims of the aqueous solution of ergotinine, hypodermically, act best. If the flooding still goes on he advises, before resorting to the extremity of plugging the uterus, that an intrauterine injection of the following solution be given pure:—Tincture of iodine 30 parts, iodide of potassium 10 parts, distilled water 60 parts.—*Med. and Surg. Reporter.*

[OVER.]

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Physicians have found by personal observation that it is a reliable emulsion—probably Scott's Emulsion is prescribed more often than all other forms of cod-liver oil combined.

To tell physicians who have prescribed it why this is so, is unnecessary—to those who have never given it a test, we shall be pleased to deliver a sample free.

FORMULA: 50% of the finest Norwegian Cod Liver Oil; 6 grs. Hypophosphite of Lime; 3 grs. Hypophosphite of Soda to the fluid ounce.

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ALKALOIDS OF COD-LIVER OIL. — Bouillot (*Comptes Rendus de l'Acad. des Sciences*) communicates some physiological and clinical investigations on the action of these substances, originally separated by Gautier and Mourges, and shown by their experiments upon animals to stimulate the processes of nutrition and produce diuresis. Bouillot has proved that these results hold good also for man. He gave the alkaloids by the mouth in daily doses of from 0.15 g. to 0.25 g., with the following results. The daily amount of urine was greatly increased, the density somewhat diminished, and the urea also greatly increased. Further analyses of the nitrogenous urinary constituents were made before and after ingestion of the alkaloids, in order to determine whether this large increase of urea was due simply to increased production, or also to more complete oxidation of the less completely oxidized nitrogenous extractives. The latter proved to be the case; the incompletely oxidized nitrogenous bodies were considerably diminished after taking the alkaloids. It is thus demonstrated that these are powerful stimulants of tissue oxygenation, as Gautier and Mourges had stated. The

clinical results obtained were correspondingly satisfactory; great improvement ensuing in every case, namely, five of weak, amenorrhœic, neurasthenic girls; two of very feebly nourished children; and two of chronic bronchitis in old persons who could no longer take oil. It thus appears that these alkaloids ought to prove valuable remedies, especially where cod-liver oil cannot be tolerated. — *British Med. Jour.*

ANTISPASMIN.—This is a chemical combination of one molecule of sodium-narceine and three of salicylate of soda. It is a white powder readily soluble in water, and contains about 50 per cent. of pure narceine. The chief advantages of antispasmine are its great solubility and the purity of the narceine it contains. It is, in this respect, far superior to the other preparations of narceine which have not as yet been used in medicine, precisely because of their insolubility and variable composition. According to the investigation of the late Prof. Demme (Berne), antispasmine constitutes an excellent hypnotic and analgesic, especially in painful spasmodic affections (hence the name). It

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Gentlemen.—I hereby certify that I have made an analysis of sample of "Almoxia Wine" received from you, and find it to be a very good wine for medicinal use; containing a considerable amount of Salts of Iron, and free from injurious colouring matter of any kind, or excess of acid.

The analysis gave as follows:

Specific Gravity	- - - - -	1034	Volatile acid	- - - - -	.02
Alcohol	- - - - -	12.28	Fixed acid	- - - - -	.07
Extractive matter	- - - - -	2.28	Ethers	- - - - -	.10
Sugar	- - - - -	8.34	Ash	- - - - -	.65

Salts of Iron in ash is equal to very nearly half a grain per ounce of wine.

Yours truly,
(Signed) THOMAS HEYS,

Consulting Chemist.

N.B.—Almoxia is a department of a Province in Spain, near Malaga, located at Latitude 36.49 N., Longitude 4.32 W. The land where these vines are cultivated is remarkable for its FERRUGINOUS properties, which gives to the wine natural Salts of Iron, as indicated in the above Analysis.

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is said not to be associated with the same risk in children as other opium preparations, and therefore deserves a high place in the treatment of infantile diseases. It is also said to be very serviceable in whooping-cough, and to ease cough generally, in children as well as in adults. The death of Prof. Demme has unfortunately interrupted these researches. The following were his favourite formulæ for the administration of antispasmine. For whooping-cough and laryngismus stridulus in children :

R Antispasmine gr. xxiv.
Cherry-laurel water ʒss.

Sig.—Fifteen drops once or twice a day in sugar and water.

For cough in adults :

R Antispasmine gr. viij.
Cognac ; Syrup of Mulberries ;
Distilled Water aa. ʒj.

M.—A tablespoonful three times a day.

—*The Medical Week.*

VERMIFORM APPENDIX CONTAINING A FOREIGN BODY FOUND IN A HERNIA.—H. Schmidt (*Munch Med. Woch.*) says the vermiform appendix is rarely found within a hernia, but few cases having ever been recorded in medical literature. The author reports one case—a woman aged fifty-three, who had a right inguinal hernia of recent origin, which became inflamed, and after a few weeks opened and discharged blood, pus, and fecal matter. During the operation Schmidt found a hernia sac in which was caught a vermiform appendix—along the side of this a sound could be readily passed into the abdominal cavity. The hernial sac was removed and its opening closed. Complete recovery. Close examination of the removed vermiform appendix disclosed the presence of a large black pin.—*Med. and Surg. Reporter.*

PULMONARY PHTHISIS—(MASCHE) :

Eucalyptol 20 parts
Creosote 8 parts
Alcohol 90% 72 parts

One to two teaspoonfuls in a pint of water. Use as inhalation.—*L'Union Med. du Canada.*

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The following is taken from the *Lancet*, of February, 1892:—

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Miscellaneous.**NEW INVENTION.**

To the Editor of ONTARIO MEDICAL JOURNAL.

DEAR SIR,—Through your journal we wish to introduce to the medical profession, an instrument we have recently invented, having several new and useful features.

This instrument answers two purposes. First—It removes the weight from an inflamed or diseased knee joint, enabling the patient to take regular exercise. Secondly—It counteracts any contraction that has taken place, and the knee is gradually straightened as the inflammatory action subsides.

With this instrument the surgeon in charge can apply extension sufficient to remove a portion, or if desired, the entire weight of the body off the affected joint, and at the same time bring pressure to bear to counteract the contraction that has taken place. The first of these instruments we made was a pair for a patient of one of the leading surgeons of this city ; a lady, who for eighteen months,

previous to our fitting her had not been able to stand up, owing to her knees having become thickened and crooked from the effects of inflammatory rheumatism. We also applied one to a young lady. This case was one of five years' standing, and so severe was the inflammatory action that a surgeon to whom she applied advised amputation. On the 17th of last month her physician wrote to us, that this young lady is well, and developing to a natural condition, and that the great benefit derived from the instrument has attracted widespread interest.

This instrument consists of a foot-piece securely fastened to the boot, having two upright steel bars, jointed at the knee and ankle, with two padded bands, one above the ankle and the other below the knee. These two bars are continued up the thigh and are secured to two steel plates by four cleats. These plates are fastened to the leather thigh. The upper part of this leather is accurately fitted under the tuberosity of the ischium and perineum, so that the patient can rest on it comfortably, the same as on an artificial leg.

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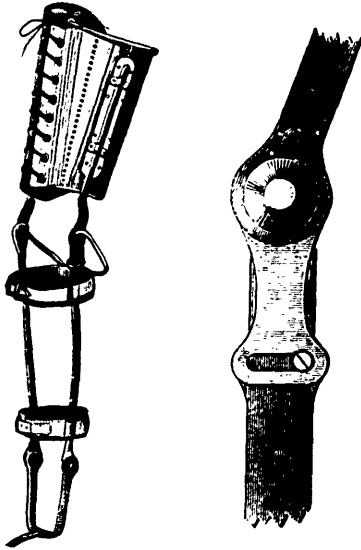
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allow the patient to bend the knee on sitting down, when desired. By this means a constant extension can be secured and the joint have the desired rest. When the inflammation has sufficiently subsided, and the surgeon desires to commence straightening the limb, he can do so by sacking the two screws shewn in the slots below the knee (a section of this joint is shewn so as to be better understood), and



then apply gentle pressure until the limb is as straight as the patient can bear with comfort. This can be repeated until the limb has become quite straight.

These instruments, it is true, are high priced, but they are cheaper than an artificial leg, and are much preferred by the patient.

We know by experience that if these instruments were more generally used, many who to-day are wearing artificial limbs, would be wearing their natural ones.

We submit the instrument to the medical profession of Canada for the benefit of their patients. We do not intend taking out any patents, willing that it should be freely used by the profession in any case they may desire to do so. All we ask is that it should be known as Authors & Cox Combination Knee Splint.

Respectfully yours,

AUTHORS & COX.

Toronto, March 11th, 1893.

Liebig says: "The vivifying agency of the blood must ever be considered to be the most important condition in the restoration of a disturbed equilibrium. The blood, therefore, must be constantly considered and kept in view as the ultimate and most powerful cause of a lasting vital resistance, as well in the diseased as in the normal portions of the body."

Purity of the blood is thus recognized by Liebig as a vital necessity, if it is to be able to vivify the body. Purity of the blood depends upon the due performance of those functions that furnish it with the proper material to replace those portions exhausted by use. Said material is supplied by the food taken, properly *assimilated* or digested.

Vegetables, including bread, enter most largely into the average diet of the human, and as this class of food contains a large amount of starch, it is of first importance that *all* this starch is converted from an insoluble, innutritious body to a soluble and nutritious one. As you well know, this is intended by nature to be accomplished by a peculiar ferment, *Ptyalin*, contained in the saliva, which has intense activity and if in a healthy state changes starch into sugar or maltose, which is always the result of starch hydrolyzed by either the ferment of the saliva or the pancreas. These sugar products are easily absorbed, and have besides important physiological significance. Schiff states that when the albumen of egg, or other insoluble food, was given to fasting animals, no digestion took place, as no pepsine was secreted; but if certain soluble foods were given at the same time, pepsine was produced and digestion took place.

Ptyalin, or Diastase, is readily absorbed and diffused, and there are strong reasons for believing that it goes with the starchy food through the alimentary tract, to complete its action and expend its force, as is shown in the fæces after taking *Morse's Diastase*.

Mr. Hazen Morse, of International Bridge, Ontario, desires to hear from the profession regarding his preparations of malt, viz.: Diastase plain, Diastase with Essence of Pepsine, and Diastase Ferrated. These preparations are made from the finest Canada malt, four times more concentrated than the ordinary syrups of malt, yet of the density of ordinary fluid extracts, and containing diastase in a normal and highly active state, with very little maltose, and as digestive aids have no equal. Samples furnished upon application.

A SYSTEM OF
GENITO-URINARY
DISEASES,
SYPHILOLOGY,
AND
DERMATOLOGY.

EDITED BY
PRINCE A. MORROW, M. D.

SOLD ONLY BY SUBSCRIPTION.

D. APPLETON & CO., PUBLISHERS,
1, 3, & 5 BOND ST., NEW YORK.

THIS System, composed of articles written by physicians and surgeons who occupy the highest positions in their respective specialties, consists of three volumes, which are divided as follows :

*Vol. I. DISEASES OF THE GENITO-
URINARY ORGANS.*

Vol. II. SYPHILOLOGY.

Vol. III. DERMATOLOGY.

The genius of modern medical literature is clearly in the direction of division of labor and associated effort. The marked favor with which the numerous "Systems" and "Cyclopædias" which have appeared in recent years have been received by the profession would seem to show that the composite treatise represents the ideal method of bookmaking. In fact, co-operation is the essential condition of thoroughness and completeness in a work covering a wide range of subjects.

The field of research in every department of medicine has grown so large that it is hardly possible for any one individual to carefully sift from the mass of new material accumulated by the great body of workers the facts and opinions which represent a distinct advance in our knowledge, and have a definite and permanent value.

Especially is this true of the three associated departments of general medicine and surgery embraced in this System. The evolutionary requirements of these specialties demand a new and standard work which shall embody the numerous and important

additions made to our knowledge of the subjects they embrace, and at the same time be sufficiently comprehensive to serve as a compendium of reference.

The editor has sought to attain this object by enlisting the co-operation of distinguished specialists, each of whom has been selected for his special fitness to write on the subject assigned, and which has been, as far as practicable, the subject of his choice. Especial effort was made, by clearly defining the ground each article was to cover, to avoid overlapping of subjects and useless repetition, and at the same time secure an organic unison of the completed work, thus making it, as nearly as possible, as coherent and connected as if written by one individual.

The articles are all of the most practical character, and appeal directly to the needs of the GENERAL PRACTITIONER, to whom they will be found to be of the greatest value; as they are epitomes of all that is known on the respective subjects up to the date of the issue of the work.

In each volume will be found material not ordinarily included in any text-book on the subjects which form the basis of the System; as, for instance, in Volume I, such chapters as those on Functional Disorders of Micturition and their Relation to Various Morbid States, the Diagnostic Significance of Pathological Modifications of the Urine, Urine Analysis, Uro-genital Tuberculosis; and in addition, the complete and elaborate monographs on Endoscopy and Cystoscopy.

A glance at the contents of Volumes II and III, which are herewith appended, will show a like departure from the plan of the ordinary text-book; and the list of contributors to these volumes is all that is needed to convince the reader that the same care has been exercised in their selection as is apparent in Volume I.

The grouping of Genito-urinary Diseases, Syphilis, and Dermatology as proper subjects of associated study had its origin in this country, and it seems eminently fitting that the fruitful results of this idea should be presented by American writers.

ILLUSTRATIONS form a prominent feature of the work, being employed wherever necessary to elucidate the text; each volume containing a large number, including several chromo-lithographs. The make-up of the System in all its mechanical features is commensurate with the intrinsic value of the articles which compose it and the publishers are confident that, as offered to the profession, the work will fully meet the requirements of both physicians and surgeons.

The following is a list of contributors, with the titles of articles furnished by each:

VOLUME I. GENITO-URINARY DISEASES.

ANATOMY AND PHYSIOLOGY OF THE GENITO-URINARY ORGANS.

By **GEORGE WOOLSEY, M. D.**, Professor of Anatomy and Clinical Surgery in the Medical Department of the University of the City of New York; Surgeon to Bellevue Hospital, etc.

Kidneys. Ureters. Urinary bladder. Prostate gland. Penis. Urethra. Male perineum. Scrotum. Testicles: Spermatic cord.

DISEASES OF THE PENIS.

By **RAMON GUITERAS, M. D.**, Surgeon to the City Hospital, New York, Venereal Department; Physician to the Skin Department, University Dispensary.

Abnormalities of the penis. Injuries to the penis: Wounds of the penis; Fracture of the penis; Dislocation of the penis. Cutaneous affections. Lymphatic affections of the penis: Erysipelas of the penis; Gangrene of the penis. Tumors of the penis: Elephantiasis of the penis; Epithelioma of the penis—Methods of amputation. Morbid conditions of the prepuce: Phimosis—Circumcision; Paraphimosis. Diseases of the glans and prepuce: Balanitis and balanoposthitis; Herpes progenitalis; Diabetic balanoposthitis; Verrucae. Diseases of the corpora cavernosa: Acute inflammations; Chronic inflammation; Bony and calcareous plates; Gummata of the corpora cavernosa.

DISEASES AND INJURIES OF THE URETHRA.

By **F. TILDEN BROWN, M. D.**, New York.

Malformations of the urethra: Absence and complete obliteration of the urethra. Congenital atresia of the urethra. Congenital strictures of the urethra. Congenital diverticula of the urethra or urinary pouches. Hypospadias: Balanic or glandular hypospadias; Penile hypospadias; Perineal hypospadias; Operative treatment. Epispadias: Glandular epispadias; Epispadias of the penis, Operative treatment. Urethral and periurethral abscess. Urethral ulcer and erosion. Urethral neoplasms: Urethral initial syphilis; Urethral cancer; Urethral vegetations and polypi. Wounds and lacerations of the urethra inflicted from without: Rupture of the urethra. Wounds and lacerations of the urethra inflicted from within. Urethral fistulae—Urethroplasty.

ETIOLOGY OF URETHRITIS.

By S. LUSTGARTEN, M. D., Dermatologist to Mount Sinai Dispensary, New York ; formerly "Privat-Doцент" on Skin and Venereal Diseases, Imperial Royal University, Vienna.

Infectious urethritis. Gonorrhœa: The gonococcus Neisser; Staining methods; Diagnostic value of the gonococcus. Pseudo-gonorrhœa. Syphilitic urethritis. Urethritis tuberculosa. Noninfectious urethritis.

ACUTE URETHRITIS.—GONORRHŒA.

By GEORGE EMERSON BREWER, M. D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons, New York.

Varieties; Clinical history; Treatment. Complications of urethritis: Posterior urethritis; Epididymitis; Periurethral inflammation; Folliculitis; Cowperitis; Prostatitis; Vesiculitis; Cystitis; Pyelitis; Balanitis; Phimosis; Paraphimosis; Lymphangitis and adenitis.

CHRONIC GONORRHŒA OR GLEET.

By WILLIAM K. OTIS, M. D., New York.

Local treatment: Injection; Suppositories; Endoscopic treatment; Drainage; General treatment.

ENDOSCOPY.

By HERMANN G. KLOTZ, M. D., Consulting Surgeon to the German Hospital, New York.

Development of the endo-scope. Endoscopic armamentarium. Method of examination. The endoscopic picture. Normal appearance of the urethra. Pathological appearances. Endoscopic diagnosis. Endoscopic treatment.

GONORRHŒAL OPHTHALMIA.

By JOSEPH A. ANDREWS, M. D., Ophthalmic Surgeon to the Charity Hospital, New York.

Symptoms; Treatment. Ophthalmia neonatorum.

GONORRHŒAL RHEUMATISM.

By FRANK HARTLEY, M. D., Surgeon to the New York Hospital.

Acute monarticular gonorrhœal rheumatism. Chronic monarticular gonorrhœal rheumatism, hydrarthrosis, gonocœle. Polyarticular acute gonorrhœal rheumatism. Polyarticular subacute gonorrhœal rheumatism. Polyarticular chronic gonorrhœal rheumatism.

GONORRHŒA OF THE RECTUM, NOSE, MOUTH, EAR, UMBILICUS, AND AXILLA.

By JAMES P. TUTTLE, M. D., Professor of Diseases of the Rectum, New York Polyclinic.

Gonorrhœa of the rectum: Mucous membranes susceptible to gonorrhœa; Mucous membranes refractory to gonorrhœa. Gonorrhœa of the nose. Gonorrhœa of the mouth. Gonorrhœa of the axilla, ear, and umbilicus.

STRICTURE OF THE URETHRA.

By J. WILLIAM WHITE, M. D., Professor of Clinical Surgery in the University of Pennsylvania; Surgeon to the University and German Hospitals, Philadelphia.

Congenital stricture. Acquired stricture: Inflammatory stricture; Spasmodic stricture; Organic stricture; Traumatic stricture—Character of stricture, Location of stricture, Changes in the urethra; Symptoms of stricture—Results, of stricture; Treatment of stricture: 1, Gradual dilatation—Catheterism; 2, Internal urethrotomy—Internal urethrotomy in children; 3, External urethrotomy—Combined internal and external urethrotomy. Perineal section: Retrograde catheterization, Drainage after external urethrotomy and perineal section, Excision, Excision with transplantation of mucous membrane, Electrolysis, Divulsion, Overdistention, Cauterization; Stricture of the female urethra.

DISEASES OF THE PROSTATE.

By W. T. BELFIELD, M. D., Professor of Bacteriology, Rush Medical College, Chicago, Ill.

Wounds of the prostate. Acute prostatitis. Chronic inflammation of the prostate and appendages, including chronic prostatitis, prostaticorrhœa, prostatic abscess, and pelvic abscess; Tumors of the prostate. Hypertrophy of the prostate: Complications. Operative treatment of prostatic enlargement: Modes of operation; Prostatectomy. Hypertrophy of the prostatic sphincter. Papilloma of the prostate. Cancer of the prostate. Cysts of the prostate.

THE FUNCTIONAL DISORDERS OF MICTURITION.

By JOSEPH D. BRYANT, M. D., Professor of Anatomy and Clinical Surgery and Associate Professor of Orthopedic Surgery, Bellevue Hospital Medical College, Surgeon to Bellevue and St. Vincent's Hospitals in New York.

Physiology of urination. Abnormal urination: Retention of urine; Overflow of urine; Irrepressible micturition; Urgent micturition; Difficult micturition; Incontinence of urine; So-called false incontinence; Involuntary micturition. Painful micturition: Diagnostic significance of painful urination; Diagnostic significance of force, size, form, and direction of the stream.

DIAGNOSTIC SIGNIFICANCE OF PATHOLOGICAL MODIFICATIONS IN THE URINE (INCLUDING THE MOST PRACTICAL METHODS OF URINE ANALYSIS).

By EUGENE FULLER, M. D., New York.

General characteristics of the urine. Chemical constituents of the urine subdivided as follows: *a*, The normal chemical constituents; *b*, Those that are normal only when present in very small amounts, abnormal when abundant; *c*, Products of chemical decomposition of normal ingredients; *d*, The abnormal chemical constituents—Albumen, Quantitative estimation, Sugar, Fermentation test. Organized sediments—Casts, Pus, Blood. Miscellany—Bacilli.

URINARY FEVER.

By J. A. FORDYCE, M. D., Lecturer on Dermatology, New York Polyclinic; Surgeon to the City Hospital.

Acute urethral fever; Chronic urinary fever. Etiology. Pathogenesis. Treatment.

ON CYSTOSCOPY.

By **WILLY MEYER, M. D.**, Surgeon to the German Hospital and the Skin and Cancer Hospital, New York.

History. Instruments: The batteries. The employment of the cystoscope: Possible dangers in using the cystoscope; Rules for performing cystoscopy; Cystoscopic appearance of the healthy bladder; Cystoscopic appearance of the diseased bladder. Cystoscopy with reference to kidney diseases. Catheterization of the ureters.

THE CYSTITES.

By **SAMUEL ALEXANDER, A. M., M. D.**, Professor of Genito-urinary Surgery, Dermatology, and Syphilology, Bellevue Hospital Medical College; Surgeon to Bellevue Hospital.

Sensibility of the bladder. The physiology of congestion: Description of the lesions; The superficial cystites; The interstitial cystites; The productive cystites; Pathology of local infection of the bladder. Conditions which favor local infection of the bladder. Clinical causes of cystitis. Symptomatology. General and operative treatment. Indications and choice of operation.

INJURIES AND DISEASES OF THE BLADDER.

By **GEORGE RYERSON FOWLER, M. D.**, Surgeon to St. Mary's Hospital and the Methodist Episcopal Hospital, Brooklyn, N. Y.

Wounds of the bladder: Contusion of the bladder. Foreign bodies in the bladder. Malformations and malpositions of the bladder: Absence of the bladder; Multiple bladder; Congenital exstrophy of the bladder; Congenital defects of the posterior bladder wall; Patent urachus; Hernia of the bladder. Other abnormalities of the bladder: Hypertrophy of the bladder; Inversion of the bladder; Atrophy of the bladder; Sacculated bladder; Bar at neck of bladder; Suprapubic vesical puncture in obstructive disease at the vesical neck; Fissure of the neck of the bladder. Puncture of the bladder.

RUPTURE OF THE BLADDER.

By **ALEXANDER W. STEIN, M. D.**, Surgeon to the Charity Hospital, New York.
Location. Character of lesions. Treatment: Cystorraphy.

TUMORS OF THE BLADDER.

By **FRANCIS SEDGWICK WATSON, M. D.**, Assistant Visiting Surgeon, Boston City Hospital; Instructor in the Surgery of the Genito-urinary Organs, Harvard Medical School; Assistant in Clinical Surgery, Harvard Medical School.

Pathology and etiology of bladder tumors. Papilloma. Myxoma (*Polypt*). Myoma. Cysts. Carcinoma: Symptoms and diagnosis—The cystoscope, Palliative treatment. Operative treatment of benign growths. The suprapubic operation—A new means to assist in the removal of intravesical growths through a suprapubic cystotomy; Partial resection of the symphysis pubis. Operative treatment of bladder tumors in the female. Ultimate results of operation for the removal of benign growths. Treatment of malignant growths. Drainage for relief in malignant disease. Resection of the bladder. Sarcoma. Extirpation of the bladder in the female.

STONE IN THE BLADDER.

By ARTHUR T. CABOT, M. D., Surgeon to the Massachusetts General Hospital ;
Lecturer on Genito-urinary Surgery, Harvard Medical School.

Definition. Chemical and physical characteristics : Color ; Consistence ; Shape ; Number ; Surface ; The spontaneous fracture of stones. Etiology : Heredity ; Diet and habit ; Diathesis ; Alkaline fermentation. Symptomatology. Diagnosis. The operation of sounding ; Exploration with litholapaxy-pump ; Examination with the cystoscope ; Digital exploration of the bladder ; Exploration through suprapubic openings ; Preventive treatment ; Solvent treatment of stone. The operative treatment of stone ; History. Choice of operation. Interference with the functions of the parts. Description of the different operations : Perineal lithotomy—lateral operation—instruments required. Completeness of cure following the different methods of operating. Selection of operation. Complications which may modify our choice of operation. Preparation for operation. Lithotripsy : History and development. Litholapaxy : The operation ; Complications which may arise during litholapaxy ; Complications after operation ; Treatment after litholapaxy. Lithotomy : Perineal lithotomy. Anatomical consideration of the various incisions : Lateral lithotomy ; Bilateral lithotomy ; Median lithotomy ; Medio-bilateral lithotomy ; Accidents and complications during operation. Complications which may arise subsequently. Wound complications. Bilateral operation. Median operation : Perineal lithotripsy ; Suprapubic lithotomy ; The after-treatment of the suprapubic wound ; Accidents and complications in suprapubic lithotomy. Stone in the female bladder : Operative treatment—Vaginal lithotomy. Prostatic calculi. Stone in the urethra. Stone in the ureter—Symptomatology, Diagnosis, Treatment.

THE SURGICAL DISEASES OF THE KIDNEY.

By LEWIS A. STIMSON, M. D., Professor of Surgery in the University of the City
of New York ; Attending Surgeon to the New York, Bellevue, and Chambers
Street Hospitals.

Wounds and injuries of the kidney : Traumatism of the kidney ; subcutaneous injuries of the kidney ; Gunshot wounds ; Incised wounds ; Open wounds ; Subcutaneous lacerations and ruptures. Nephrolithiasis—gravel—kidney stone : Chemical composition ; Nephrolithotomy ; nephrectomy. Pyelitis, pyelonephritis, pyonephrosis, nephritis, tuberculosis : A, Pyelitis, pyelonephritis, tuberculosis ; B, Primary suppurative nephritis—gangrene of kidney. Perinephritis, perinephritic abscess : 1, Primary perinephritis—*a*, Traumatic ; *b*, Spontaneous. 2, Secondary perinephritis—*a*, Due to a general cause (infectious perinephritis) ; *b*, Due to a local cause (perinephritis by extension). Renal and perinephritic fistulae. Hydronephrosis. Cysts of the kidney : 1, Isolated cysts ; 2, Conglomerate cysts, or cystic degeneration, or large polycystic kidney ; 3, Hydatid cysts. Solid tumors of the kidney : A, Malignant tumors ; B, Benign tumors. Displaced kidney—movable kidney. Operations upon the kidney : The lumbar incision ; The longitudinal incision ; The transverse incision. Nephrotomy ; Nephrolithotomy ; Nephrectomy ; Nephrorrhaphy or nephropexy.

TUBERCULOSIS URO-GENITALIS.

By JOHN P. BRYSON, M. D., Professor of Genito-urinary Surgery, St. Louis
Medical College, Washington University.

Definition—Varieties. Avenues of infection—Heredity. General diagnosis. Primary renal tuberculosis. Differential diagnosis of primary renal tubercle in early stage and renal stone in early stage—Surgical interference. Tuberculosis of the bladder : Symptoms and diagnosis ; Cystoscopy. Tuberculosis of the seminal vesicles. Tuberculosis of the prostate : Symptoms and diagnosis. Tuberculosis of the urethra. Tuberculosis of the testis and cord.

DISEASES OF THE SCROTUM.

By CHARLES W. ALLEN, M. D., Surgeon to the City Hospital, Genito-urinary Department; Attending Physician to Bellevue Hospital, Outdoor patients, Genito-urinary Department; Clinical Assistant to the Chair of Genito-urinary and Venereal Diseases, University Medical College.

Anomalies; Atrophy; Hypertrophy; Abscess; Injuries; Fungus of the scrotum; Oedema. Emphysema. Skin diseases: Eczema; Pruritus; Pediculosis; Dermatitis; Molluscum contagiosum; Sebaceous cysts; Erysipelas. Elephantiasis of the scrotum. Tumors of the scrotum: Cystic tumors; Hæmatoma; Angeioma or vascular tumor; Fibroma; Epithelioma; Tuberculosis.

DISEASES OF THE TESTICLE.

By JAMES BELL, M. D., Associate Professor of Clinical Surgery, McGill University; Surgeon to the Montreal General Hospital.

Hæmatocele: Hæmatocele of the cord; Free bodies in the tunica vaginalis. Anomalies of the testicle: Absence of the testicle; Supernumerary testicles; Hypertrophy of the testicle; Atrophy of the testicle; Seat of the testicle—Misplaced testicles; Retraction of the testicle; Injuries of the testicle.

DISEASES OF THE TESTICLE.

By EDWIN C. BURNETT, M. D., Chief of Clinics of Skin and Venereal Diseases, St. Louis Medical College.

Acute orchitis. Epididymitis: Etiology. Chronic orchitis: Etiology. Chronic epididymitis: Syphilitic sarcocele; Fungus of the testicle.

DISEASES OF THE TESTICLE.

By JOHN P. BRYSON, M. D., St. Louis, Mo.

Cystoma testis. Dermoid cysts of the testis and scrotum. Solid tumors of the testicle: Enchondroma; Fibrous tumors of the testis; Calcareous masses; Carcinoma of the testis; Sarcoma of the testis. Excision of the testis. Irritable testis.

HYDROCELE AND SPERMATOCELE.

By JOHN A. WYETH, M. D., Professor of Surgery, New York Polyclinic; Visiting Surgeon to Mount Sinai Hospital, New York;

And W. W. VAN ARSDALE, M. D., Adjunct Professor of Surgery, New York Polyclinic; Assistant Surgeon, New York Cancer Hospital.

Acute hydrocele. Chronic hydrocele: Periorchitis proliferata, Periorchitis adhesiva, Periorchitis hæmorrhagica; Hydrocele communicans; Hydrocele of the spermatic cord; Diffuse hydrocele of the cord; Bilocular hydrocele; Multilocular hydrocele—Complications of hydrocele; Differential diagnosis of the various forms of hydrocele and their complications. Spermatocele.

VARICOCELE.

By EDWARD L. KEYES, M. D., Consulting Surgeon to Bellevue and Charity Hospitals, New York.

Symptoms. Diagnosis. Treatment. The operation. Ablation of the scrotum.

DISEASES OF THE SEMINAL VESICLES.

By PAUL THORNDIKE, M. D., Surgeon to Out-patients, Carney Hospital, Boston ;
Surgeon to Genito-urinary Department, Boston Dispensary.

Anatomy. Physiology. Injuries; Fistulæ. Tumors; Malignant disease; Sarcoma; Cysts. Spermatic colic. Inflammation. Tuberculosis. Radical operation for the removal of a tubercular seminal vesicle.

FUNCTIONAL DISORDERS OF THE MALE SEXUAL ORGANS.

By PRINCE A. MORROW, M. D., Clinical Professor of Genito-urinary Diseases,
University of the City of New York ; Surgeon to Charity Hospital.

Spermatorrhœa: Nocturnal pollutions; Diurnal pollutions; False spermatorrhœa; Pathological significance—Masturbation, Sexual excess; Continence—Course of spermatorrhœa, Local effects, Constitutional effects; Treatment. Impotence: Physiology of erection; Organic impotence; Psychological impotence—Relative impotence; Irritable impotence; Paralytic impotence; Treatment. Sterility: Physiological characters of the semen; Pathological modifications; Aspermia—Relative aspermia, Temporary aspermia; Oligospermia; Oligozoöpermia; Azoöpermia; Chromospermia—Hæmatospermia; Treatment.

GONORRHŒA IN THE FEMALE.

By ANDREW F. CURRIER, M. D., Assistant Gynæcologist to Skin and Cancer
Hospital; Attending Gynæcologist, Bellevue Hospital Outdoor patients
Department.

History; Variety of forms; Vulvitis; Bartholinitis; Vaginitis—Senile vaginitis; Urethritis; Endometritis; Salpingitis; Ovaritis; Peritonitis. Complications: Condylomata; Enlarged inguinal glands; Gonorrhœa of nose and mouth; Gonorrhœa of anus and rectum; Gonorrhœal arthritis; Cystitis; Syphilis and chancroid; Relation of gonorrhœa to sterility; Treatment.

Volume II. SYPHILOLOGY.

SYPHILIS.—HISTORY, GEOGRAPHICAL DISTRIBUTION.

By J. NEVINS HYDE, M. D., Chicago.

General considerations respecting the clinical features, course, and stages of syphilis. General pathological anatomy.

ETIOLOGY OF SYPHILIS.

By JOHN A. FORDYCE, M. D., New York.

The syphilitic poison. Micro-organisms as a cause of syphilis. Sources of syphilitic contagion. Vehicles of contagion. Syphilis in animals.

MODES OF INFECTION.

By L. DUNCAN BULKLEY, M. D., New York.

Direct contact. Mediate contagion. Hereditary transmission. Syphilis insontium. Susceptibility to the syphilitic poison.

THE PRIMARY AFFECTION.

By EDWARD B. BRONSON, M. D., New York.

Incubation of the chancre. Varieties of initial scleroses: Number, Seat, Clinical characters. Induration of the lymphatics and ganglia. Diagnosis.

CONSTITUTIONAL SYPHILIS.

By JOSEPH ZEISLER, M. D., Chicago.

Secondary incubation. Prodromata. State of the blood. Syphilitic fever. Affections of the ganglia. Cachexia. Chloro-anæmia, and other constitutional states. Influence of syphilis upon traumatism.

SYPHILITIC AFFECTIONS OF THE SKIN.

By PRINCE A. MORROW, M. D., New York.

Varieties. Clinical features. Diagnosis, etc., of the syphilides.

SYPHILIS OF APPENDAGES OF THE SKIN.

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Hair and nails.

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Mouth and tongue.

SYPHILIS OF NOSE, LARYNX, AND TRACHEA.

By JOHN N. MACKENZIE, M. D., Baltimore.

SYPHILIS OF THE VISCERA.

By WILLIAM T. COUNCILMAN, M. D., Baltimore.

General visceral syphilis. Syphilis of the placenta. Stomach. Intestines. Heart. Blood-Vessels. Lungs. Liver. Spleen. Pancreas.

SYPHILIS OF THE RECTUM AND ANUS.

By JAMES P. TUTTLE, M. D., New York.

SYPHILIS OF THE GENITO-URINARY ORGANS OF BOTH SEXES.

By EUGENE FULLER, M. D., New York.

Kidney. Penis. Testicle and cord. Vesiculæ seminales and prostate. Uterus and vagina.

SYPHILIS OF THE NERVOUS SYSTEM, ACQUIRED.

By B. SACHS, M. D., New York.

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Dactylitis syphilitica.

SYPHILIS OF THE EYE AND ITS APPENDAGES.

By CHARLES STEDMAN BULL, M. D., New York.

SYPHILIS OF THE EAR.

By J. ORNE GREEN, M. D., Boston.

HEREDITARY SYPHILIS.

By FREDERICK R. STURGIS, M. D., New York.

Invasion. Evolution. Eruptions on skin and mucous membranes. Affections of various organs.

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By W. N. BULLARD, M. D., Boston.

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AFFECTIONS OF THE EYE IN HEREDITARY SYPHILIS.

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AFFECTIONS OF THE EAR IN HEREDITARY SYPHILIS.

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DIAGNOSIS AND PROGNOSIS OF SYPHILIS.

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PROPHYLAXIS AND TREATMENT OF SYPHILIS.

By J. WILLIAM WHITE, M. D., Philadelphia.

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By EDWARD MARTIN, M. D., Philadelphia.

Chancroidal poison. Nature. Source. Seat. Varieties. Clinical features. Course. Diagnosis. Prognosis. Treatment.

COMPLICATIONS OF CHANCROID.

By EDWARD MARTIN, M. D., Philadelphia.

Inflammation. Phagedæna. Mixed chancre. Simple and virulent bubo. Lymphitis, simple and virulent. Treatment.

Volume III. DERMATOLOGY.**PART I.—GENERAL.****ANATOMY AND PHYSIOLOGY OF THE SKIN.**

By LOUIS HEITZMANN, M. D., New York.

SEMEIOLOGY.

By PRINCE A. MORROW, M. D., New York.

Objective symptoms. Elementary lesions: Primary, Secondary, Special. General symptoms. Subjective symptoms.

ETIOLOGY.—PATHOLOGY AND DIAGNOSIS.

By WILLIAM A. HARDAWAY, M. D., St. Louis.

TREATMENT.—CONSTITUTIONAL, LOCAL.

By HENRY G. PIFFARD, M. D., New York.

CLASSIFICATION.**PART II.—SPECIAL.**

Hyperidrosis. Sudamen. Anidrosis. Bromidrosis. Chromidrosis. Uridrosis. Miliaria. Furunculus. Anthrax simplex. Anthrax maligna. Phlegmona diffusa. Ulcus. Equinia. Adenoma sebaceum. Adenoma sudoriparousum. Rhino-scleroma. Actino-mycosis.

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