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THE

Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XIV. HALIFAX, NOVA SCOTIA, MAY, 1902. No. 5.

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(*b*) LABORATORY AND SPECIAL DEMONSTRATIONS.

These demonstrations are given daily from 10.30 to mid-day, and will consist of one or more of the following: Modern treatment of Tuberculosis, Prof. Finley; Operative Midwifery, Prof. J. C. Cameron; Mental Diseases, Dr. Burgess; Medico-Legal and Sanitary Topics, Prof. Wyatt Johnson; Clinical use of Roentgen Rays, Prof Girdwood; Demonstration of the actions of certain important and new drugs, Dr. J. T. Halsey; Medical and Surgical Anatomy, Drs Springle, Henderson and Tait McKenzie; Clinical Chemistry and Urinalysis, Prof. Ruttan; Morbid Anatomy of certain diseases. Prof. Adami and Dr MacTaggart; Treatment of Diarrhœal Diseases of Infancy, Prof Blackadar; Treatment of deformities, Dr. Tait McKenzie; Medical Examination for Life Insurance, Prof. Wilkins.

(*c*) MEDICAL AND SURGICAL CLINICS.

For four days each week during the first two hours of the afternoon, there are clinics on groups of cases in the wards of the Montreal General and Royal Victoria Hospitals. Those given in the Medical Wards of the Montreal General Hospital are given by Profs. Blackadar, Finley and Lafleur, in the Surgical Wards by Prof. Shepherd and Dr. Elder; in the Royal Victoria Hospital Medical Wards, by Prof. Stewart, Prof. C. F. Martin and Dr. Hamilton; in the Surgical Wards by Prof. Bell and Dr. Garrow. In addition two or three ward classes are given weekly.

(*d*) CLINICS IN SPECIAL DEPARTMENTS OF MEDICINE AND SURGERY.

One or more of these clinics are given in the Hospitals each afternoon after the regular Medical and Surgical Clinic, and during the entire afternoon on Wednesday and Saturday of each week, the following special Clinics are given: Ophthalmology, including demonstrations of the use of Ophthalmoscope in the Royal Victoria Hospital by Prof. Buller and Dr. Byers; in the Montreal General Hospital by Dr. J. J Garöner and Dr. Sterling; Dermatology, Prof. Shepherd; Genito-Urinary Surgery, Prof. Bell; Orthopedics, Dr. C. W. Wilson; Laryngology Prof. Birkett and Dr. H. D. Hamilton. Special Demonstration on Diseases of the accessory nasal cavities by Dr. Hamilton, Gynæcology, Prof. Wm. Gardner and Dr. Chipman in the Royal Victoria Hospital, and Dr. Lockhart and Dr. J. D. Cameron in the Montreal General Hospital; Diseases of Children. Prof. Blackader and Dr. G. G. Campbell; Obstetrics, Prof. J. C. Cameron and Dr. Evans. The use of the Cystoscope and Urethroscope, Dr. Springle.

The above courses of instruction are given wholly apart from the regular lectures clinics, etc., for undergraduates in medicine. Physicians may enter on the course at any time after April 28th.

The fee for the course including Hospital fees is $50.00. Special fees arranged for single courses.

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1902.

Medical Society of Nova Scotia.

34th ANNUAL MEETING.

The Annual Meeting will be held in New Glasgow, Wednesday and Thursday, July 2nd and 3rd, commencing at 2 p. m. on Wednesday. All who intend reading papers or presenting cases at this meeting must notify the Secretary before June 3rd, 1902.

JOHN W MACKAY, M. D., *President,* New Glasgow, N. S.

JOHN STEWART, M. B. *Hon. Secretary,* Halifax, N. S.

1902.

Maritime Medical Association.

TWELFTH ANNUAL MEETING.

The Annual Meeting will be held in Charlottetown, P. E. I., on Wednesday and Thursday, July 9th and 10th.

Extract from Constitution:

"All registered Practitioners in the Maritime Provinces are eligible for membership in this Association."

All who intend to read papers at this meeting will kindly notify the Secretary as early as possible.

F. P. TAYLOR, M. D., *President,* CHARLOTTETOWN, P. E. I.

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CONTENTS FOR MAY, 1902.

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TAKING THE CURE IN WINTER.

THE HYGIENIC TREATMENT OF TUBERCULOSIS IN THE LAURENTIAN MOUNTAINS.

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THE
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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIV. HALIFAX, N. S., MAY, 1902. No. 5

Original Communications.

REMARKS ON MOVABLE KIDNEY.*

By JOHN STEWART, M. B., C. M., Halifax, N. S.

The term "movable kidney" is not sufficiently significant of the pathological condition implied. For, in the first place, the kidney is normally movable within certain limits, and, in the second place, a kidney may be very freely movable, without producing any symptoms. The term "dislocated kidney" is also unsatisfactory, for a displaced kidney may be fixed in its abnormal position.

The symptoms due to a mobile kidney are due to the fact that it has dropped from its normal position and drags upon its attachments. The term "dropped kidney" is thus more satisfactory, but perhaps the best name suggested for the condition in question is the term nephroptosis, which falls in series with a member of terms already in common use for similar pathological conditions.

It is one of the curiosities of medicine that this condition is so frequently overlooked. It is not uncommon to meet with practitioners who regard it as a rare affection. It is very much more common among women than men, and it is probably within the mark to state that twenty per cent of all women who, for any reason, have their abdomens examined, have a movable kidney. Some observers give a ratio twice as great. (I have noted the condition in three individuals in one day.) It is about six or eight times as common in women as in men. It is not infrequent in children. And the right kidney is found dropped nearly four times as often as the left.

*Taken as read at meeting of Maritime Medical Association, St. John, July, 1900.

The causes of this condition and the reasons for these anomalies of distribution form a very interesting study. It may be a congenital condition, and here the term "floating kidney," so often misapplied, may be correctly employed. In these cases the elongated renal vessels and the ureter form a sort of pedicle on which the peritoneum is reflected in such a way as to form a true mesonephron, and the kidney is free to move in all directions. Such cases are rare. As a rule the kidney remains an extra-peritoneal organ and its movements take place behind the peritoneum. In a great many cases nephroptosis is merely a part of a general descent of the abdominal viscera, and forms a factor in the complex of symptoms described by Glenard and often styled gastroptosis. But in many cases the kidney alone appears to be concerned, and it is to these I refer here. The displacement may be due to alterations in intra-abdominal pressure, as seen in pregnancy, and there is no doubt that women who have borne children are by far the most frequent subjects of this affection Marked diminution in the amount of perirenal fat is assigned as a cause. It is certainly a notable fact that the condition is often detected after or during the course of wasting diseases, and it is also to be remarked that the subjects of this affection are very often the meagre victims of neurasthenia. Diseases of the pelvic viscera, in consequence of the reflex connections of these with the kidney, may be accountable in some cases for repeated congestions of that organ, thus predisposing to relaxation of its supporting structures.

A large number of cases are distinctly due to traumatism. In this connection it may be noted that injuries which cause rupture of the kidney in men, appear to result in dislocation of the kidney in women Mechanical influences acting not violently, but continuously or intermittently, may gradually displace the kidney. Tight lacing is frequently assigned as a cause, and it is a very likely cause, but the condition has been found in women of savage races, untrammelled by garments. Cases have been attributed to severe vomiting, coughing or asthmatic attacks. Sudden and violent pressure, as in railway and carriage accidents may cause "acute renal dislocation," and strain or muscular effort may cause it.

An elderly lady slipped on the ice at her garden gate. Grasping the gate-post and making a violent effort, she averted the fall but sustained a painful wrench of her right side. She felt so ill that she had to lie down. On examination, I found a rounded tumour, very

tender on pressure, in the right lumbar region. The tumour was movable upwards and when displaced upwards was less distinct. Rest in bed, with a bandage and pad in the lower part of the lumbar region gave relief, and after a few days the tumor disappeared.

The symptoms produced by this lesion vary in the widest degree. In many cases there are absolutely no symptoms and the patient is happily unconscious of the condition. I say "happily unconscious," because one of the most troublesome concomitants of nephroptosis is an inordinate amount of mental distress and morbid fear of evil consequences which attacks many when they have become aware of their condition, even when other symptoms are so slight that they have been previously unnoticed. Many of the symptoms are nervous and due no more to the condition of the kidney than to that of other organs.

Among the more common annoyances complained of are dragging prickling or burning pains felt in the lumbar, hypochondriac or epigastric regions, or referred to points more distant; visceral neuralgias, attacks of vomiting, and cardiac disturbances, as tachycardia. These symptoms are generally caused, or aggravated by exertion, and relieved by lying down. They are in all probability the direct or reflex result of dragging on the renal nerves and vessels. But the most serious symptoms are those produced in the digestive system, or in the renal apparatus itself. The connective tissue attaching the kidney to the duodenum may be very slight, and then the kidney may prolapse without affecting the bowel. But in other cases there are strong bands of tissue present, and then the displaced kidney, dragging upon the duodenum, may cause a kink in it, even closing its lumen and leading to all the symptoms of pyloric obstruction or even of acute gastric dilatation. Or acting in the same way, it may interfere with the flow of the bile through its ducts, and so lead to jaundice. Or, in the case of the left kidney, the splenic flexure of the colon may be dragged upon and kinked, and so a persistent constipation with all its evil results, is set up.

In consequence of the downward displacement of the kidney the ureter becomes relatively too long, and subject to undergo flexure or even torsion. In this way a hydronephrosis may be caused. Many cases of intermittent hydronephrosis are produced in this way, and abscess of the kidney may be the result.

The descent of the kidney, while causing slackening of the ureter, causes tension in the renal vessels. Constriction of the renal vein will

cause passive congestion of the kidney and some cases of renal hæmorrhage are apparently caused in this way.

A lady was sent to me on account of hæmaturia. The condition was intermittent, and when present was accompanied by rather severe pain, referred to the lumbar region, but also along the line of the ureter, and to the neck of the bladder. An examination of the bladder with the sound, and with Kelly's cystoscope revealed nothing abnormal. But a movable tumor having the characteristic shape of the kidney was felt in the right lumbar region. It was tender on pressure, and could be slipped upward and backward into the region of the kidney. A well fitting bandage with a pad to press backward in the lumbar region, after replacement of the kidney, was recommended, and this simple treatment put an end to the troublesome phenomena.

As a result of interference with the ureter, as mentioned above, or with the renal vessels and nerves, all the symptoms of renal calculus may be induced, and when hæmaturia is added the clinical picture is almost complete. It is small wonder then that operations have been undertaken for supposed renal calculus, in cases where the sole lesion was nephroptosis.

When this condition is discovered incidentally, and is unaccompanied by symptoms, I think it is better to say nothing about it to the patient. When the symptoms are so persistent or troublesome as to require attention, the use of a belt, and pad, as already indicated, may be quite sufficient. Some care is required in fitting the belt, and in securing the best shape of pad. The pad should not, of course, press directly on the kidney.

But in the majority of cases, operative measures are probably necessary. The pad and belt fail to keep the kidney in position, or the patient is intolerant of their pressure.

A young women was brought to me, complaining of constant aching pain in the right side. I found a dropped kidney, and recommended the pad and bandage. But there was also present this curious condition:—the tip of the twelfth rib was bent outwards at a right angle and the skin over it was extremely sensitive, so that the belt could not be worn. I performed nephrorrhaphy and at the same time excised the projecting tip of the rib. The result was quite satisfactory, but a few weeks after the patient unfortunately fell down stairs, with the result that the kidney was torn from its moorings, and prolapsed again. The patient was naturally much discouraged,

thinking another operation would be necessary, but reflecting that the recently torn adhesions might readily contract and heal again, and that the difficulty in the way of wearing a belt and pad no longer existed, I recommended rest in bed for two or three weeks, with the belt and pad in addition, and these to be worn for some weeks or even months. The result was as anticipated. The kidney contracted fresh adhesions, and when I last saw the patient she was quite free from her former troubles.

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FURTHER NOTES ON MOVABLE KIDNEY.*

These notes are in continuation of the above paper presented at the last meeting of the Maritime Medical Association.

As a result of numerous autopsies Glenard has found that when relaxation of the suspensory ligaments of the stomach and intestine has occurred, there follows a stenosis of the intestine. As a result of this, there is diminished tension of the abdominal wall, and this in turn, may be followed by a descent of the liver, kidney and other organs.

Nephroptosis is, doubtless, often part of a general splanchnoptosis, but in many cases there is no evidence of any other viscus being affected, and all the symptoms are due to the affection of the kidney itself. I would again draw attention to the probability that reflex disturbances of the renal circulation predispose to nephroptosis. We

*Read at meeting of Maritime Medical Association, Halifax, July, 1901.

know from experiments in the laboratory that the bulk of the kidney may vary widely and rapidly according to the action of its vasomotor nerves, producing anæmia with contraction. or, on the other hand, engorgement. When we consider the way in which the abdominal and pelvic viscera are related to each other through the complex ramifications of their nervous supply, we can understand how a disturbance of almost any viscus may influence the circulation in the kidney. I believe that the preponderance of cases of movable kidney in women is due, to some extent, to the constantly recurring disturbance of circulation due to reflex action in the closely associated plexuses of nerves supplying the kidney, uterus and ovaries.

The symptoms produced by nephroptosis may be caused reflexly, through the nervous system, or mechanically. Thus vomiting may be induced reflexly, in the same way as in renal calculus, or the dragging or torsion of the kidney may cause kinking of the bowel and mechanical obstruction. At the forthcoming meeting of the British Medical Association, I notice a paper is to be read on a case of pyloric stenosis and contraction of the duodenum caused by a movable kidney Hæmatemesis, hæmaturia, and even intestinal hæmorrhage may be produced through reflex congestions or mechanical obstructions.

The effect upon the kidney itself of these disturbances, repeated engorgements, torsion of its vessels, kinking of the ureter, interferences both with its blood-supply and with its secretory function, must be very injurious. I believe we have evidence that renal abscess may be caused in this way.

While it is certain that a movable kidney may give rise to no troublesome symptoms, it is important to keep this abnormality in mind when studying abdominal and pelvic cases. The condition is very often overlooked. Within the last year I have noted in various journals the following mistaken diagnoses:—gastric ulcer, neurasthenia, fæcal accumulation, malignant tumour of bowel, ovarian tumour, hydrosalpinx, enlarged gall bladder, displaced liver. In all of these the real condition was nephroptosis. Several cases are on record in which the symptoms led to the diagnosis of hepatic colic. At the operations no gall-stones were found, but a movable kidney was sutured in place, and the symptoms disappeared. On the other hand, movable kidney has been diagnosed in a case of cancer of the colon, and in a case of stone in the hepatic duct.

PRIMARY TUBERCULOSIS OF THE LARYNX AND PHARYNX, WITH REPORT OF CASE.*

By R. E. Mathers, M. D., Halifax, N. S.

I will endeavour in this short paper to give a resumè of the latest literature on the subject of laryngeal tuberculosis, with notes of one acute primary case which is, I think, of sufficient interest to report.

We understand by laryngeal phthisis an invasion of the tissue of the larynx by the tubercle bacilli accompanied by formation of tubercular deposits.

Tuberculosis of larynx is in the vast majority of cases secondary to pulmonary tuberculosis. Although it may be primary, Sir R. Lake says a primary infection occurs more frequently than we are able to show.

Authorities vary with regard to the frequency of laryngeal involvement in pulmonary tuberculosis. Thus Heinze, of Leipsic, found fifty-one per cent. of pulmonary tuberculosis had laryngeal involvement while Schrotter, of Vienna, found only six per cent. I believe most writers place it at thirty per cent.

Laryngeal phthisis may occur at any age, but is usually observed between eighteen and forty. It occurs far more frequently in males than females, about twice as often. Occupation does not seem to exert much influence on the disease, although those requiring to use the voice in the open air (pedlars, etc.) and those who are exposed to noxious and dust laden atmosphere may be more subject to the disease. Other predisposing causes are chronic laryngitis, acute laryngitis, syphilis, abuse of alcohol, improper use of voice. The mode of invasion is either from within (through the blood and lymph channels) or from without through abrasions of mucous membrane. The most probable way is through the lymphatics, thus we can readily understand why the laryngeal and pulmonary involvement are usually on the same side.

The comparative immunity of the larynx has been accounted for in two ways; one is, that the tubercle bacilli are slow in developing and need not only a suitable spot but quiescence, conditions which the

*Read at Nova Scotia Branch British Medical Association, April 22rd, 1902.

larynx from its constant movements in respiration, coughing and phonation does not afford. The other is, that abrasions of the larynx are quickly protected by exudate and granulations and these latter have some resisting power over bacteria.

Dr. Shurley, of Detroit, mentions having scarified the pharynx, epiglottis and arytenoids of healthy and tuberculous monkeys and applied thereto sputum from tuberculous cases without producing any local infection. He also mentions a case of a patient of his who was suffering from pulmonary tuberculosis and who had a chicken bone lodged in his larynx ten hours, and in the patient's efforts to remove it the mucous membrane was much lacerated, yet laryngeal tuberculosis did not occur.

Pathology. Whether involved primarily or secondarily the pathological process is the same. The introduction of the tubercle bacilli beneath the mucous membrane of the larynx produces a round cell infiltration and the formation of the tubercle and giant cell. Where the proliferation of these cells takes place rapidly they crowd upon each other and interfere with their nutrition, assisted by the toxins of the tubercle bacilli, cloudy swelling and cheesy degeneration of the cells in the centre of the tubercle take place. If pus producing organisms gain access to the degenerated cells necrosis and suppuration takes place and the second stage or that of ulceration will be found. The first stage may pass unnoticed, as there may be no symptoms referable to the larynx. The laryngeal ulcers are usually superficial, irregular in outline, mouse nibbled in appearance. The regions most frequently affected are arytenoids, aryepiglottic folds, epiglottis and posterior wall of larynx in interarytenoid region.

Symptoms. In the early stage of the disease, the most noticeable symptom is hoarseness and changeable voice. The patient may speak clearly for a little while, but suddenly becomes hoarse. Upon clearing the throat the voice may become perfectly clear again. Not more than ten per cent of all cases escape some affection of the voice. There is a sense of uneasiness or dryness in larynx, cough, usually short and hacking, and some tenderness; as the disease progresses there is painful and difficult deglutition. This in some cases is so marked that patients will go many hours without food rather than suffer the excruciating pain accompanying deglutition. Other symptoms are painful and difficult phonation (dysphonia) and extinction of voice (aphonia.) As in malignant disease, pain in the ear may be complained

of. Lesions of epiglottis and arytenoids produce painful deglutition much earlier than those situated in other regions. In addition to these symptoms, we have the constitutional manifestation of tuberculosis, namely, emaciation, hectic temperature, anæmia, night sweats, insomnia and some anorexia.

On examination the mucous membrane of larynx will as a rule be found very pale in colour with small areas of congestion. This is always very suspicious and the sputum of such patients should be frequently examined. We should remember, however, that in acute laryngeal tuberculosis the mucous membrane may be swollen, bright angry red in appearance. Very characteristic of the tubercular stage is a pear or club shaped œdematous swelling of the aryepiglottic folds. Some fairly typical conditions found are: swollen turban shaped epiglottis, which may be red and ulcerated, and thickening in the interarytenoid region. This in a patient suffering from pulmonary tuberculosis is strong evidence that the larynx is involved. The cords may be ulcerated and then have an irregular or sawlike appearance. Mucus may be seen stretching from side to side. It may be noticed that during attempts at phonation the cords do not approximate in the median line or one cord may lag behind the other. This may be due to the thickening in the interarytenoid region mechanically preventing approximation of arytenoid cartilages. Other conditions are involvement of muscles of larynx, ulceration of vocal cords, etc. The pharynx is seldom infected unless as a part of a general acute miliary tuberculosis. When this is the case, the outlook, according to Sir R. Lake, is hopeless.

The differential diagnosis is by no means easy. Tuberculosis of larynx may be confounded with syphilis, lupus, benign or malignant growths, and chronic laryngitis. I have seen Bosworth, of New York, in error in mistaking tuberculosis of larynx for syphilis. Of course it must be remembered that these two affections may occur in the larynx at the same time.

Syphilitic ulcerations are more rapid and more deeply excavated, a more regular boundary zone of congestion encircling them, more secretion and failure to find bacilli or physical signs of tuberculosis in the lungs.

In lupus its course is very slow; there is nodule formation in some parts, slight superficial ulceration in others, while cicatricies may be found in others. Pyrexia is usually absent. The tubercular infil-

tration in the interarytenoid region may be mistaken for non-malignant growths such as papillomata, or for malignant growths. Papillomata are usually more warty in appearance and are not accompanied by the club shaped œdematous swelling of the aryepiglottic folds. Examination of the sputum also aids in the diagnosis.

In malignant growths the mucous membrane of the larynx is deeply congested while in tuberculosis it is usually pale. Malignant growths are rare before forty-five while tuberculosis of larynx usually occurs between eighteen and forty. Pain in malignant growths is severe even before ulceration appears. The prognosis is always grave.

History of Case.

W. M., male, single, 18 years of age. Lived in the country up to three years ago when came to Halifax. Mother and father both dead. Father died seven years ago of "throat trouble" which I an told was tuberculous. No brothers or sisters. Patient has had ordinary diseases of childbood. About two years ago had typhoid fever. Also had a peculiar outbreak of boils.

No specific history. Occupation, assistant book-keeper. Habits good, does not use alcohol or tobacco.

About 13th September last I was called in consultation by Dr. Mader to examine patient's throat. He had taken rather suddenly ill three days previously with what seemed like an ordinary bad sore throat and was confined to his bed when I saw him. For some few weeks before this he said he used to have sharp twings of pain in his larynx. On examining throat it looked like an ordinary acute pharyngitis, only the uvula was markedly œdematous and hung down throat, bothering patient a good deal. The larynx presented the most interesting condition. By use of the laryngeal mirror a pear shaped œdematous swelling in the aryepiglottic fold (left side) was to be seen, obliterating the little nodule which indicates the cartilage of Wrisberg. No ulceration was present. The submaxillary glands were very much enlarged and hard but not tender. The voice was not hoarse at this time, but a slight cough and desire to clear the throat was present and some pain on deglutition. The evening temperature was higher than the morning, varying between 100° and 101°; pulse frequent.

I suspected tuberculosis of larynx and pharynx and asked Dr. Mader, the attending physician, to carefully examine the lungs and

sputum. His examination of the chest was negative. The lungs appeared to be in perfectly healthy condition. Dr. Chisholm also examined the chest but found no evidence of tuberculosis. We did not get the report of the examination of the sputum for some few days. Being convinced that the case was tubercular we had the patient removed to a place where he could get better attention and plenty of fresh air. Patient seemed to improve somewhat under treatment.

About this time, Septmber 24th, a positive diagnosis was given that the bacilli were present in the sputum. A rather interesting condition now appeared in the pharynx. At the junction of the uvula and soft palate on the right side a number of small greyish, translucent elevated spots about the size of the head of a pin appeared. A day later the tubercles began to appear on the right anterior pillar of fauces. These miliary tubercles near the uvula began to break down and an ulcer was formed, the edges of which had a mouse nibbled appearance and the ulcer was bathed with mucopus. In a few days another ulcer appeared on the anterior pillar of the fauces. As yet no ulceration could be seen in the larynx but the epiglottis was very much swollen and raw looking making it difficult for the vocal cords to be seen. The voice was becoming aphonic, and deglutition was very painful. Sprays containing cocaine, menthol, and antipyrine having to be used before eating. The temperature kept high, sometimes going up to 103° in the evening. Patient was losing flesh rapidly and was confined to his bed nearly all the time. It was now decided to send him to the Willow Park Sanitarium where he could get more individual attendance and the fresh air treatment carried out more effectually. He improved a trifle for a time but soon began bringing up blood when clearing the throat. The food sometimes regurgitated through the nose due to the ulcers on the soft palate affecting the muscles in that region. The pain in the throat was now excruciating at times.

As the patient was rather a refractory one it was a little difficult to carry out local and general treatment as vigorously as we would have liked to. He did sleep fairly well but now had to be given morphia. The patient sank rapidly and would take no food and after fasting four days died. No evidence of lung trouble was to be found till up to a week before his death when we observed evidence of consolidation on right side beneath scapula. Death occured on 18th November. In this case as in all the others I have seen, local and general treatment seemed to be of little avail. Of course it is impossible to say whether this case was primary or not. I know such cases are extremely rare but this patient had no evidence of tuberculosis of the lungs up to a week before death.

THE MICROSCOPE IN DIAGNOSIS.

By N. S. Fraser, M. B., St. John's, Newfoundland.

The general practitioner is apt to look upon microscopical work as of scientific rather than practical value. Those of us who are really busy find little time for such special work, and are content to make our diagnosis by clinical signs; or, when doubtful, to wait patiently until time clears up the doubt and makes the exact nature of the case clear to us. Nevertheless, it is a fact that even the busy practitioner can, with very little extra trouble, gain valuable information from the microscope—information which may relieve him from a great deal of worry and anxiety, and be of importance to his patient. The two following cases will illustrate my contention.

Case 1. J. R., aged 12 years. Seen the last of November 1901, when he was complaining of pain in the right side and shortness of breath. He had a good family history and his previous health had been excellent. All the signs of pleurisy, with effusion at the right base, were present, and an attempt was made to cause absorption. This having failed the aspirator was used, and about a pint of clear fluid withdrawn. This was December 10th., and at that time the left lung was normal, the temperature 99.6° F., respirations 30 and pulse 100. On December 13th I was sent for again, and found that the temperaature had gone up to 102.8° F., respirations 35 and pulse 140, and that he had considerable cough. On examination the main trouble now appeared to be on the *other* side—the left—and the physical signs were those of consolidation, viz.:—dulness, tubular breathing, moist sounds and increased vocal resonance. The question arose as to the nature of the consolidation. He seemed too ill for an ordinary pneumonia of such limited extent, and the frequent association of pleurisy with tubercular disease, together with the fact that for months previous a source of tubercular infection had existed in the next house, made me lean towards tubercle as the probable cause. Before giving a prognosis, however, I secured a specimen of the sputum, which I stained and examined, first for tubercle and afterwards for the pneumococcus. There were no tubercle bacilli to be found, but in the second specimen numerous pneumococci. In con-

sequence of this I altered my prognosis, and the result has borne me out. Resolution did not occur at the usual time—it being sixteen days before the temperature reached the normal—but recovery, though gradual, has been perfect and the patient has been up and out since January 5th.

Case 2. J. H., aged 24 years. Complained October 20th. of cough with slight expectoration. By his own statement he had caught cold the day previously. His family history was not good, the father having died at an early age of consumption; no brothers or sisters. He is of small delicate build, 5 feet 7 inches tall and 120 pounds weight, but not subject to cough, expectoration or shortness of breath. At the time of my visit his temperature was 100° F., respirations 24 and pulse 98. Physical examination revealed nothing in the chest, save an occasional sibillation over the left apex, posteriorly. The apices in front retained their vesicular breathing without any accompaniments and the percussion note was normal. After a thorough examination I could not discover anything abnormal in any other part of his body and the question arose, what was the cause of the fever? It is not usual to have a temperature of 100° F. in an adult, without pains, as a result of a simple cold. Securing some of the expectoration I examined it microscopically and found numerous tubercle bacilli scattered throughout the whole specimen.

With this definite information I was able to give him intelligent advice. As soon as the temperature came down to normal (in a week) he resumed his office work, keeping the window open from the top all the time, and he secured as much of the outdoor work, in connection with his office, as possible. In fact, he observed to the letter all advice given him as to diet, exercise, bathing and ventilation and in addition received hypodermically fifteen minims of anti-tubercle serum twice a week, as recommended by Stubbert of New York. The result has been most satisfactory. Frequent examinations of the sputum have been made, and though the bacilli were constantly present, their numbers have been gradually decreasing. At the last examination it required a diligent search to find them at all. With this there has been a steady increase in weight. He has now gone for a trip to France and I trust the cure will be a permanent one.

The aid given by the microscope in this last case was invaluable, and enabled us to cope with a deadly disease at its very commencement, before it had caused any destruction of tissue. Without its aid the diagnosis would not have been made, until, after months of gradual progress, sufficient destruction of lung tissue had occurred to be detected by auscultation and percussion. It would then have been too late to do much for the patient and it is difficult to say how many others he would meanwhile have infected.

Selected Articles.

REFLECTIONS ON SOME OF THE CAUSES FOR THE HIGH DEATH RATE AND HIGH VENEREAL NON-EFFICIENCY OF THE TROPICS.*

By P. R. EGAN, M. D., Surgeon, U. S. Army.

The high death rate of Puerto Rico has been engaging the thoughts of Americans since the invasion. The late General Henry, at my request, when chief surgeon of the district of Ponce, convened a board of survey, October 12, 1898, consisting of an engineer officer, Captain Ellicot, and a medical officer, Captain Proben, U. S. V., to report upon the water supply of Ponce and its possible contamination.

The prevalence of typhoid fever in the city of Ponce and the suspicious character of its water supply came under my observation on assuming charge of the office, September 30, 1898. The board was called to see what measures, if any, could be taken for prevention and improvement.

The members of the board deserve great credit for the interest they took in the subject and the thoroughness of their investigation in the limited time at their disposal.

The reservoir for the supply of Ponce was reported open to various sources of contamination, and the aqueduct was sagged at various points, admitting water from the outside. The unsavory condition of the river above the intake is best given in the words of the report: "All told, there are 143 huts along the stream; of these, 20 are along the branches, and 123 along the main stream. All are within 300 feet of the river; there are 40 within fifty feet; some directly within twenty feet. Where the roads cross the river, habitation is always marked, and here the greatest source of pollution occurs, especially within 3, 5, and 7 miles, above the dam. Forty-seven such huts were counted, which were situated almost directly on the stream, and these form a very profile source of contagious elements of pollution. These small huts are entirely devoid of sanitary arrangements; they contain, on an average, four to five persons each, who dispose of their excreta directly into the river. They use the

*Read before the County Medical Society, Salt Lake City, Utah, February 24, 1902.

water for washing their clothes, etc., and for watering their cattle. All refuse of any character is thrown directly into the stream. We have been unable to find any water closet, except one . . . . that is extremely filthy. . . . Along the watershed we have been able to count forty pigs and a number of dogs. Four or five places had pigpens directly near the river edge."

This lengthy extract will serve to show the terrible contamination to which the water supply of Ponce is exposed; yet it must be remembered that only four large towns have any attempt at a water system. The inhabitants of the other towns draw the water in gallons or barrels from the river in which hundreds of women are washing clothes, entrails of animals, etc., and which receives the excreta of hundreds, nay, thousands, of people living along its banks; for we must not forget that Puerto Rico is about the most thickly populated country in the world, and that a privy of any kind is practically unknown in the country districts.

The proceedings of the board were endorsed by me, recommending a system of sand filtration that had been considered some years previously, the only reliable means of purification. This suggestion, because of its cost, was not adopted; but since my departure from that city, I have learned that a system of filtration has been built across the bed of the river. This, as was natural to suppose, was carried away by the first heavy rainfall, so that to-day there is no system of filtration worthy of the name in the whole island, and the water supply is drawn from rivers of which the board describes one of the purest.

Add to this that no city contains a system of sewerage, except San Juan, and that is so imperfect as to be unworthy of the name, that, in towns where any kind of privy pit exists, it is only partially partitioned off from the kitchen, or is next door to it; and that, finally, poor families in towns live nearly always in single rooms, without ventilation, and as crowded as sardines in a box. In towns as large as Cayey, many of the houses have no kind of closets, and the people have to attend to the wants of nature wherever they can.

While in Ponce I went to investigate an epidemic of small-pox in the neighboring town of Penuelas. There were thirty cases, with several deaths. Similar epidemics were prevalent all over the island.

I was one of the directors of the five districts into which the island was divided for vaccination purposes. I accounted for 160,000 people in the district of Guayama, and the other directors did even better in their districts. Since then, according to returns, there have been but a few deaths from small-pox on the island.

To diminish the high death rate of that country, and of the forces therein, it is evident that the first necessity is a sand-filtered water supply; some adequate system of excreta removal, and sanitary habitations for all classes of the population.

Now, the two great causes of death in Puerto Rico are anæmia and tuberculosis, but the former is nearly twice as common as the latter. In 1900, the deaths were twice as numerous as the births, the number being 41,854 and 20,259, respectively. In the three years of American occupation the deaths exceeded the births by more than 50,000. The year ending June 30, 1901, had, according to an incomplete report, 11,535 deaths from anæmia alone.

Soon after the invasion of the island, an assistant surgeon belonging to the regular army found the ankylostoma in nineteen cases of severe anæmia. Thereupon, this worm was vaunted as the cause of Puerto Rican anæmia, just as Griesinger had declared, in 1854, as the result of a single autopsy, that it was the cause of Egyptian chlorosis. But it is doubtful if clinical facts warrant such deductions. The only scientific work so far done in Puerto Rico to elucidate this subject, was that of my friend, Assistant Surgeon E. F. Russell, U. S. army. He found that 54 per cent. of the perfectly healthy, and 84 per cent. of persons sick from every variety of disease, harbored this parasite, while, according to Manson, the ankylostoma is found in over 75 per cent. of natives to whom thymol had been given. Very many of those so affected are strong and healthy, and show not the least symptoms of anæmia.

Of all the bread stuffs necessary to life, the tropics produce only corn and rice. A white man cannot live for any length of time on corn and rice alone, or on bananas or palm nuts. Neither are the foods produced sufficient for the population, and so a chronic condition of famine exists in very many tropical countries. Among the inhabitants who can enjoy a generous diet, such as we use, anæmia almost never occurs, while in those suffering from chronic starvation, it is

ever present. The dependence of the so-called pathological effects of the ankylostoma on lack of food or on diseased conditions, and its innocuousness when these conditions are absent, needs further elucidation. The English Tropical School has promised some observations on the life history of the ankylostoma, and these I await with great eagerness, as it is hoped they will throw light on this, to me, inexplicable relationship. The eggs of the parasite are discharged with the excreta, and easily find their way into the water which is drunk by the inhabitants, so that, in Puerto Rico, the worm can probably be found in almost every cadaver, as in Egypt. Our want of further information regarding the life history of the ankylostoma was forcibly impressed on me only yesterday by reading an extract of an article in the *British Medical Journal* of January 25, 1902.

There the larvæ figure as the cause of "ground itch," a completely new role to me, as I had heard of only one or two experiments in which it penetrated the skin.

Mr. C. A.Bentley, M. B., the author of the article, states: Ground itch is an affection of the skin confined entirely to the lower extremities, and probably always associated with the presence of larvæ of the *Ankylostoma duodenale* in the affected areas; endemic in Assam and the West Indies, and possibly in other parts of the tropics; characterized by its periodical epidemic appearance in the infected areas coincident with the onset of the rainy season; with typical lesions consisting in a primary erythema, followed by a vesicular eruption which frequently becomes pustular, and in severe cases may result in obstinate ulceration, or even in gangrene. All observations point to the earth as being the infecting medium, and fæcal contamination of the soil as being the most active agency in the propagation of the disease. The first symptom is an intense itching and burning at the spot where afterward the eruption appears. In the papular and early vesicular stage of the disease, the application of a strong solution of salicylic acid in collodion or in methylated spirit will cause the eruption to dry up. If, however, pus has formed, the only treatment of any service is the opening up and disinfection of the pustules with pure carbolic acid, and the after-treatment of the sore as an ordinary ulcer. The adoption of a proper conservancy system would probably entirely prevent the occurrence of the disease. The

wearing of shoes is known to be an almost certain preventive of the disease (*New York Medical Journal.*)

Reflecting on all these unsanitary conditions, I, many and many a time, concluded that, if Puerto Rico were not naturally one of the most healthy sites on the globe, all the people would long since have been dead from some epidemic or other.

Venereal diseases are a scourge in most parts of the world. Nearly thirty years ago it was estimated that there were in England two millions of diseased persons, and Mulhall, according to *American Medicine*, thinks that the number of soldiers in Europe ill from the disease averages 19 per cent. of the forces. Czerny, according to the same authority, thinks 50 per cent. of all sterility is due to this cause, and the reports of twenty-four specialists have shown that 41 per cent. of pelvic inflammation is traceable to its action. But it is only in the tropics that it seems to flourish in all its glory. While there are no statistics for the natives, yet in soldiers it has been known to reach over 20 per cent. of the total illness. In 1899, the British army in India discharged 164 men for secondary syphilis and gonorrhœa, or 2.43 per 1,000. This was only exceeded by the diseases of the circulatory system, 2.55 per 1,000, and approached by tuberculosis, 1.03 per 1,000 and diseases of special sense, 1.35 per 1,000. In various quarters it has recently been advocated to make the transmission of venereal diseases a punishable offence, and for boards of health to treat it as a contagious disease. For years I have advocated that a soldier be deprived of his pay for every day that is lost to the government through his immorality, as I believe is now the rule in the British army. It has been urged in opposition to this plan that, if he knows he is going to be deprived of his pay, he will conceal his disease and not report for treatment. This is done to a considerable extent at present, and in Europe from 25 to 50 per cent. of these cases ares aid to be treated by charlatans. I was delighted to find that the committee of seven of the Medical Society of the County of New York, who recently reported on this matter, state that hospital care is not needed for the large proportion of venereal cases, that most of them are ambulatory cases, and that dispensary treatment, which does not interfere with their employment and their wage-earning capacity, is best adapted to their re-

quirements, for I had always advocated that a soldier should only be admitted to hospital, as a rule, for the following venereal conditions, viz: Epididymitis, suppurating bubo, ulceration of the mouth, and iritis.

In this manner I believe the others would willingly come up and receive the necessary treatment without going on the sick list when they know it would not count against them, while the above-mentioned patients would be compelled by their suffering to apply for admission to hospital. I have also expressed the opinion more than once that, admitting a soldier, as at present, for an uncomplicated urethral discharge, or for a simple syphilitic skin eruption, was nothing more or less than setting a premium on immorality.

In the Lane Lectures (*New York Medical Journal*, October 26, 1901, p. 778) Mr. Malcolm Morris says: "It cannot be too emphatically stated that a person suffering from secondary manifestations of syphilis is a danger to all around him. He is charged with a poison more baneful than that of the most venomous snakes, which is conveyed on whatever he touches with his polluted lips—from a pipe to a communion cup." I presume Mr. Morris refers to the ulcerated mouth mentioned above. I have heard of doctors who contracted non-venereal syphilis from punctures received while operating on secondary cases, others from obstetrical examinations, and I have known cases arise from ulcerated mouths; but, although a graduate of the City Hospital, New York, I have never known a non-venereal case occur in any other way. But then, as in Manila, it is sought to protect the women that give and receive these diseases by converting every military hospital into a lock hospital. Judging by the patients I have seen coming from Luzon, and from what I have known in the Antilles, the attempt is not likely to meet with much success. That class of the population seems to be thoroughly saturated and in little need of protection, while the private or clandestine women are generally a degree beyond the soldier.

But, to use Mr. Morris's story, the very name syphilis is "the de'il and a'" to the line officer who generally knows nothing about it except the name; local venereal and tertiary ulcers are all contagious syphilis to him. With the positiveness born of ignorance he declares he won't have a case in his company. The non-venereal men in the

hospital he never considers; they are not his company, and in medical matters he is allowed at present altogether too much authority. So, venereal diseases have at times amounted to over 20 per cent. of the total illness of the forces in the tropics.

As hospital care is not necessary in the majority of cases, a surgeon only needs to compel their regular attendance for treatment while performing their usual duty, to reduce the non-efficiency from this cause to 1 or 2 per cent. of the total illness. Yet, you will be astonished when I tell you that the surgeon has not the power to enforce a sanitary measure of this kind. He can only recommend it to the line officer in command; the medical department having, as Dr. Reed aptly expresses it, absolutely no authority whatever. It is only justice to most general officers to say that such a recommendation would be immediately complied with, but experience shows that a very few general, and very many field and minor officers, ignore such suggestions, even ordering men into hospital as a result of the superior knowledge which the divine right to command gives them. Yet all this they can do with impunity. As a Boston lawyer recently wrote to me, rank gives a man great power, and if he uses it arbitrarily there seems to be little relief. So, the medical officer is always at the mercy of the caprices and prejudices of the line officer, from the youngest lieutenant in charge to the general commanding.

In England they think they have just escaped from this bondage through the recently appointed advisory board. The first step in this direction has only recently been taken in this country by a bill, introduced in the House, to make line officers responsible for ignoring sanitary measures suggested to them. This should receive the support of medical societies and the medical press. These bodies won the advisory board in England, where there is much more prejudice against the "d—d doctors" than there is here.

But we must not forget that our army medical department has been losing ground for about the last ten years, and that the control of the sanitary department by the medical officer is necessary for the saving of much time and money to the government by reducing the high death and venereal non-efficiency rates.—*New York Medical Journal.*

MENTHOLIZATION OF THE MUCOSA OF AIR PASSAGES.

By W. A. Briggs, M. D., Sacramento, Cal.

Mentholization of the mucosa of the air passages before, during and after etherization has given me such satisfaction as to impel me to submit the method to the profession at large. The method is as follows: Sprinkle a dram of oil of peppermint or of saturated alcoholic solution of menthol in the cone; let the patient inhale of this freely for three minutes, then saturate the cone with ether and bring it down slowly over the face; after a few full inhalations crowd the cone down well and push the etherization as rapidly as is consistent with safety; continue the use of the mentholized cone through the whole period of anæsthesia, replenishing the ether as usual. After the operation let the patient inhale oil of peppermint or menthol from a handkerchief freely and often until the tendency to nausea subsides.

The advantages of this over the usual method are the following:

1. Entire freedom from cough and sense of impending suffocation and comparative freedom from nausea, vomiting, and retching.

2. Ease and rapidity with which anæsthesia may be induced and the ease and smoothness with which it may be maintained.

3. The entire absence or marked abbreviation of the period of excitement.

4. Economy both of ether and of time.

5. Profounder first anæsthesia, under which minor operations may be done with more certainty.

6. Probably less postoperative nausea and vomiting.—*American Medicine.*

THE
MARITIME MEDICAL NEWS.
A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIV. HALIFAX, N. S., MAY, 1902. No. 5

Editorial.

THE LATE DR. MUIR.

Extended references to the death of Dr. W. S. Muir have been published in a number of our contemporaries, extracts from which are here appended.

The obituary notice in the *Montreal Medical Journal* was written by his esteemed friend, Dr. W. H. Drummond, from which we take the following:

"Little did any of us dream that Dr. Muir, the big, hearty, magnificent Nova Scotian, whom we met at Winnipeg last August, would so soon be numbered with the dead; and none of us, who had the good fortune to be in his company on steamer and train from Montreal to the west, will ever forget the pleasant hours spent together, for Dr. Muir was distinctly a vivid personality, and we loved him for his strong, rugged virility, which at all times radiated from the man like the flashing of a precious stone under the beams of the morning sun.

Dr. Muir was a sentinel who seldom asked for exchange of guard a medical soldier who rarely deserted his post of duty, save to perfect himself still further in the art dear to him as the breathing of his life, that life, public and private, which all might read and reading approve; therefore it is not surprising that to the people of Truro, his native town, Dr. Muir's death came as a veritable calamity, bowing every head in grief. Not a man, woman or child but felt the loss of a personal friend, a man to whom all could look up to for guidance

or council, in joy or distress, a human oak, upon whose giant form the weak ones might fling their twining tendrils in full confidence of support. But the oak has tottered and fallen, seemingly long before its natural term of life, and Dr. Muir has passed away in the midst of a loyal and devoted people. Extraordinary it is in these prosaic days to witness such scenes of grief and lamentation as were exhibited in the town of Truro during the passage of the funeral cortege to the burial ground, every store, factory and place of business being closed, while the streets were filled with mourning citizens desirous of paying their last sad tribute of respect to the devoted physician, whom all had worshipped, and wondering if ever they might look upon his like again."

Dominion Medical Monthly.

"It is a distinct pain to us to have to publish the obituary of Dr. W. S. Muir, of Truro, Nova Scotia. This great, noble-hearted man has passed away from us, in the prime of life, if not full of years, at least full of honors. It is doubtful if any other practitioner in the Dominion of Canada had such a host of friends as "Bill" Muir. He died from appendicitis, after but three days' illness; and his demise is a very great loss indeed to the medical profession throughout this Dominion. * * * The place of Dr. Muir will be difficult to fill, for he was genial and kindly, ever ready and willing, always able and energetic. His, indeed, was a jovial nature, a strong, robust, manly manhood."

The Canadian Practitioner and Review.

"Dr. Wm. Muir, of Truro, Nova Scotia, was probably better known by physicians of Quebec, Ontario, Manitoba, the North West Territories and British Columbia than any other doctor in the Maritime Provinces. We learn with much grief from the *Maritime Medical News* that Dr. Muir died of appendicitis March 10th, after an illness of four days, aged 49. * * * He was best known to the Westerners through his connection with the Canadian Medical Association, of which he was one of the strongest and most enthusiastic members. We are quite in accord with the *News* in its statement, that "His frank and genial nature, his transperent honesty, and his whole-souled devotion to his profession, gained him the confidence of the public, and the esteem of his colleagues."

The Canadian Journal of Medicine and Surgery.

"We are safe in saying that, for years past, death has removed no more pouplar or more lovable member of our profession than in the person of Dr. W. S. Muir, of Truro N. S., last month. Dr Muir died from appendicitis after but three days' illness, and just like the noble chap that he always was, he died with a kindly word for everyone on his lips. He had been complaining for just a day or two, and if he had not been forced to give in, he would have been found in harness when the call came. * * * As a citizen, our deceased friend was an all-round man in every movement that was for the good of his town He has long been associated with the work of the Society for the Prevention of Cruelty. When it was reorganized in Truro a few weeks ago, he was appointed Vice-President. After the death of the President, Mr. Longworth, Dr. Will was asked to take that position by the unanimous request of all the members. His noble and sympathetic speech on that occasion will long be remembered by those who heard it. He particularly urged that it was the duty of those who were left to take the place of the toilers who fell by the way—and now, before he has had his first meeting of this Society, which he had called for Monday, March 17th, he too, has given up life's work, and rests from his labors."

Southern California Practitioner.

"We also learn just as we are going to press of the death of Dr. W. S. Muir, of Truro, Nova Scotia. It was only a few weeks ago that Dr. Muir was present at a meeting of the Los Angeles County Medical Society and made some interesting remarks. And at about the same time he was banqueted at the California Club in Los Angeles, and the chord of friendship and good fellowship vibrated from his great hearted personality to every member of the profession with whom he came in contact.

The warm sympathy of the physicians of Southern California goes out to our fellow townsman, the Hon. John A. Muir, the brother of the deceased. Yet we know what a satisfaction it must be to our friend Muir, to think that he has had this delightful visit from his brother.

Dr. Muir stood high with the profession in Nova Scotia, and his death has caused great sadness."

A MEDICAL LIBRARY.

Perhaps the greatest need of the profession in this city at present is a good library.

The papers presented and the discussions which follow at our various medical societies reveal, as a rule, a want of knowledge of recent literature. This is only to be expected when the medical man relies upon periodicals. Schemes for the promotion of a library have hitherto been treated with indifference and apathy.

In this respect we are far behind our legal friends, who, by concerted effort, have secured fairly decent libraries, which keep them in touch with recent work.

The late Dr. Charles Cogswell, of London, donated $5000.00 to the Medical Society of Nova Scotia, the interest from which is to be applied to sustaining a library for the profession. The Medical College has also received several donations of books and medical journals. A joint committee of these two bodies have endeavored to make arrangements by which the profession may take advantage of the books so far collected, but without much success.

The locality is not convenient of access; most of the books are old, and the funds do not permit of the purchase of many recent publications. The professors do not seem to care about the library, and the only patrons at present are medical students.

In other countries, more particularly in the United States, many state supported libraries have medical departments, and a portion of the revenue is devoted to the purchase of additions to that section of the library.

Now that Halifax, through the generosity of Mr. Carnegie, will soon have a magnificent building and a fairly adequate sum to maintain it, the profession should take steps at once not only to secure a share of the space available for books, but also a percentage of the sum to be expended for the purchase of books.

The collections now in existence, if consolidated, would be an excellent nucleus, and would soon be followed by valuable donations.

In advocating this scheme we are not animated by selfish motives. The advantages of a good library are not confined to the profession; the whole community profits by medical men having easy access to the best and most recent publications.

We trust that the profession will take prompt action in this matter, so as to ensure an early representation of their views to those more intimately concerned in organizing the new City Library.

MEDICAL SOCIETY OF NOVA SCOTIA.

Our readers are reminded of the date and place of the next annual meeting, viz.: July 2nd and 3rd, at New Glasgow. As this enterprising town is somewhat centrally located, there should be a very large representation present. A portion of the programme has already been published, and details will be referred to in our next issue. The loss of our late indefatigable secretary, Dr. W. S. Muir, will naturally cast a shadow over our proceedings, but we are confident that the members will exert themselves and lighten the work of our new secretary, Dr. John Stewart, in the discharge of his duties. Do not procrastinate, but send without delay the name of your paper or case report.

MARITIME MEDICAL ASSOCIATION.

The approaching annual meeting at Charlottetown on July 9th and 10th will evidently eclipse previous gatherings assembled there—that is if improvement be at all possible. Our medical friends in the neighboring province have already proved their worth in arranging details at former meetings, so it is superfluous to even surmise what attractions await visiting members this summer.

Some of the papers so far promised are the following:

"A Plea for the Surgical Treatment of Appendicitis," by G. Clowes VanWart, N. B. "A Talk on Therapeutics," by W. B. Geikie, Toronto. "Bulbar Paralysis, also a Case of Osteomyelitis," by J. C. Houston, Souris, P. E. I. "Health and How to Save It," by R. Macneill, Charlottetown. "Report of Cases of Cancer of Uterus," by T. J. F. Murphy, Halifax. "Etiology of Cancer," by A. Halliday, Halifax. "Further Report of Cataract Operations," by E A. Kirkpatrick, Halifax, "A Case of Acute Intestinal Obstruction," by M. Chisholm, Halifax. "Report of Cases of Phthisis." by C. Dickie Murray, Halifax.

Matters Personal and Impersonal.

Dr. E. A. Kirkpatrick lately returned from a short trip to New York.

Dr. H. V. Pearman is now in the neighboring republic for a two weeks soujourn.

Dr. James Stewart, Professor of Clinical Medicine, McGill University was elected president of the Association of American Physicians at the annual meeting held at Washington last month.

Dr. L. M. Murray, of this city, will have the deep sympathy of the profession in the loss of his sister who recently died at Truro. A melancholy incident occurred at the same time when a telegram came announcing the sudden death of a brother in Nevada and the forwarding of the body home. As there was considerable doubt as to the identity of the body, investigation proved the mistake. We are glad to know that Mr. Murray is alive and in good health.

Dr. A. J. Cowie is recovering from a severe attack of bronchitis, which at first threatened to be of a serious character.

Dr. F. U. Anderson has moved his office to 91 Hollis Street in the building formerly occupied by Dr. J. F. Black.

Dr. W. D. Finn has taken the house 69 Hollis Street lately vacated by Dr. Anderson.

Dr. T. W. Walsh has followed suit and now occupies Dr. Finn's former residence, 116 Argyle Street.

Dr. D. N. Morrison, who practised for a number of years at Oxford, N. S., was given a farewell reception by the Masonic and Oddfellow Lodges in recognition of his valuable services as a physician in that locality. Unfortunately, Dr. Morrison has lately not been in good health, and it is his purpose to remain in Halifax for a few months' rest.

Two Hollis Street physicians lately returned from a successful fishing excursion on the Gaspereaux river. A fifteen (or a fifty, we have forgotten which) pound salmon was captured by one, who is also a successful disciple Nimrod. It is rumored that the salmon will be "stuffed."

Dr. J. G. McDougall, of Amherst, who last month developed septicæmia after operating on a septic finger, has fortunately recovered after a most serious illness.

Dr. R. W. Dunbar, of Shubenacadie, has lately joined the benedicts, and the NEWS has much pleasure in extending its congratulations.

Henry K. Wampole & Co. have opened a branch office in Montreal, No. 20 St. Alexis St., (over the Bank of Ottawa) which will be in charge of their representative, Mr. R. E. Pineo. It is the intention to carry but a limited stock in this office, that small city orders for immediate delivery can be promptly handled.

Messrs. M. J. Breitenbach Company, of New York, have been successful in their lawsuit against Messrs. Henry Thayer & Co., of Boston, who for some time used the same style of package as Pepto-Mangan, which contained a preparation with a similar sounding name. The reputation of such a reliable agent as Gude's Pepto-Mangan is well established, and we congratulate Messrs. M. J. Breitenbach Company in their successful suit against unworthy imitators.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Feb. 19th, 1902.—Dr. T. W. Walsh, President, in the chair.

Dr. H. D. Weaver read an interesting paper on the "Therapeutics of Static Electricity."

Dr. Weaver said that necessarily his paper was largely composed of he theory of static electricity gathered from various authors, as he had not been using the current long enough to verify all the claims made for it.

Rockwell defines electricity as a stimulant and sedative. Static electricity possesses certain advantages and disadvantages over other forms of electric treatment. Static belongs to that class of electricity called currents of high potential and high frequency. That is to say that the voltage (or speed and pressure of current) is enormous, while the amperage (or volume of current) is insignificant. It is stated that it takes from 50,000 to 80,000 volts of pressure to give an inch spark. When we consider that a good many static machines will produce a ten to twelve inch spark we can get an idea of their enormous voltage. On the other hand the amperage is insignificant,

some observers having placed it as low as $\frac{5}{1000}$ of a milliampere. This will account for the peculiar effects of static electricity upon the nervous system and upon nutrition. One great advantage of static electricity over the other forms is that in most methods of treatment you are giving the system a general tonic while at the same time concentrating the treatment on some particular part of the body.

There is a wide range in the treatments from the simple charging, which the most nervous person will not mind, to the drawing of sparks three to four inches long from the patient, which gives a strong form of counter-irritation. It is seldom that there is any necessity for the patients to disrobe at all.

No doubt some of you think that suggestion plays a large part in the treatment. Of course it does, and so it does in all treatments. There is not a dose of medicine taken but what there is a suggestion in it of cure, or at least relief. In some hysterical cases, no doubt, suggestion acts very powerfully.

The effects produced according to Rockwell are:—

Static electrification increases the excretion of urea, and lessens the uric acid in the system by promoting oxidation. Increases appetite and digestion. It lowers the blood pressure, causes a gentle perspiration to ensue, accompanied by a general sense of well-being. It promotes the nutrition of every part it excites. It produces marked local and general circulatory effects. It excites to functional action the whole nervous system.

Static electricity cannot be used for electrolysis or cataphoresis and some kinds of pain are more easily relieved by the galvanic current. But in many cases it is an advantage to occasionally change the applications.

The following are some of the principal diseases in which, if obstinate, static or some other kind of electricity should be tried:—

Many different kinds of nervous diseases in which if it does not cure it frequently relieves. Lumbago and other forms of muscular rheumatism. Some doctors claim many good results in articular, but so far, my experience has been against it. Gout is a disease that is said to yield readily to it; and knowing the physiological action of static electricity, we would expect good general effects whenever there is a uric acid diathesis.

In neurasthenia and hysteria static electricity has attained some of its greatest triumphs. Like the other forms of electricity, it acts well

in paralysis, particularly the static induced current. In anæmia, it is said, at times to be more beneficial than iron.

We might say that static and the other kinds of electricity are the right sort of treatment for many chronic but not acute diseases. In conclusion I would say that they are most valuable auxiliaries to other methods of treatment. In some cases electricity alone will cure, but more often when combined with other kinds of treatment it will turn the balance in our favor when otherwise it would have gone against us.

Dr. Ross mentioned his experiences with electricity in cases of chronic gonorrhœa but did not find it satisfactory.

Dr. Mader enquired concerning use of electricity in diagnosis of some forms of nervous diseases.

Drs. M. A. B. Smith, Lowerison and the President also commented upon Dr. Weaver's paper.

Dr. Weaver, in reply, referred to the treatment of phthisis by ozone. He also spoke of the diagnosis of nervous conditions by the galvanic current. Had seen a case of multiple stricture in which electricity had done good and believed a copper sound should be used in such cases and in chronic gonorrhœa. Many cutaneous cancers had been cured by X-rays, also sarcoma and cancer of the breast. Reference was also made to the different methods of treatment by X-rays.

Dr. Chisholm mentioned good results he had seen in some cases of chorea by electrical belts.

Dr. M. A. B. Smith referred to the use of an intra-gastric electrode in atonic dyspepsia.

March 5th 1902. Dr. Chisholm exhibited a case of a man with a rash which might be mistaken for smallpox on account of the latter disease existing in the city. He considered it lichen planus.

Dr. Ross agreed with Dr. Chisholm's diagnosis.

Dr. D. A. Campbell then read a paper on "Notes on Vaccination." At present there was no protection of the citizens in Halifax, a large proportion being not at all or insufficiently protected. Only a sharp epidemic could bring people to their senses. Thirty or forty years ago the necessity for vaccination was appreciated and infant vaccination was thoroughly carried out. The chief factor for determining opposition is the bad results from wholesale vaccination hastily carried out.

In medical schools little attention is given to instruction in vaccination and less in text-books and to a young practitioner information is

not easily obtainable. Dr. Campbell laid down the following rules:

I. It is not advisable to vaccinate all persons indiscriminately—should not vacinate the following:

(a) Young and delicate infants particularly bottle-fed.

(b) Persons run down in health.

(c) Persons with organic and other diseases.

(d) Persons over sixty years old.

II. Choice of virus. Better off now than ten years ago. It is easier to obtain a reliable virus. Bovine lymph-glycerinated when well prepared should be free from germs. It may be stored on points or in sealed tubes which many prefer.

III. Fresh lymph. Do not come too near to date on tube—strike off a month. In England it is used as fresh as possible.

IV. Preparation of arm. We open a door for entrance of microbes so should be careful as to cleanliness. Asepsis is usually impossible so be consistent and satisfied with ordinary cleanliness.

The average charge for vaccination is $1.00, but if you do an aseptic operation $5.00 should be a fair charge.

V. Site. On the arm at the insertion of deltoid.

VI. Method of Insertion. Abrasion of skin without drawing blood, with an ordinary needle; rotary motion removing epithelium.

VII. Instruments. Needle does not require disinfection as a fresh one can be used each time. The same applies to ivory point.

VII. Extent. A number of points and small areas for babies, but in adults one abrasion an eighth of an inch square will give necessary scar.

IX. In using tubes of glycerinated lymph, remove superfluous serum from the abrasion before applying lymph.

X. Shields are now condemned. A soft handkerchief may be used over vesicle and renewed daily.

XI. Itching is relieved by a dusting powder.

XII. If ulceration is threatened, remove crust by boracic poultice and dress antiseptically.

Dr. Campbell then read Copeman's description of efficient vaccination also that of Chicago Board of Health, recommending repeated revaccination which is now generally accepted.

Dr. Chisholm spoke of the difficulties of the Board of Health in relation to vaccination. Had to move slowly. Epidemic was light

and the Board was defied by the people owing to the law being faulty.

Dr. Ross referred to smallpox cases in which vesicles had developed as vesicles and not umbilicated. Dr. Doyle had also told him of seeing such a case though papules were present as well.

Dr. Murphy spoke of the advantage of vaccinating early. He had seen multiple insertion followed by ulceration. Had found boracic ointment a good dressing after arm had dried. If inflamed, use a hot compress.

The President asked Dr. Campbell how young he would vaccinate. He himself vaccinated if possible under three months.

Dr. Mader said he would vaccinate during pregnancy if he had reason to do so. He considered that vaccination would be less severe than smallpox, which was generally fatal to both mother and child. In inflamed conditions be applied ichthyol.

Dr. E. D. Farrell spoke of the necessity for cleanliness in infants.

Dr. C. D. Murray criticized the action of the City Health Board in regard to vaccination.

Dr. Chisholm defended its action.

Dr. Campbell in reply, said he considered it preferable to vaccinate infants between six weeks and six months old.

Book Reviews.

SYPHILIS. A Symposium.—Special contributions by L. D. Bulkley, Louis A. Duhring, Prof. Fournier, Eugene Fuller. W. S. Gottheil, E. L. Keyes, G. F. Lydston, etc. Price $1.00. Published by E. B. Treat & Co., New York.

This small work contains chapters written by seventeen different authorities on the subject of syphilis. As a concise statement of the knowledge of this far reaching disease it will be found of much value and easy of reference.

Books Received.

INTERNATIONAL CLINICS.—Twelfth Series. Vol I. Published by J. B. Lippincott Co., Philadelphia.

THE DIAGNOSIS OF SURGICAL DISEASES.—By Dr. E. Albert. Translated from the German by Dr. Robert T. Frank. Published by D. Appleton & Co., New York.

Therapeutic Suggestions.

ABORTIVE TREATMENT OF BOILS.—

℞ Hydrargyri oxidi rubri ..... ʒ j
Lanolini..... ʒ x

M. Sig.: To be rubbed in once or twice a day.—*Kansas City Medical Journal.*

ANTIPYRIN IN CHOREA.—The following combination containing antipyrin is recommended in treatment of chorea:

℞ Sodii bromidi,
Potassii bromidi, ää.....dr. i 4
Antipyrini .....gr. xxx 2
Aq. mentha pip. q. s. ad. .....oz. i 32

M. Sig.: One teaspoonful three or four times a day according to age.

—*Jour. Am. Med. Association.*

SALVE TO REMOVE CORNS.—The following combination in the form of a salve is recommended for the removal of corns:

℞. Pulv. plumbi acetatis.
Pulv. myrrhæ.
Pulv. camphoræ.
Plumbi. oxidi .....aa dr. j
Ol. olivæ.
Petrolati, aa q. s. to make paste.

—*Jour. Amer. Med. Association.*

THE "NORMAL SALT SOLUTION."—There is some variation in the formula given by the different writers. Dr. Charles A. L. Reed, in his new Text-book of Gyneology, remarks that Lock has suggested the following formula, and reported favorably upon it:

℞. Calcium chloride .....gr. iij$\frac{3}{4}$
Potassium chloride .....gr. jss
Sodium chloride.....dr. ijss
Aqua dest .....q. s. ad. Oij

M. The solution may be injected subcutaneously, into the intestine, or into a vein.

—*New York Med. Jour.*

To Combat Collapse in Pneumonia. Dr. Duleau (*Jour. de Med. Interne*, Feb 15) uses injections as follows:

℞. Strychnine sulphate.....15-100 of a gr.
Distilled water.....150 minims.

M. Three injections, of about 20 drops each, daily.

Where the tendency to collapse is not great, he recommends the following:

℞. Extract of cinchona .....45 grains
Tincture of cinnamon .....75 minims
Ammonium acetate .....150 grains
Syrup of orange peel .....3 ounces
Brandy .....3 ounces
Melissa water, to .....8 ounces

M. A teaspoonful every hour.

—*New York Med. Jour.*

Gonorrhœal Epididymitis.—Dr. Earl Harlan, of Cincinnati, says: Use the following liniment from the beginning. Its action is exceedingly rapid and effective, and I have never seen it fail:

℞. Ammonii chloridi .....
Potassii iodidi, of each .....dr. ij
Alcoholis.....
Aquæ dest., of each.....f oz. ij

M. Sig.: Apply with a small camel's hair brush four times daily.

—*Cincinnati Lancet-Clinic.*

Nitrites in Brain Syphilis.—Dr. W. Browning, in *Med. News* states that the nitrites, being the most powerful vasodilators, are of great benefit in overcoming the tendency to the narrowing of the lumen of arteries, especially in disease of the arteries supplying the brain. After the vessels are dilated, specific medication has a much better opportunity to gain access to the diseased parts. He also finds the nitrites of value in diabetes of old syphilitics in conjunction with specific treatment. He prefers to administer them by the mouth rather than hypodermically.—*Jour. Amer. Med. Assn.*

Watery Gleet.—A good injection is:

℞. Tannic acid .....gr. iv.
Mucilage .....dr. i.
Aq., q. s. ad. .....oz. j.

M.—*N. Y. Med. Jour.*

AN APPROPRIATE ILLUSTRATION

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Wampole's Pulverous Pills

may be found in those containing Asafoetida, Sumbul, Valerian, etc., which at all times possess the strong and characteristic odor of the drugs entering into their composition.

Frequently we are criticised for not manufacturing pills in which this disagreeable feature is overcome; our contention has always been, however, that to mask the odor an insoluble sub-coating must be used, which cannot help but retard a prompt therapeutic effect after administration.

Command us to send samples of our pills—they are made by twentieth century methods, and will at all times be found dependently active.

We invite, in fact are anxious for the most critical examination and comparison of **WAMPOLE'S PULVEROUS PILLS** with those of other manufacturers, as regards therapeutic efficiency, rapid disintegration, and beauty of finish.

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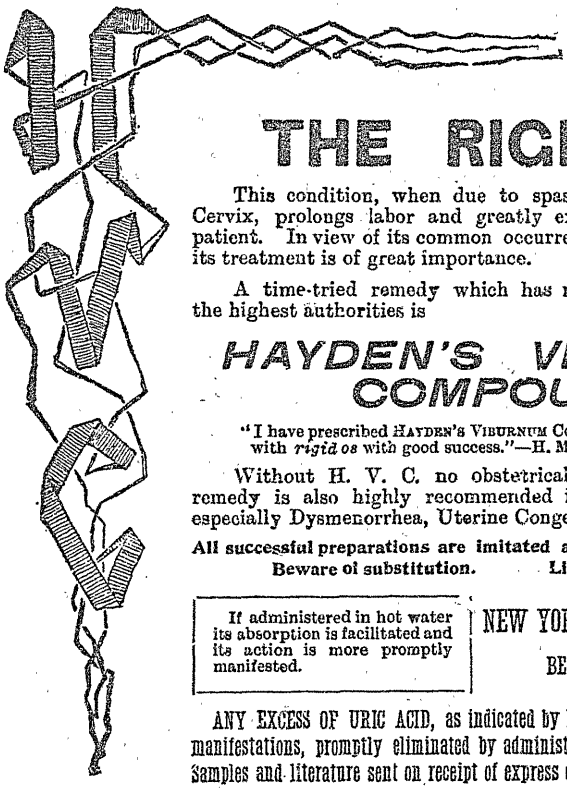

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This condition, when due to spasmodic contraction of the Cervix, prolongs labor and greatly exhausts the vitality of the patient. In view of its common occurrence in obstetrical practice, its treatment is of great importance.

A time-tried remedy which has received the endorsement of the highest authorities is

HAYDEN'S VIBURNUM COMPOUND.

"I have prescribed HAYDEN'S VIBURNUM COMPOUND in cases of labor with *rigid os* with good success."—H. MARION SIMS, M. D.

Without H. V. C. no obstetrical outfit is complete. This remedy is also highly recommended in all menstrual disorders, especially Dysmenorrhea, Uterine Congestion, etc.

All successful preparations are imitated and H. V. C. is no exception. Beware of substitution. Literature on request.

If administered in hot water its absorption is facilitated and its action is more promptly manifested.

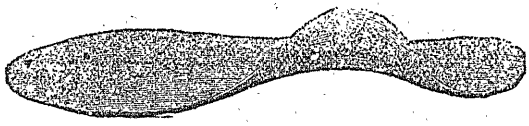
NEW YORK PHARMACEUTICAL CO.,

BEDFORD SPRINGS, MASS.

ANY EXCESS OF URIC ACID, as indicated by Rheumatic, Gouty and many local manifestations, promptly eliminated by administering HAYDEN'S URIC SOLVENT. Samples and literature sent on receipt of express charges.

HOLLAND'S IMPROVED INSTEP ARCH SUPPORTER.

NO PLASTER CAST NEEDED.



A Positive Relief and Cure for FLAT-FOOT.

80% of Cases treated for Rheumatism, Rheumatic Gout and Rheumatic Arthritis of the Ankle Joint are Flat-Foot.

The introduction of the improved *Instep Arch Supporter* has caused a revolution in the treatment of *Flat-foot*, obviating as it does the necessity of *taking a plaster cast of the deformed foot.*

The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the *heavy, rigid, metallic plates* formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *Flat-foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot.*

IN ORDERING SEND SIZE OF SHOE, OR TRACING OF FOOT IS THE BEST GUIDE.

Sole Agents for Canada: LYMAN, SONS & CO., Surgical Specialists.
380-386 ST. PAUL ST., MONTREAL.

CEREBRAL CONGESTION.—The following has been highly recommended:

℞. Potassium bromide.....dr. iij.
Fl. ext. ergot .....dr. ij.
Aq., q. s. ad. .....oz. vj.

M. Sig.: One tablespoonful to be taken t. i. d. This mixture has been found serviceable as a prophylactic after severe head injuries.—*N. Y. Med. Jour.*

EPISTAXIS FROM ANY CAUSE.—Dr. P. Chevallier, as quoted in *St. Paul. Med. Jour.*, recommends injection of gelatinized serum prepared as follows:

℞. Sodii chloridi .....dr. ij.
Aq. dest. ....O ij.

M. To this solution add gelatin in proportion of 10 parts to the 100 and sterilize. This becomes solid when cooled, but can be warmed in a water-bath when needed. As an astringent powder the following is recommended:

℞. Acid borici .....
Pulv. sacchari .....aa gr. 75
Antipyrini .....
Acidi tannici ..... aa gr. 15.

M. Sig.: To be blown upon the bleeding surfaces.

If it is not then checked, packing the nostril will then have to be resorted to.—*Jour. Am. Med. Asso.*

Notes.

SANMETTO IN GENITO-URINARY TROUBLES AND IN DISEASES OF THE MUCOUS MEMBRANES OF A CHRONIC CHARACTER.—I do not generally endorse proprietary medicines but Sanmetto is such an elegant combination that I must make an exception in its favor. I have used several bottles of it in my practice with the most gratifying and surprising results. I have used it in a case of inflammation of neck of bladder. Have also used it in several other cases and will say that I have never used any preparation which has given me such satisfactory results in genito-urinary diseases as does Sanmetto. I am afraid that the druggist, in one case, substituted the elixir of saw palmetto, which they have tried to have me use instead of Sanmetto, as it did not taste as it should, but I have tried so many preparations of saw palmetto with no beneficial results that I want the genuine Sanmetto or none.

RACINE, WIS. H. G. PECK M. D.

TREATMENT OF TYPHOID FEVOR.—Lieut. Col. G. Sterling Ryerson, M. D., of Toronto, later British and Red Cross Commissioner in South Africa, at a recent meeting of the Toronto Clinical Society ("Canada Lancet") reported that the treatment of typhoid

fever was practically the treatment which is adopted in Toronto and everywhere else. Disinfection of the bowel either by means of listerine or boric acid, taken internally, or enemata, proved in many cases to be remarkably successful. Another form of treatment was that of starvation. They were starved for seven or eight days. He considered that in some cases it might be dangerous, because a number of men were exhausted when brought in. The medical officer in charge of these cases, and under whose supervision this plan of treatment was carried out, informed Dr. Ryerson that he had fewer deaths than in any other hospital in Bloemfontein. Dysentery: this was another very prevalent disease, and you hear of a great many men affected with this disease when they merely had ordinary diarrhœa. Dr. Ryerson said that during his service as surgeon with the troops engaged in the suppression of the North-West Rebellion in 1885, he had observed the good effect of several drachm doses of listerine in treating camp diarrhœa and dysentery, caused by drinking the alkali water of the plains.—*Sanitarian, Nov. 1901.*

A Systemic Alterative Effect.—The following from *Gaillard's Medical Journal*, by Dr. A. H. Ashley, of Boston, Mass., will interest our readers because of the original way in which he expresses his pronounced admiration for something tried, trusted and not found wanting. The letter was written to our old friends, The Antikamnia Chemical Company, and reads as follows:

Gentlemen—Your various combination tablets, as well as antikamnsa tablets have been used by me for a number of years, and I can only say that they have uniformly given me the best results. But, my dear sirs, why have you waited so long to give us the very best combination of them all? I, of course, allude to your "laxative antikamnia & quinine tablets."

If their is anything known to the medical profession which will take their place in that class of diseases where one wishes to releive pain, control the temperature and at the same time produce, by laxation, a systemic alterative effect, it has not been my good fortune to find it. In those cases of severe neuralagia and particularly in ovarian and menstrual pain, where morphine was our only hope (and where, after its administration we had indigestion, bowels bound up, nausea, habit, etc.) you have in Laxative Antikamnia & Quinine Tablets a remedy which will, my experience has taught me, replace morphine and meet all requirements.

I am slow to be carried away by enthusiasm for any drug or combination of drugs, but I freely and voluntarily confess that in these tablets you have given to the profession a remedy so effective and reliable in its action that it offers good excuse (or a mitigating circumstance anyhow) for a little effusion from one who, as a general thing, is not given to gushing.

With my best wishes for your future and many thanks for your elegant preparations, I am sincerely yours,

A. H. Ashley, M. D.

The Rigid Os.—We all know how very trying it is to the physician, to say nothing of the unfortunate patient, who after some hours of suffering from labour pains finds herself tired and greatly exhausted, because of a rigid os.

This condition is so frequently encountered by all obstetricians, and unless relieved, prolongs labor and deplets the vitality of the patient. In these cases H. Marion Sims, M. D. uses Hayden's Viburmum Compound with good success and if this eminent practitioner so readily endorses ff. V. C. we have no hesitancy in freely recommending its use in the above condition.