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THE

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VOL. XX. HALIFAX, NOVA SCOTIA, MAY, 1908. NO. 5.

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THE
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Vaso-Constriction and Vaso-Dilatation.

Two luminous papers dealing with this subject appear in the *Medical Record* of April 25. George B. Wallace, of New York, discusses the anatomical relations of the vasoconstrictor and vasodilator nerves and their centres. The vasoconstrictor centres are mainly in the medulla, while there are other centres in the cord. The sympathetic ganglion cells produce tonus, and the neuromuscular junctions aid in this. The vasoconstrictor sympathetic nerves seem to require for their function the presence of an adrenal secretion. Vasodilator centres have not yet been ascertained to exist. The splanchnic areas are most freely supplied with vaso-motor nerves. The amount of blood in the brain is dependent on the amount in these areas. A rise or fall in general blood pressure is generally due to constriction or dilatation of the vessels in the splanchnic region. Vascular reflexes may be divided into two sets, one confined to the vascular system and another with impulses from other organs. The first set come from the heart. The second may come from the brain, and these are most important, and other organs. Those from the skin are well known.

Egbert Le Fevre, of New York, sketches the condition of the entire vascular system in pathological high and low blood pressure. There are three stages of changes in high arterial pressure; first, hypertonicity of the muscular coats of capillaries and arterioles; second, progressive hypertrophy of the muscular tissues of the cardiovascular system; third, diminished muscular control on account of progressive fibrosis, causing obstruction of vessels. Treatment must consider cause and stage of the process. We must recognize that hypertrophy is not confined to the heart, but to the whole vascular system. Only the first stage is curable. All causes of irritability in the daily life must be sought and removed, such as tobacco, alcohol, improper and excessive food, etc. Medical treatment should be directed to increasing the activity of the emunctorie. In the second stage we must not lose sight of the fact that hypertrophy is a conservative condition, and should not reduce it unduly, but only control it. Habitual excess in proteids may produce hypersensitiveness of the nervous system and reflex high tension. Other reflexes act in the same way. The general conditions affecting the kidney and the simply local sense diseases must be distinguished. When the kidney is diseased high pressure is necessary. Large amounts of water should not be used as a diuretic, as it increases the work of the heart. Vaso-motor dilators will relieve many symptoms. Used too freely they are dangerous. Sedatives should be used only when cardiac overaction occurs under excitement. Baths are most useful. Cold baths raise arterial tension and hot baths reduce it. Massage may be used to raise or lower pressure, according to the movements used.

Shortening Normal Labour. J. Landou describes a method which he has employed for the purpose of shortening normal labours (*Berliner Klinische Wochenschrift, British Medical Journal Epitome*, March 28). He only applies the method when the pains are regular and strong and the head lies in the pelvis. He passes one or two fingers, or even more, into the cervica' canal, and manually dilates the os, pressing the lips of the same over the progressing fœtal head. This is carried out without anæsthesia. The attempts must be limited to the period of the pains, and the head must be fixed sufficiently to insure that the manipulations do not force it back. He considers that gloves should always be worn for its performance, and that before the fingers are inserted, the external genitals should be disinfected. The manipulations usually induce powerful contractions on the part of the uterus, and thus within a short time the rigidity of the os passes away without any damage ensuing to the mother. He realizes that the method is not new, but he states that it is not mentioned in any text book at the present day. He does not believe that it is dangerous, provided that one is particular with regard to asepsis. The stretching must be carried out without any undue force, so that no risk of tearing the parts is present. His method differs from the manual dilatation for combined version, in that the latter is undertaken for pathological conditions, such as eclampsia, placenta prævia, etc., while the former aims at shortening the normal labour. He publishes the details of the method because he feels that at the present day the tendency to make incisions in all situations and under all sorts of conditions has gone much too far, and he is therefore anxious to stem this inclination. Further, he speaks openly against the attempts to render the labour painless by various, by no means harmless, medicaments —for example, morphine-scopolamine—instead of attempting to shorten the time during which the parturient woman has to suffer pain.

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Alimentary Intoxication. W. J. Butler, Chicago, writing in the *Journal of the American Medical Association* for April 4, discusses the condition called alimentary intoxication by Finkelstein, the clinical picture of which is better known under the names enterocolonic catarrh, milk poisoning, bowel infection, etc., and in its severer form, cholera morbus. It occurs in children who have been slightly abnormal, as shown by the temperature and weight charts, but without striking morbid symptoms. It is always preceded by a qualitative or quantitative increase or change of diet and the onset of intoxication is announced by marked nervous symptoms. After a varying period of inability, the infant is seized with convulsions followed by stupor or coma, or it becomes apathetic, drowsy and even comatose. The temperature usually rises sharply, but not always. The stools are often more frequent, but may seem normal at the beginning of the attack. There is considerable depression, and, in the severer cases, marked collapse with low blood pressure and livid skin. Before, or with the rise of temperature there is a sudden decline in the weight curve, the breathing is accelerated, rather deep, and may be misinterpreted as a pulmonary symptom. A striking feature at the height of intoxication is the alimentary glycosuria, dependent on lactose and galactose, and due to

their absorption and failure to undergo oxidation. Albuminuria and cylindruria may coexist. A leucocytosis, not exceeding 30,000, is always seen during the acute stage. The physiognomy is markedly different from that of the normal infant. The symptoms vary with the case, in some being typical, in others, one or other symptoms predominating. Finkelstein recognizes several forms; the choleraic with great loss of weight and collapse, and without marked cerebrospinal symptoms: the hydrocephaloid forms simulating a tuberculous meningitis; the soporose form, and asthma dyspepticum, in which the peculiar breathing is the most marked symptom. The incipient dyspeptic stage may develop into a chronic intoxication, a marasmus, instead of the acute intoxication described. Butler reviews the arguments for and against the bacterial pathology of the disorder and concludes that the cause must be sought, not in bacterial infection or food decomposition, not in toxins supposed to be contained in milk, as this condition may occur with the most careful preparation of food, but in an intolerable quota of nourishment, either quantitatively or qualitatively, or both, supplied to an infant already suffering from the nutritional disturbance resulting in an abnormal destiny of the nourishment in intermediary metabolism. The presence of glycosuria at the height of the intoxication would indicate some grave perversion of metabolism. The indications for treatment consist in combating the collapse, cutting short the intoxication, and bringing the child back to a diet commensurate with its caloric requirements. The first indication can be met by hypodermoclysis of salt solution, using from 50 to 100 c.c., and repeating when deemed necessary. The second is met by entire withdrawal of food and administration of water only for twenty-four hours. With the subsidence of all symptoms, he begins feeding with teaspoonful dose five times a day of centrifugated breast milk if possible, or, an equal quantity of buttermilk, adding neither sugar nor meal. If this is not available, fat-free milk may be used. As a diluent, water and a thin cereal gruel may be used. After twenty-four hours, if this is well tolerated, and no signs of the intoxication reappear, the milk may be increased to two teaspoonfuls, which after two or three days, all going well, may be again doubled, and so on two or till the diet (fat-free in artificially fed infants) is reached that will meet the caloric needs, having added in the meantime, with the increased tolerance of the buttermilk when employed, 30 grams of sugar, preferably maltose, and 15 grams of flour to each liter of buttermilk while boiling. In case of breast-fed infants, after four or five days' feeding carefully with centrifugated breast milk, the child may be returned to the breast, the amount of nursing being carefully controlled. The buttermilk diet should not be kept up over six weeks, after which whole milk dilutions will be required. Slight relapses are liable to occur during the treatment if the food toleration limit is passed. It is best to go slow, allowing forty-eight hours for judging the effect of each food increase. Cathartics and intestinal antiseptics are not needed unless there is constipation, as is sometimes the case in the soporose form, when a laxative is indicated.

Deaths Under Anæsthetics. A paper under this caption is contributed to the *Lancet* of March 21, by F. J. Waldo, based upon the author's inquiries into the mortality from anæsthetics in Great Britain. He reaches the following conclusions: (1) That present available data as to deaths during anæsthesia are so imperfect as to be useless for the purpose of formal investigation. (2) That the returns of such deaths are for the most part obtained from coroners' returns of deaths occurring in hospital practice. (3) That only a small proportion of deaths under anæsthesia in private practice ever come to the notice of registrars or coroners. (4) That imperfect as are the returns for England and Wales, those of Scotland and Ireland are still less trustworthy. (5) That with such imperfect data it is impossible to form any trustworthy conclusions as to the absolute rate of fatalities to administrations, or to the relative proportions of deaths to administratives in the case of particular anæsthetic drugs. (6) That it is highly desirable to arrive at satisfactory conclusions as to the precise facts of all deaths under anæsthesia, both for the safety of the public and the furtherance of scientific knowledge. He therefore recommends: (1) That no general or local anæsthetic shall be administered by any but a duly qualified medical man, except in most exceptional circumstances, which shall be duly reported to some recognized official authority. (2) That full details be kept by the anæsthetist of all administrations of anæsthetics, whether in hospital or private practice, including date, name and address of patient, of operator and administrator, nature of operation, the drug used, and other pertinent details. (3) That a register of all administrations of anæsthetics be kept in all medical charities, Poor law infirmaries, asylums, and other public institutions. (4) That so far as possible special skilled anæsthetists be appointed to all hospitals and infirmaries, and that resident anæsthetists be provided in all the larger institutions. (5) That when the administration of an anæsthetic is intrusted to a junior qualified man, he should be supervised by a skilled anæsthetist, except, where he can produce a certificate of special skill and experience as an administrator, or where a skilled anæsthetist is not available. (6) That notification be made to the coroner of all deaths occurring at any stage of general anæsthesia by the anæsthetist or by others concerned. (7) That coroners be required to hold a public inquiry into all cases of death during anæsthesia, and that they make a detailed report to the Registrar General, together with the verdict. (8) That a Royal Commission might with advantage be appointed to inquire into the present facts of death under anæsthesia, so far as may be ascertainable.

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Restoration of the Pelvic Floor. H. Hill, Kansas City, in a paper contributed to the *Journal of the American Medical Association* for April 4, remarks on the defective descriptions of the anatomy of the female pelvis in most English and American text books, and gives a detailed account of the various structures and their relations to each other and to surrounding organs. In perineal tears, the superficial injury to the vaginal wall, when extensive, is always to be found in the sulci on one or both sides and never involves the posterior vaginal column, a point to be considered in the repair of

hese lesions. The levator vaginæ, ccording to his observation, is torn n the median line down to the rectal wall and the attachment to the sphincter ani is ruptured, usually most on one side, although the fibres inserted into the cornua of the sphincter are torn on both sides. The explanation of complete tears is found in the firm attachment between the levators and the cornua of the sphincter in some cases. As a result of the laceration of the levator fibres attached to the sphincter, the anal canal prolapses downward and is drawn backward by the sphincter, giving rise to the so-called rectocele. Injury to the urogenital trigone is very common on account of its inelasticity, it being torn backward and separating into two portions, which, however, are easily found in operating. He calls attention to the frequency of rupture of these parts without tearing of the superficial perineal muscles, causing rectocele and cystocele with apparently normal perineum. This internal rupture is easily diagnosed by one acquainted with the anatomy, by palpation with one finger in the rectum and the other in the vagina. The fundamental principle in the repair of these injuries is the same as that underlying operation for ventral hernia, viz., bringing together the various anatomic structures into their original positions and securing them there by buried sutures. We should remember that these parts play on each other to a certain extent and that through-and-through suturing that would interefere with this should be discarded and layer sutures adopted throughout. He notices the work done in this line by Marcy, Goldspohn, Harris and others, and calls attention to the stress laid in their articles on the importance of the pubo-rectalis and the slight attention given to the suturing of the trigone and the reattachment of the sphincter ani. He then proceeds to describe the method which he has followed nearly a hundred times with excellent functional results. He cuts down to the sphincter, separates the lateral vaginal walls from their bed from about the middle of the vagina down to the rectum to expose the lower ends of the pubo-rectales; these are sutured together and to the sphincters at their lower ends, approximating them and pulling the sphincter toward the symphysis and up into the pelvis a variable distance, depending on the amount of displacement. The trigone is then sutured from below upward, and after two or three turns of the suture are introduced, the vaginal wall at its upper part must be separated from the trigone by blunt dissection and another stitch introduced. This last step is important, as it restores the vulvar orifice. When the trigone has been approximated to the proper extent the suture is then reversed and brought back from above downward as a subcuticular suture approximating the mucous membrane and afterward the skin, and is finally tied to the free end below, thus burying the knot beneath the skin. The various steps are illustrated. The after-treatment consists in keeping the wound dry by means of subiodid of bismuth and the application of a sterile vulvar pad.

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Treatment of Bone Tuberculosis.

"The Modern Treatment of Bone Tuberculosis" is the subject of a paper presented to the Medical Association of the greater city of New York, by Reginal H. Sayre, and reported in the *New York Medi-*

cal Journal for May 2. Having remarked that the scientific treatment of any disease must rest upon a clear understanding of its ætiology and pathology, he referred to the complete eradication by operation of tuberculous foci advocated by many surgeons before the natural history of tuberculosis was as well understood as at the present day, and said that in still earlier times the opinion had prevailed that non-interference was advisable in bone tuberculosis. The proper mode of treatment lay between these two extremes, for, while the good results noted from this course had been arrived at empirically, recent laboratory investigation had shown the scientific basis for the facts which were observed clinically.

The speaker dwelt for some time on the causation, course, pathological characteristics, and clinical history of bone tuberculosis, and emphasized the prime importance of early diagnosis. To this end it was requisite that the patient should be stripped, and if disease was suspected in the hip, knee, or ankle, both sides should be examined thoroughly. If there was any doubt as to the presence of disease in a joint, it was a great mistake to resort to an anæsthetic in making the examination, as this would take away the most reliable guide we possessed for diagnosis of early inflammation, namely, the involuntary muscular spasm by which nature protected the joints from traumatism. Almost the first symptom to be manifested in joint inflammation was spasm of the muscles controlling the joint, and it was one of the last symptoms to subside. In the course of his remarks on diagnosis he referred to the use of tuberculin, and said that as yet but little had been reported as to the reliability of this test.

Treatment of Neuralgia.

E. Schlesinger records his experience with the injection treatment of neuralgia in *Deutscher Medizinische Wochenschrift*, of February 6th. He considers that, with the exception of those rare cases in which syphilis or malaria are the causal factors of the neuralgia, one is forced to employ symptomatic treatment, since the actual nature of neuralgia is not known. Schleich first pointed out that the injection of certain solutions in the neighborhood of affected nerves removed the pain. Various modifications have been suggested since this time (1899). At first cocaine was a necesary constituent of the solutions. As time went on, the solutions used became weaker, and still later it was realized that the effect was not due to pharmaco-dynamic action, but to mechanical effects. One therefore tried the effect of injecting large quantities of isotonic salt solution. Acting on the suggestion made by Oelsner, Schlesinger attempted to combine the mechanical with the thermic effect, and therefore employed saline solution which had been cooled down to below 0° C. It has been shown that even extreme degrees of cold do not impair the vitality of nerve tissue. He carried out his injections by first producing a wheal by injecting some of his cold solution into the skin through a very fine needle, then he inserted a needle of not too coarse calibre, about 8 Cm. in length, deep into the tissues, injecting a little solution as the needle proceeded. He does not aim at injetcing the solution into the nerve sheath, as he realizes that even in the most skilled hands this can be only attained by accident. It might even be harmful, if one succeeded, especially in mixed nerves like the sciatic, where the motor fibres would be attacked as well as the sensory. He

is therefore satisfied to inject the fluid in the neighbourhood of the nerve trunk. In all he has treated 42 cases of sciatica by this method. In these cases a cure was obtained in all but four by a single injection. He dealt with five acute cases. Three of these required more than one injection. In one of them, two injections only removed the pain for a few days. The other four were permanently cured. Of the chronic cases he mentions two in which the sciatica developed in the course of diabetes, and both of these were cured without any harm being done by the cold fluid. In other forms of neuralgia he obtained good results. These included supraorbital, trigeminal, and intercostal neuralgias. He has also had satisfactory results from the injections in girdle pain in tabes and also in gastric crises. He, however, only touches on the last named cases, and does not wish it to be thought that he claims this method to be a "cure all."

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Heart Block. In the *British Medical Journal* for April 4th, E. O. Jellinek and C. M. Cooper report, with comment, six cases of heart block, with the results of the post-mortem examination in one case. Three of the patients were comparatively young, twenty-seven, thirty and thirty-one years respectively, and two of these died, the third being in the preparoxymal stage and recovering. All of the patients came under observation complaining of attacks of the nature of semi-faints, the patients not quite losing consciousness. Several of the patients complained of aurae or preseizure sensations. These may be due to: (1) Extra systoles which coincidently in some cases, in others perhaps regularly, precede the seizure, the description given being not unlike the so-called "aurae" in Adams-Stokes's disease. (2) Slight, short seizures, preceding more prolonged ones. (3) The pumping in of blood into comparatively empty blood-vessels after an extra systole has failed to open the aortic valves; this, for instance, causing an additional pulsation in some of the vessels. The attacks seem to occur in spells and are an indication of the temporary breaking down of the ventricular compensation. It is remarkable from what seizures or series of seizures people can recover and afterwards lead a useful life for years. Pulsations of the veins of the neck can only be detected during the shorter, milder attacks. The sounds as heard over the auricles are shortened miniature toneless imitations of the normal first and second sounds as heard at the apex. In no case was there any œdema. Clinically hearts of four of the six patients were greatly dilated and hypertrophied. Rest in bed was the most salutary factor in treatment, drugs having but little or no influence.

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Removal of Local Stasis. William Benham Snow, of New York, claims for static electricity and radiant heat, the power of removing stasis whenever it occurs as an active process. In cases where it is the result of degeneration or is of the passive form, these measures do not succeed. In the early stage of inflammation moist heat or radiant light are of great value. Radiant heat from a source of high candle power is more penetrating than any other form of heat. It increases the inhibitory power of the tissues against bacteria. Electricity of great potential, low periodicity, and small quantity removes obstacles to regenera-

tion in inflammation and promotes tissue proliferation by inducing profound contraction, tissue vibration and cellular activity. The wave and static induced currents, static brush discharge, sparks, direct vacuum tube, and spray are the applications of value. Contractions are produced and stasis removed. In acute cases the exudate is absorbed, tissues softened and swelling disappears. In chronic cases fibrin and inflammatory products are eliminated and local circulation and metabolism are restored. Indolent ulcers are stimulated and germs destroyed. Pain early disappears. The author has found benefits to be obtained in prostatitis and seminal vesiculitis, urethral caruncles, sciatca, brachial neuritis, herpes zoster, intercostal neuralgia, tic douloureux, Bell's palsy, anterior polomyelitis, sprains, synovitis, and rheumatoid arthritis.

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Medical Emergencies.

The National Volunteer Emergency Service, instituted in 1900, has recently been re-organized by the election of Dr. James Evelyn Pilcher, the distinguished editor of *The Military Surgeon*, as the Director General, and Dr. F. Elbert Davis, of New York, as its Adjutant General. Its work will be conducted along military lines, the details being worked out in three separate Corps, a First Aid Corps, a Public Health Corps, and a Medical Corps—the latter consisting of physicians, with rank from Lieutenant to Colonel, according to length of service, to whom are afforded special opportunities for emergency training. It includes among its personnel a large number of notable personages, and is rapidly extending its membership throughout the country. Full details regarding the Service and its great work may be obtained by addressing Director General Pilcher at Carlisle, Pa.

The Fifth Pan-American Medical Congress will take place in Guatemala, C. A., this year from Aug. 5th to August 8th, inclusive.

THE MEDICAL PROFESSION: WHAT'S THE MATTER WITH HER? SHE'S ALL RIGHT! IS SHE?

By H. A. MARCH, M. D., M. P. P.

Bridgewater, N. S.

(Read before the Halifax and Nova Scotia Branch, British Medical Association, March 4, 1908.)

HAVING in a moment of abstraction, contingent upon the appreciated honour conferred, permitted myself to respond in the affirmative to an invitation to write a paper for this branch of the British Medical Association, and the time for the preparation of the same having come, my temerity began to dawn in a magnificently bewildering manner. Not because of the lack of interesting subjects, not because of the paucity of literature upon topics medical and surgical, nor yet because any any want of interest in the grand work of the profession; but simply that I felt it would be little less than criminal to take up the time, the valuable time, of so many busy physicians without giving them something of worth in exchange therefore. Then, too, not being a specialist, nor addressing myself to specialists, my only recourse seemed to be some non-specialistic theme, which, strictly speaking, bearing in mind the multiplicity of the divisions of modern medical and surgical work, I found could not be found. And so, Mr. President and gentlemen, permit me if you please, to address to you a few observations under the caption "The Medical Profession: What's the Matter with Her? She's All Right! Is She?"

If I were asked to parse "medical profession" in the above, I should say the medical profession is a noun, common, third person, singular, and in the objective case.

The medical profession from its nature and intent, involving as it does the essentials to all that is best in "the life that now is," namely health, is and should be, not only by its devotees, but by all, considered worthy of respect, deference and assistance, without which its ideals cannot be approached, the good which it might do cannot be done.

It is not necessary for the purpose of my argument to show you wherein the medical profession is all right. To detail even the names of the modern benefactors in the line of pathological and physiological research would consume the whole time at my disposal. And who would attempt to depict the wonderful results of their labour! The patience and daring of the host of modern surgeons would furnish of itself a theme for a large volume? The sacrifice of time, means and life itself, on the part of the army of unselfish practitioners would make a history at once as romantic and pathetic as any extant. Seek you for examples of aptitude, courage, devotion, energy, force, greatness, heroism, judgment, kindness, loyalty, magnanimity, nobility, usefulness, veracity, scientific veracity and work, and you may find them all in the highest degree exemplified by the truly great in the medical profession.

I said a few moments since, if I were asked to parse "medical profession" I would call it a noun, common. This is one of our great faults of to-day. We are too common. We are becoming too much like other people. In the struggle to exist the profession is resorting to the competitive methods of the tradesman and the artizan. We are becoming so myopic that our ideals fail to reach and impress the retina. This kind of myopia is I find infectious, one case in a community of medicos, if not quarantined strictly and the habitat thoroughly disinfected, is liable to infect others. The disease itself leads certainly to degeneracy and premature decay. That this has not escaped the observation of the keen-eyed and unscrupulous quack is evidenced by the flippancy with which he takes the name of the physician in vain in his circulars and in his advertisements in the public press.

Time was when the family physician's was a name to conjure with. To-day, although he is as a rule certainly more competent, being in possession of larger knowledge and experience, he is laid aside as a garment. He has become common. So much is this the case that in my examinations for life insurance I am frequently shocked to find upon asking the question: "Who is your family physician?" that the applicant looks at me with a querulous expression, something like a small boy doing mental arithmetic. The fact is he is puzzled in couting up the names of the physicians he has employed during the last year or two, to select one to whom he may possibly apply so strange and unfamiliar a name. What is the reason for this? "The day of large families is passing away among the so-called better classes, and in consequence the demand for the family physician is not so pressing as formerly," says one. But whence the wisdom which makes this passing of the family possible? Truly the medical profession is too common.

The medical profession is in the next place in the third person. That is it occupies a retrograde position relative to that which it should occupy and which it might occupy as a profession in the world to-day. The avenues of influence are peculiarly open to it, more so than to that of any other. Its acquaintances and friendships are more familiar, its companionships, so to speak, are of all ages, ranks, and conditions. Character analysis is its business; mind reading its legitimate opportunity; to impress, both by precept and example, healthy sentiments its prerogative; and yet in its corporate capacity it is powerless to secure in many instances legislative enactment which would redound to its own credit and the best interests of mankind in general. Wherein lies the weakness? The world accepts our sacrifices and benefaction as a matter of course; calls upon us when in dire extremity, and frequently laughs at and flouts our necessity. The trouble is there is a sad lack of corporate assertiveness. Self-abnegation, self-subjection, the true children of the life of the profession on the one hand; and sordid selfishness and criminal quackery its illegitimate progeny, on the other, have been laying waste the professional estate.

In the next place, sir, it is singular as well as in the third person, and singular in more ways than one. That a profession with such traditions; with such a history of achievement; a profession which contributes to the health and in consequence to the wealth and happiness of the human race more than any other, as

far at least as time is concerned, showed in the hour of its magnificent triumph in the cause of humanity and upon the eve of still greater, fail to recognize fully its importance and the whole magnitude of its mission, is, to my mind, most singular. It is also singular in view of the fact that whilst most other trades and professions are organized up to the hilt, bringing to bear every resource, reaching out into every avenue, the medical profession with its resources of inheritance, of willing talent and true righteousness should lag behind.

Some one says this is all the language of a pessimist—a sort of medical blue ruin insanity rant. I wish I could believe it. The medical profession is the grandest, the noblest, the most Christ-like profession existing. Hunters, McDowells, Pasteurs, Listers, Virchows, Kochs, Wrights, Keens, Bromaruntons, Bullers, Oslers, Kellys,—their name is legion, and the end is not yet. Who can begin to estimate the results of their labour? These have merely paved the way to greater achievements. After all upon the great unnamed devolves the privilege of distributing their humanities. But, are they doing it with reachable precision? Is the profession in general "On to its job?" How may this best be done? How can we remedy the defect, mend the breaks, stop the leaks, oil the machinery, ballast the road-bed and superintend all successfully? That—that is the problem.

There are two chief kinds of influence in the world to-day—money influence and influence of position. To use a slang but expressive term, the medical profession does not "shine" at all prëeminently because of the former, and is at least in partial eclipse respecting the latter. This is the singular part of it, for the influence of position is its peculiar property.

In the next place, sir, the medical profession is in the objective case. It is the butt of the charlatan and quack,—the daily competitor on questions of diagnosis with the cancer doctor, the busy-body and the complacent and superstitious but omniscient old dame. The courts of the land compel it to disgorge its hard-earned knowledge without remuneration, and frequently subsequently comment upon the entire worthlessness of the result, which latter, even if true, is well worth the money. That it is possible for a physician to be called into court to give testimony upon medical matters—his stock in trade so to speak—unremunerated, is a disgrace to the profession and unmitigated legal unrighteousness. That the health of our Province is a matter of so little consequence that the chief official is remunerated to the magnanimous extent of less than one thousand dollars and no cents—Well! There is no sense to be recognized in the fact.

The truth of the old adage—"An ounce of prevention is better than a pound of cure" is axiomatic. We may or may not be competent to arrest disease, but it is within our province to prevent it. This is the great work that bacteriology has done so much to elucidate. Herein the physician of the future will find his most acceptable and gratifying employment. But in order to the accomplishment of the best we must have the loyalty of not only the profession, but of the people in general. How are we to remedy our professional defects and secure the sympathy of the populace in this work of prevention? We have our medical societies, through education and organization, but these as a rule are not doing what they might, because they only

reach the few. We are not, nor have we been as a profession, fully up to the high responsibilities devolving upon us by virtue of our profession along the line of prevention. Diphtheria, streptococcic, staphylococcic, pneumococcic, herpetic, syphilitic and other throat infections, are matters of intense interest to the profession in this connection. I have found an apparently slight sore throat through bacteriological examination to be diphtheritic, when otherwise I should not have had the slightest suspicion of it; and on the other hand when, where the throats of the affected had every appearance of a severe form of the dread malady, bacteriological examination has proved the contrary. Mistakes made through lack of precaution in these cases have to my certain knowledge been the means of severe epidemics of diphtheria. Isolation in these cases can do no possible harm, as the patient is the better for the rest and quiet in consequence, and in the event of the disease being infectious his family and friends are protected. There is a tendency in some authoritive quarters to minimize the value of quarantine which in my humble judgment is a decidedly retrograde step. Our methods may have been open to criticism, but to isolate, and that strictly and conscientiously, is the only reasonable course to pursue in the light of present knowledge, and this isolation should include infections at present omitted in the list of our health legislation. It has been argued that the stringency of our quarantine regulations frequently leads to concealment and evasion. This is true of every law and can only be combatted by education.

The prevention of tuberculosis is, I am pleased to say, occupying the attention of the profession and many of the laity as well. Leagues are being formed and as a result we may look forward hopefully to the time when we shall be relieved of the horrors of that most hopeless of all diseases. But in order to reach the desired end, even here education of the masses must be vigorously prosecuted. Herein opens up an opportunity for the profitable investment of time, talent and money. The gospel of enlightenment to the ignorant and of hope to the hapless incipient must be proclaimed with no uncertain sound. Strenuous efforts here, as in the suppression of all infection, will pay, humanity will be helped and the profession reinstated.

Now, Sir, what does all this lead up to? Is there anything practical in it? In the first place, the profession should bestir itself, not primarily as a close corporation but in the public interest. It has been said that we have grown weary in our efforts to assist the people against their will. This I submit is not an attitude to be thoughtfully assumed. We want legislation in behalf of the people. I would go so far as to say that before a physician should be entitled to practice medicine or surgery in our province he should be solemnly bound to uphold all the medical and health legislation of the province. When a law for the protection of the public health is enacted the carrying out of it should be obligatory. And secondly, the Provincial Health Officer should be remunerated to an extent that would permit him to devote his whole time and attention to matters of public health, because they are of paramount importance. Professor E. Ray Lankester, of England, one of the most eminent of modern biologists, says in a work he has recently written called the "Kingdom of Man":—"The knowledge of the causes of disease has become so far advanced that it is a mat-

ter of practical certainty that by unstinted application of known methods of investigation and consequent *controlling action, all epidemic disease could be abolished within a period so short as fifty years.*"

The laity know very little about themselves or their diseases. Some know enough to wear a nutmeg suspended from their neck, others a small bag of saltpetre; whilst others, still wiser, send for the cancer doctor to destroy their facial contour because of a small wart on the eyelid or an herepetic eruption upon the lips. One sends his children to his neighbours to get the measles, and another declares it's only chicken-pox when it is small-pox, on the authority of his physician, for fear he might lose the sale of a pound of nails, a spool of thread or a postage stamp.

My object in presenting you with these desultory remarks is a twofold one. In the first place, I want to try to impress upon the profession this fact, which we do not seem to realize in the degree we should, that we are responsible to the people, for the reason that we, and we alone, are cognizant of the whole facts, and in the second place and finally, that if we do realize the conditions we are not as intelligently active as, under the circumstances, we should be.

There are, of course, obvious reasons for the state of affairs suggested. Perhaps the chief reason is the overcrowding of the profession, which begets and fosters commercial competition. Why should we be delicate about using every legitimate means to press the claims of the people? For our protection, in this regard, ensures their safety.

Our Provincial and County societies should be one organization, the latter reporting to and subservient to the former. Our Health Leagues, Anti-tuberculosis Leagues, should report to, and be a part of, the controlling organization. All the machinery for the protection of the public health in our province should be interdependent and working harmoniously. Now if I am not criticizing the honest, self-sacrificing work of the few upon whom hitherto all the organized work of the profession has devolved, but simply making a plea to the profession as a whole through a very worthy and influential branch of it.

Just one word more and I am done. We should use the public press, as a profession, more than we do in the great work of educating the people. Valuable articles suitable for public contemplation, frequently are confined to the medical journal. "All these things require money," is suggested. Well and good! Get medical men in line, and the confidence of the people which ensures legislative support, and the money will be forthcoming.

Now, Mr. President and Gentlemen, I am fully aware that no new thing has been said or suggested, but simply a reiteration, and a re-reiteration of well recognized facts. My desire, however, has been to assist the work in which we are all engaged, and I believe that reviews are profitable even though frequently unappreciated.

At the expense of being charged with presumption and egotism, permit me to quote what Ruskin has said of himself, in my own defense respecting these observations: "Not an unjust person; not an unkind one; not a false one; a lover of order, labour and peace. That, it seems to me, is enough to give me right to say all I care to say on ethical subjects. More I could only tell definitely through details of autobiography such as none but prosperous and (in the simple sense of the word) faultless lives could justify; and mine has been neither."

EMPYEMA

By W. H. MACDONALD, M. D. C. M.,

Rose Bay, N. S.

(Read before the Halifax and Nova Scotia Branch British Medical Association March 4, 1908.)

AS empyema or suppurative pleurisy is an affliction with which the general practitioner is quite frequently called upon to deal, it becomes us to occasionally review the subject. It is not my intention to attempt an elaborate discussion of the subject, but simply to treat it in a very practical way from the standpoint of the general practitioner, and particularly to deal with the symptomatology and treatment of the more acute forms. Empyema is an accumulation of pus in the pleural cavity independent of the lung substance, and is met with (1) as a sequence of acute pleurisy through infection, (2) as a secondary inflammation to some infectious disease, such as scarlet fever, measles, influenza whooping-cough, pneumonia, tuberculosis and (3) from local causes—injuries to chest wall or lung, malignant disease or perforation of visceral pleura.

As to the nature of the infection, the organisms most frequently present are the pneumococcus, the streptococus, the staphlococcus, tubercle bacillus, typhoid bacillus, and bacillus coli communis. The pus varies in character from the thick, creamy, sweet-smelling form found complicating pneumonia, to the thin, brownish, extremely foul-smelling form due to the bacillus coli communis.

It appears at times to be epidemic in character. In the County of Lunenburg four or five years ago, during an epidemic of la grippe, an unusually large number of cases of empyema were reported. In my own practice, during the years of 1901 and 1902, I saw about fifteen cases, while during the past two years not a single case has occurred, although there has been the usual number of pneumonias and other infectious diseases.

The symptomatology of empyema is of first importance, as a successful issue largely depends on an early diagnosis. Cases seen early result favourably under proper treatment, and the sooner the purulent fluid is removed, the quicker the recovery. These cases should never be allowed to grow old. Few cases should be allowed to die even in the latest stages, without an attempt to relieve them by operation.

The disease may begin abruptly with chills, pain in the side, dyspnea, high and irregular temperature, rapid pulse and the usual physical signs, but more frequently, and almost altogether in my experience, it comes on more or less gradually in the course of some other disease.

Following pneumonia, for instance, the patient may be running the usual course, or the temperature may have dropped to normal, when gradually, or perhaps, suddenly, the temperature rises, a chill is experienced, and the respirations become rapid. The usual symptoms of septic infection appear, deepening pallor, leukocytosis, sweats, loss of appetite and increasing weakness. The cough is sometimes, but not always, a prominent symptom.

On physical examination a comparison of the two sides must be

made, and we observe the disproportion and the difference in expansion between the two sides of the chest and the absence of vocal fremitus on the affected side. The absence of voice vibrations in empyema, as in all effusions, is a valuable physical sign.

Then the intercostal spaces will be more or less obliterated or they may even bulge. A symptom not often mentioned in the text books, but which I have almost always found present, is the peculiar boggy conditions of the chest wall over the fluid area. This is peculiar to this condition, and in my limited experience has proven a useful diagnostic sign.

The position of the heart will probably be altered, the cardiac impulse being found to the right or left of sternum according to side of the chest involved. On percussion the marked dulness of the one side, varying in etxent according to quality of fluid present, and the skodaic resonance above the level of the fluid are found. The dulness is of a peculiar woody quality with this, with the doughy feeling mentioned above, presents a condition found nowhere else.

These are the symptoms found more or less regularly in cases of empyema, but they alone would not produce positive evidence of the true condition. An exact diagnosis can seldom be made without the aid of an aspirating needle. Early and frequent use of a proper sized needle should be made in every suspicious case. Pus may frequently be found with the small hypodermic syringe, but one cannot be satisfied as to its *absence* until a fair sized needle has been repeatedly inserted in different locations. I wish to emphasize this point. A thoroughly clean syringe, properly used, can do no harm, and the operation can be made almost painless, by the use of a local anæsthetic, or even by a drop of strong carbolic acid on the skin.

If pus be found, in the acute conditions, with which we are more particularly dealing, there is no question as to the treatment. It should be dealt with as any abscess. Aspiration is not sufficient and should not be adopted except as a temporary measure in severe cases or as a preliminary step in cases where there is much displacement of the heart. The indication is for early and free incision and proper drainage.

The practice of repeated aspirations has still many advocates and many patients have been cured by that treatment, but the operation of thoracotomy is so simple, so void of pain or danger, and so vastly more satisfactory, that I can conceive of no reason why, except in extraordinary cases, it should not always be employed.

The use of a general anæsthetic, as advised by several authorities, is unnecessary and involves considerable danger for the patient who is laboring for oxygen under the pressure of an empyema.

The insertion of a small quantity of a cocaine solution, or better still, of some local anæsthetic such as codrenin, into the skin and through the chest wall, will enable the operator to make a satisfactory incision and inflict little or no pain. The opening in these cases, as in all cases of abscess, should be made as low down as possible to procure effective drainage. The eighth interspace at the posterior axillary line seems to be the most satisfactory position.

The patient is placed on the table, lying on the sound side with arms folded to draw up and steady the scapula, the chest wall made surgi-

cally clean, the local anæsthetic injected and a free incision made in a line with the rib and on a level with its upper border to avoid the intercostal artery. The pus will at once well out,—but its escape should not be too rapid. A hole is cut in a piece of iodoform gauze, a good sized tube of stiff rubber guarded by a large safety-pin passed through this hole, and inserted into the incision a proper depth. By means of a tape tied to the ends of the safety-pin and passed around the chest wall, the tube can be held nicely in place. It should then be loosely covered with sterile gauze and absorbent cotton, and bandaged. The outer dressings should be changed as often as necessary and the tube cleaned daily. As the quantity of pus diminishes, the tube can be shortened, and a few days after the discharge has ceased it can be removed altogether.

This simple treatment I have followed in some fifteen cases, and as they all made good recoveries and are still living and well, I am satisfied to continue until results prove less satisfactory, or until a simpler or more expeditious method is demonstrated.

To aid in the expansion of the lung after operation, good results are obtained by having the patient blow through a tube and by air pressure, transfer water from one bottle to another. Large bottles should be used and the length of time so occupied, increased as the patient grows stronger.

The general treatment is, of course, also important. Fresh air, nourishing, easily - digested food, eggs, milk, etc., are all necessary. Tonics,—iron, quinine, strychnine and cod liver oil—are useful in increasing the resisting power and hastening convalescence.

In regard to the treatment of empyema, as in all things, different opinions are held, and several authorities maintain that simple incision is not sufficient, and that resection of a piece of rib, sometimes leaving the periosteum, should be done in all cases. This is a more serious operation, requiring a general anæsthetic and greatly increasing the shock in an already exhaused sufferer. There are, no doubt, cases where resection is advisable, but the indications should be clear before recommending it.

Other lines of treatment are suggested, but time will not permit my discussing them.

Concerning the treatment of the more chronic forms I shall say little, but leave it for discussion by the members of this society. No doubt in many cases with contracted lung, Estlander's operation, *i.e.*, excision of portion of several ribs, facilitates retraction of the chest wall and the obliteration of the pleural sac, which is essential to a cure. I have seen no such cases outside the hospitals, and those I have seen in the hospitals certainly did not offer much encouragement.

Decision of the thickened pleura in chronic cases is highly recommended by some surgeons.

Flushing the cavity with antiseptic solutions has its advocates; in acute cases this is not necessary.

The treatment of tubercular empyema requires special consideration. Here you have a tubercular infection and we are anxious, here, as in tubercular disease of the hip joint, in psoas abscess, and in tubercular disease generally, to avoid a mixed infection. The poor results obtained from opening tubercular empyemata compels us to see the wisdom in the advice of Mr. Watson Cheyne and

Mr. Barker, of London, who advise in these cases the aspiration treatment only.

I have briefly noted the important features of eight cases, which seem to present a variety of conditions and a good contrast between the acute and chronic types.

CASE I.—M. L., school boy, age twelve, good family history. Lobar pneumonia. Ran regular course with high temperature, crisis on the 9th day. Temperature below 99.5 for 3 days. Sudden rise to 101 with chill—next day 103. Increased dyspnea, dulness on percussion and physical signs of fluid—aspiration with hypodermic needle showed pus. Operated, simple incision in 7th interspace, post, axillary line. Copious discharge of creamy, sweet-smelling pus, continuing for 1st week, gradually decreasing. Temperature dropped to 99 second day after operation and general condition rapidly improved. Discharge stopped during second week. Tube removed at third week. Complete recovery, well and strong to-day.

CASE II.—W. G., 4 year old boy. Lobar pneumonia, severe attack, pulse 135, temperature 104, respirations 60 for several days, gradually dropping, but no crisis. On 12th day temperature rose two degrees. Dulness on affected side increased and the peculiar boggy condition of chest wall observed. Inserted small hypodermic needle with no result. Thirteenth day inserted larger needle which brought pus. Respirations had markedly increased in frequency and condition looking serious. Operated, doing simple thoracotomy, large quantity thick, creamy, sweet-smelling pus welled out. As large a tube as could be entered was used. Wound dressed once a day—discharge gradually lessening until at end of fourth week tube was finally removed. Patient is now perfectly well and has been so since operation.

In this case a general anæsthetic would have been dangerous. Though a very nervous child, he did not mind operation at all.

CASE III.—A. C. Age 20. Fisherman. Lobar pneumonia, very severe illness. Temperature, pulse and respirations running unusually high. About tenth day was marked improvement lasting two or three days, when, with a chill, condition became worse, respirations increasing to 55.

Aspiration revealed presence of pus. Patient very weak, chest was opened at once by simple incision and large quantity creamy pus drained slowly off. Here we had some difficulty in keeping a drainage tube in position. A hard rubber tracheotomy tube was used and found to work exceedingly well for first week, the inner tube being easily removed for cleaning. After operation temperature began to drop and in four or five days reached normal. Discharge gradually disappeared and tube removed about third week. Patient made a good recovery.

Two and a half years later this man was accepted for life insurance. Examined two years ago, three years after operation, patient perfectly well but evidence of thickened pleura.

CASE IV.—This case occurring in the practice of Dr. H. K. McDonald, of Lunenburg, was so interesting that I secured the notes from the doctor, as they go to show that even in desperate cases the simple incision is sufficient.

A. R., age 18. Fisherman. Pleurisy, right side, not aspirated. In six days pus discovered. Incision made and tube inserted. Did well for a few days when respirations increased to forty-five, with chill and dulness

on left side. Patient was greatly exhausted and condition seemed hopeless. Aspiration with hypodermic needle, negative; but larger needle of pocket aspirator revealed pus. Thoracotomy at once performed. Pus drained off. In spite of the worst hygienic conditions and nursed only by charitable neighbours, with both tubes draining off pus, patient made a slow, but steady recovery, and in five weeks was about the streets again. He is now well and pursuing the all important cod on the grand banks.

CASE V.—Mrs. S. Good family history. Three weeks after confinement developed pain in left side with chills and rise of temperature to 103. Some cough. Dulness and boggy condition of left chest wall. Aspiration disclosed presence of dark coloured fluid. Operation by simple incision and escape of large quantity brownish coloured, extremely foul-smelling pus. Recovery tedious, but uninterrupted. In this case had considerable trouble with recurring and painful eruptions about site of operation. Recovery satisfactory. Patient now well.

CASE VI.—Mr. A., age 26. Fisherman. Tubercular family history. Pneumonia, severe attack. Temperature running to 105; respirations, 60; puse 135. At height of illness pus discovered on affected side. Condition so serious, decided to do preliminary aspiration. Removed three pints creamy pus with potaine aspirator. Condition relieved and gradually improved. In two days dyspnea returned, aspirated again, removing four pints pus. Gradual improvement. Aspirated again in third week, and again in eighth week. Patient made slow recovery, objecting to operation. Fifth aspiration in third month. Patient afterwards said he could feel presence of pus inside, but was getting along fairly comfortably, and steadily improving. Seen by Dr. John Stewart, who advised, as patient was doing so well, to continue on as he was. No aspiration since, and now six years afterwards, patient is a well, active and quite fleshy butcher who keeps me busy attending his wife in the obstetric way. There is, however, dulness in lower chest wall and thickened pleura. Here operation would have given better result.

CASE VII.—J. M., age 70. Pulmonary tuberculosis. Had attack pleurisy. On aspiration pus discovered. Decided here, as patient was old and weak, to aspirate with potaine aspirator. Drew off two or three pints browish coloured fluid having a fearful odor of H 2 S Condition improved and second aspiration performed in two weeks. Patient was fairly comfortable until his death six months later from pulmonary tuberculosis. This fluid in gelatine culture showed presence of gas-forming bacillus, resembling in appearance the bacillus coli communis.

CASE VIII.—J. W., farmer, age 36. Pulmonary tuberculosis. Pleurisy left side—twice aspirated—demanded operation. Thoracotomy was done and discharge continued for nearly a year. Went to Victoria General hospital, where a resection of portion of two ribs was performed, but condition two years afterwards remains same. No signs of healing. Here probably repeated aspirations, aseptically performed to avoid mixed infection, would have produced better results.

Pneumonia and pleurisy cases particularly show satisfactory results from thoracotomy.

In conclusion I wish to repeat what to me seem to be the points most important to note.

1.—The great importance of early diagnosis.

2.—The wisdom of and necessity for early and repeated aseptic use of the exploratory needle for diagnostic purposes

3.—The immediate evacuation of the pus by the safest and simplest method that will insure satisfactory drainage.

4.—Simple incision under a local anæsthetic in the majority of cases, particularly pneumonia cases, will prove sufficient.

5.—That the operation is simple, not dangerous, and can be performed by the general practitioner without assistance, if that be unavoidable.

6.—That in tubercular empyemata aspiration is the preferable procedure.

To COMBAT TUBERCULOSIS in NEWFOUNDLAND

EDITOR MARITIME MEDICAL NEWS:

SIR,—An association has recently been formed in Saint John's, Newfoundland, for the purpose of fighting the dreaded plague of consumption throughout the whole colony.

The work such an institution has before it is a very heavy one, and to accomplish anything in the way of reducing the very high mortality will mean much self-sacrifice on the part of its members.

Very fortunately the association has begun under the very best auspices. His Excellency, Sir Wm. McGregor, Governor of the Colony, is interesting himself in the good work, and knowing the colony and its requirements as he does, will make a valued adviser. He is, as is very well known, a Doctor of Medicine, which will, of course, make his assistance all the more valuable. The Honourable John Harvey, a distinguished member of the Legislative Council, and one of the leading business men of the colony, is the real originator of the movement, and has been appointed president of the association. Besides all the leading men, including members of the Executive Council, members of the Legislative Council and of the House of Assembly, clergymen, physicians and business men throughout the whole colony are becoming interested in the work and with such a beginning there is every reason to believe that much good shall result.

There is in Newfoundland a population of about 230,000, and from leaflets already distributed by the association, we gather that 1000 persons die annually of one form or another of tuberculosis of the lungs. It is also estimated that 20,000 persons in Newfoundland are at present more or less infected. Since 1901 the leaflet informs us, the increase in the mortality from tuberculosis is nearly fifty per cent., and it is still increasing. One-half of all deaths between the ages of 18 and 35 are caused by consumption.

This makes the situation look very alarming, and the necessity of a vigorous association to combat the scourge is very apparent.

Fortunately the right men are behind the movement and if anything can be done these men will do it.

Preventive measures have done much to reduce the mortality in other countries, and there is reason to believe that such measures cannot fail if carried out in this country. Something certainly has to be done, or eventually it will mean ruin to the colony. Dr. Morton, in his very excellent presidential address, delivered last November, before the Halifax and Nova Scotia Branch of the British Medical Association, said that he believed there was more tuberculosis in Nova Scotia, or in the Maritime Provinces, than any other country of the same population in the world, but if the statistics gathered by the Saint John's Association be correct, it is difficult to imagine a worse condition of affairs than exists in Newfoundland.

The cause of so much consumption in Newfoundland is very plain to anyone knowing existing conditions, notably to the medical men in the outports, To remedy these conditions the association has a very heavy problem before it, but when ability and earnestness combine with a liberal supply of funds, which, by the way is very essential, much can and will be done.

J. I. O'CONNELL, M. D.

Harbour Briton, Newfoundland, April 1908.

INTRA-UTERINE PREGNANCY INDEFINITELY PROLONGED.

By N. STONE SCOTT, M. D.,

Cleveland, Ohio.

(From the CLEVELAND MEDICAL JOURNAL.)

STRANGE as it may seem many problems pertaining to the newer specialties, such as bacteriology, are more definitely settled than certain fundamental questions connected with child-bearing. Probably more people both in the profession and out of it have given concentrated thought, have endeavoured to make careful observation, concerning the reproduction of the species than along all other medical lines put together.

"What is the duration of a normal pregnancy?" How simple to ask! How difficult to answer!

The assumption of His, Hausmann[1] and others that the spermatoza are capable of fertilization after their sojourn of three or more weeks within the oviduct is well founded, so that the real duration of pregnancy in any human female is an unknown quantity.

The profession is, however, pretty well agreed upon an average of ten lunar or nine calendar months, or forty weeks, or two hundred and eighty days from the last menstruation; or two hundred and seventy-two days from the date of conception. Authorities differ somewhat in regard to this latter point, Schilchling[2] giving two hundred and seventy-three days, Matthew Duncan two hundred and seventy eight days, Lowenhardt-Ahtfelt 281.6 days.

That pregnancy can be considerably prolonged without the death of the child seems reasonably certain.

Depaul[2] reports one case of 300 days duration, Schroder 320, Winckel 320, Thompson 317, from the last menstruation, 301 from the last sexual intercourse.

Jardine[3] says, "I have seen a case which continued 305 days;" and Simpson[4] reports a well authenticated case of 336 days.

The writer delivered a patient who had overrun her time a full six weeks.

The importance of this point is reflected also by the legal questions which arise in relation to illegitimacy. In Austria[2] births within the limit of 240 to 307 days after the death of the father have been legally pronounced legitimate.

In France, 300 days only is the ruling of the Court as to the maximum.

In America and England we find no absolute limit. Cases of 313 and 317 duration have been allowed legitimacy by judicial decision.

In sharp contrast to such liberality there is a fair minority among the authorities who are exceedingly rigid in their views.

Wm. S. Stewart says, "Gestation is never prolonged beyond the possibilities which may arise from delayed conceptions."

Duff[5] raises the question, "Is gestation ever prolonged?" and quotes Müller, who says "Protracted gestation is unworthy of credence."

Villard[5] informs us that it is a "figment of the imagination, an error of dating conception."

A most notable instance is found

in the testimony, given before the House of Lords, in the famous Gardner [6] peerage case in 1816. Sir Charles Clark voiced the sentiments of his confreres, Gorch, Blegborough, Davis and Pennington, when he declared, "I have never yet seen a single instance in which the laws of nature have been changed, believing the law of nature to be that parturition should take place 40 weeks after conception."

But this paper is not intended to discuss questions of legitimacy nor indeed is it primarily concerned with the living child.

A fetus that dies at any stage is usually expelled with little delay; if, however, it should be retained for a longer time, labour will almost invariably occur at the end of the ninth month.

If fetal death takes place before the end of the third month without resulting abortion, the condition is called missed abortion [7]; from the beginning of the fourth to the end of the seventh month, missed miscarriage; after that, missed labour. These terms do not occur with frequency in medical literature, certainly not in the textbooks; and yet the subject, lying in the borderland between obstetrics and gynecology, is most important, not only from the medical but from the medico-legal and moral standpoints as well. Yet its importance by no means prevents great difference of opinion as to the symptomology, pathology and etiology of the subject.

Sinclair [8], quoted by Jewett [9], and Nassauer [10] think that missed abortion does not occur among young and vigorous primaparæ; this is certainly too sweeping a statement not founded upon fact, as is shown in the case reported by the writer at the close of this paper.

The late Angus McDonald [3], as quoted by Jardine, removed one horn of a bicarbonate uterus, containing a fetus which had been retained for a year. He maintained that all cases of missed labour were really instances of conception in one horn of a bicarbonate uterus, where there was an obstruction to the passage of the child. The writer's case does not confirm such an opinion, nor does it fall under any of the headings mentioned by Edgar [2], who, in discussing the etiology of missed labour, says, "This is obscure, some variety of obstruction is usually present, such as tumors of the soft parts, exostoses, contracted pelvis, cancer of the uterus, cicatricial bands of the cervix or vagina. The possibility of ectopic gestation or of pregnancy in one horn of a bicarbonate or unicornate uterus must be remembered.

Without further reference to the etiology of the subject, which is at best obscure, let us hastily review the literature that has been collected. We find that highly domesticated animals furnish instances of intra-uterine gestation greatly prolonged; which logically prepares the way for our expectation that the same condition may exist in the female of the human species. Most of the earliest cases on record were discovered at postmortem.

Hortez [12] reports a case which should have been delivered in March, 1848; a year later some fetal bones were discharged per rectum. The patient died in May, 1851, a postmortem revealed the fetus in utero.

Schmidt's Jarhbuch [13], 1848, contains the history of a woman who had a fetid discharge for 11 years and died septic. The fetus was found in the uterus at the postmortem.

Hans Chiari [14] found, at postmortem, in the case of a woman sixty

years old, a lithopedion in the left rudimentary horn of the uterus.

A uterine pregnancy of more than five years duration is reported by Cox[15]. Labour pains occurred at the seventh month followed by a copious flow of milk; thereafter she menstruated regularly. Finally an attack of peritonitis caused her demise, after which an intra-uterine pregnancy was demonstrated.

One of the earliest cases, however, terminated more happily[16]. She should have been delivered in December, 1827; in October, 1829, just below the umbilicus an opening formed. This was enlarged and the fetus removed, followed by recovery of the patient.

Halley[17] records, in 1867, a remarkable instance of retention in utero of the greater portion of the skeleton of a dead fetus for a period of four years. These remains were removed with a long pair of forceps after dilating the os.

Rudolph Elbing[18] reports a lithopedion of the left horn of the uterus, followed later by a pregnancy in the right horn; the condition was discovered at the birth of the living child.

Jardine[3], Kitson and Playfair[19] report cases of pregnancy lasting for 16 months. Hodges one of 20 months.

More than a dozen years ago Graefe[20] collected from medical literature some 70 cases of missed abortion. In quite a number the fetus was retained for more than a year; in one instance for 28 years.

My own case presents many points of especial interest and is as follows:

Mrs. B. consulted me first, May 13, 1904, with the following history: age 32 years, married five years, no children, no miscarriages. While always enjoying a fair degree of health she has never been very strong. She first menstruated at 14 years of age, was usually regular except that on several occasions within the past 10 years menstruation had been delayed, at one time as much as four months.

For a number of years past she has had some pain in the right side attended by slight dyspeptic symptoms. She last menstruated 14 months ago; morning sickness, frequent urination and enlargement of the breasts were also present, and fetal movements were felt at the fourth month. At the beginning of the fifth month of pregnancy she had an attack of grippe, so called, with a temperature of 103.5° F. The fetal movements were last felt about one week after the onset of the influenza. For a time she had considerable abdominal pain, so much so that she feared a miscarriage; this gradually subsided during the few weeks following.

However at the ninth month of the supposed pregnancy there was a return of the abdominal pain, though with no bleeding or watery discharge. This also shortly subsided for a season, then returned with increasing frequency and severity until the fourteenth month, when she was compelled to seek further medical advice. The abdominal enlargement, which had been pronounced, and progressive up to the time of the grippe attack, gradually receded together with the other signs of pregnancy, except the amenorrhea, so that she questioned the condition of pregnancy.

On physical examination nothing of a pathologic nature was found except in the lower abdomen and pelvis. The uterus was in normal position but decidedly enlarged, as though with a three months' pregnancy. The appendix was tender and considerably thickened. A diagnosis was made of chronic appendicitis,

and operation, consisting of appendectomy and exploration of the uterus, was advised. This was performed May 13, 1904, at Charity Hospital. The incision, not over an inch in length, was placed directly over the appendix, which upon removal, was found to present the characteristic pathology of a chronic appendicitis with a marked hypertrophy of the structures of the organ. The uterus was dilated and the diagnosis of pregnancy confirmed. The membranes were as yet intact, on rupturing these the fluid within was found to resemble thick pus rather than liquor amnii. There was, however, only a slight attendant odor and that not of an offensive character. The amount was very small, being estimated at not more than a couple of ounces. The fetus was removed piecemeal; notwithstanding the length of time since its death, the fetus was not macerated, as is so frequently the case in retained dead embryos, but presented a shrunken, shriveled appearance.

An estimate of the age of the fetus was rather difficult. The size was but little more than would be expected at three months, but the bones were larger and more fully developed than in a three months' fetus; so that we were inclined to believe that the patient's estimate of five months was probably correct. The placenta was firm in consistency and contained but little blood. The uterus was thoroughly curetted and douched with bichlorid. The patient made a speedy and uninterrupted recovery with no signs of infection at any time.

The history of this case refutes the conclusions drawn by many of the authorities. A prolonged intra-uterine pregnancy occurs in a young, reasonably vigorous primipara, without any apparent etiologic factor, such as tumour, or bicarbonate uterus, or other pathologic lesion, or anatomic anomaly. It seems to be undergoing the changes incident to the formation of a lithopedion. Nor is there reason for thinking the condition might not continue indefinitely, provided sepsis does not supervene.

Lastly the case terminates in a complete recovery as the outcome of the simple but timely operation, dilating and curetting.

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THE USEFULNESS OF MEDICINES.

(*The Sun*, New York.)

THERE never was a time when the denunciation of drugs was more fashionable than it is at the present day. It is so easy to achieve notoriety by the promulgation of radical views on any subject that even some medical men of eminence are loud in minimizing the usefulness of medicines; and the profession cannot find much fault if their declarations on this subject are accepted by the public as verity and incline people to seek relief from their sufferings by recourse to those irregular practitioners whose systems of treatment condemn the use of all drugs.

Therefore we are interested to see evidences of a sentiment of protest in the medical profession against the doctrine that drugs are of no avail in the relief and cure of disease. At the recent meeting of the Medical Society of the State of New York at Albany, Dr. A. Jacobi, of this city, delivered an address on 'Nihilism and Drugs,' in which he boldly mentioned that good practitioners are always found to be men entertaining the greatest confidence in the power of medicines. Assuming the correctness of the facts stated in this paper, it is not only a great mistake to suppose that medicines are largely useless in the treatment of disease, but the truth is that they constitute an armory of almost indispensable weapons with which to combat the maladies which most frequently assail mankind.

Probably no man ever did more to discredit drugs in the public estimation than the late Oliver Wendell Holmes when in 1860 he wrote: 'Throw out opium and a few specifics which our art did not discover and is hardly needed to apply. Throw out wine, which is a food, and the vapors which produce the miracles of anæsthesia, and I firmly believe that if the whole materia medica as now used could be sunk in the bottom of the sea it would be better for mankind and all the worse for the fishes.' That the same idea is still current appears from a recent utterance in England by Dr. William Osler, certainly one of the most distinguished of living American physicians, who is credited with having said in an address to a body of students in London: 'Be sceptical of the pharmacopœia. He is the best doctor who knows the worthlessness of most medicines. Study your fellow men and fellow women and learn to manage them.'

Dr. Jacobi would modify the advice of Dr. Osler so as to have it read as follows: 'Be critical of the pharmacopœia as of everything else. He is the best doctor who knows the worth and worthlessness of medicines. Study your fellow men and fellow women and learn to serve them. Therapy means service.' In brief Dr. Jacobi insists that a large number of medicines, many of which he specifies, are unquestionably of the utmost value in the treatment of the sick, and that to teach otherwise is to teach that which the great weight of medical opinion and observation shows to be untrue. He does not question and assuredly would not deny the great benefits conferred upon mankind by what is called preventive medicine; but his thesis is that the principal function of a medical man has been, is and always must be to cure the sick, and that to accomplish this purpose he must avail him-

self of those numerous medicines whose usefulness has been demonstrated by the experience of the profession.

It is not alone in America that we find expressions of protest against the prevalent tendency to discredit medicine as useless. In an address recently delivered before the Faculty of Medicine of Paris by Sir Dyce Duckworth, M.D., of St. Bartholomew's Hospital, London, on 'The Personal Factor in Disease,' that distinguished English physician said:

'We are, I much fear, suffering in these days from a widely spread spirit of incredulity, timidity and hopelessness in the whole realm of therapeutics. We spend much time in cultivating elaborate diagnosis, and this is quite right, but we greviously neglect our main business as healers and mitigators of disease. Our knowledge of the materia medica has declined out of all proportion to that gained by the progress of bacteriology, which claims to supersede the older therapeutical art. It will never supersede it, for there are, as Sir William Jenner said, but two great questions to be answered at the bedside of a sick man: What is the matter with him? and, What will do him good? Are we not too apt to-day to forget the second question, to experiment with synethical novelties and to neglect the old long approved remedies? In short are we not, as physicians, slowly drifting into the position of abstract scientists and gradually losing our proper relation to the sick as skilful medical artists?'

This prediction that the older therapeutic art, which means the art of treating the sick by the administration of medicines, will never be superseded by the progress of bacteriology is eminently worthy of note, coming as it does from one who occupies so high a position as a medical practitioner and instructor. What a sick man wants when he calls a doctor is not a description of the particular sorts of bacteria which are working havoc in his blood, or a statement of his opsonin index, but to be treated in such a manner as to be relieved of his pain and cured of his malady; and he does not care how this end is effected so long as it is accomplished. The question is whether the abandonment of the use of drugs by the medical profession to anything like the extent suggested by Dr. Holmes and Dr. Osler would not cause failure in thousands of cases in which under the prevailing practice the patient is made whole.

THE Annual Meeting of the Maritime Medical Association will be held in the School for the Blind, Halifax, on July 1 and 2. Full particulars of Programme, etc. will be published in the next issue of the NEWS.

FISH TO FIGHT THE DEADLY MOSQUITO.

(*Evening Post*, New York.)

Barbados has long been known as the only West Indian island practically free from malaria and the anopheles mosquito. Some time ago it was pointed out that, whereas the culex can breed in pools above the ground, the anopheles can breed only on the ground level, and that all the low lying pools and swamps in Barbados are stocked with swarms of tiny fish (known locally, from their vast numbers, as 'millions'), whose favorite food is the larvæ of the mosquito. It is obvious that the anopheles, if unable to breed above the ground level, must fall a prey to this enemy. The fish has been identified by Mr. Boulenger, F. R. S.., of the British Museum, as 'Girardinus poccilodes.' Some specimens were sent to England, and flourished for some time in the inset house at the Zoölogical Society's Gardens. A suggestion that the 'millions' should be imported into malarial districts in other islands has been adopted with felicitous results. For instance, the Country Health Board of Antigua, being convinced of the useful part played by 'millions' in consuming mosquito larvæ, arranged for their systematic distribution throughout the ponds and streams of the island. Similar news comes from Jamaica, whither a consignment of the fish was sent in November, 1906. The Secretary of the Agricultural Society writes that the tanks at a prominent hotel are full of them, and that 'there has been a marked diminution of fever round about, the 'millions' evidently accounting for the mosquito larvæ They have also been sent to Colon and to British Guiana. It is now proposed that these fish be tried in the deadly districts of Africa.

ANNAPOLIS-KINGS MEDICAL SOCIETY.

In accordance with By-Laws the Annual Meeting of the Annapolis-Kings Medical Society will be held at Aylesford on Thursday, June 4th, at 11 a. m. The business will be:— Reports of President, Secretary and Treasurer; Auditors Report and Election of Officers for ensuing year; also to arrange for a public meeting to be held in Wolfville to discuss the question of Municipal Sanatoria and other matters dealing with public health; Reports of Committees and such other business as may come before the meeting. The Executive especially urge every Practitioner within the bounds of the Society to attend this meeting.

SOCIETY MEETINGS.

HALIFAX AND N. S. BRANCH BRITISH MEDICAL ASSOCIATION.

HALIFAX, N. S., MARCH 18, 1908.—The regular fortnightly meeting of the Branch was held on this date in the City Council Chamber, the President in the chair.

There being no routine business to transact the programme of the evening was proceeded with, the President calling upon Dr. C. H. Morris, of Windsor, who had come to read a paper on this occasion. Dr. Morris preferred coming after Dr. Chisholm, who was also on the programme. Dr. Chisholm therfore was called and read an interesting paper on "Cæsarean Secton," dealing with his subject briefly under the various headings:—Origin of the Operation, Fatality, Indications, Technique. The exact date of origin of the operation is not known, various writers accrediting its first employment to different sources; but history points to its having been resorted to as a means of relief under difficult circumstances at a very early age. Its method of application was crude in the extreme, one negro woman slave having even ripped herself open with a common sheath knife and delivered herself of her babe and recovered. The fatality attending the operation when first introduced was horribly fatal. Nowadays, with modern aseptic precautions, improved surgical methods, etc., results are not so much to be feared when resort has to be had to it. The indications for the operation—in the main those which call for the performance of craniotomy. This latter is a most inhuman and barbarous practice at best, taking of one innocent life and exposing another to great danger. Cæsarean Section takes the place of it as a scientific procedure, fraught with little danger when properly performed and full of hope for the preservation of both lives concerned. The Doctor described minutely the technique of the operation, illustrating with a clinical report in full of one but a short time previously performed by himself, which was the means of saving the life of an infant which would otherwise have perished as well as, perhaps, the mother too. On motion, discussion of Dr. Chisholm's paper was deferred until after the reading of Dr. Morris'.

Dr. C. H. Morris called. Apologised for not having any written paper to read. His subject was Placenta Prævia, and as much is already known of the condition from the accounts given in text books, he had thought it better to give a recount of actual experience with cases which had occurred in his own practice. He referred now to placenta prævia true and complete. He had had four such cases in a practice of only ten years, and pointed to differences between these and others of marginal of partial placenta prævia, which are much less difficult to deal with, of which, also, he had had cases. The Doctor read a very interesting report of his four cases, each from the time of its first coming under observation, until delivery was effected, with notes on previous histories and results in each. Artificial delivery had had to be done in

all in order to save life. In two cases which died, death resulted directly from anæmia produced by sudden profuse hæmorrhage occurring before help could be had. In a third case the cause of death remained to him still a mystery. Version had been performed and delivery completed, the woman had lost a good deal of blood, but after transfusion and other stimulants, seemed to rally well, and was in good enough condition four hours after to warrant the medical attendant's leaving. Yet in hardly an hour more she suddenly gave a cry, began to gasp, and in a minute or two was dead. He had tried, but could find no means of explaining this result.

Discussion followed upon both papers, and was taken part in by most of the members.

Dr. Trenaman.—In all of about 2,000 labours which he had conducted he had seen only one case of complete placenta prævia, and that one was remarkable. He found the placenta well down in the vagina, being pushed along by the advancing head, and both were soon delivered. There was very little indication of severe hæmorrhage, but the woman soon afterwards died very suddenly. He could not explain the cause of death. He thought papers such as Dr. Morris' of great service to us, as it is well for us to have the experience of those who have had such cases and can report them. He thought Dr. Chisholm was to be congratulated upon his success in the case reported by him.

Dr. Doyle.—We are deeply grateful to Dr. Morris for his paper. He had seen one case of complete placenta prævia; bleeding had been recurring at intervals for some time. The woman had a sudden severe hæmorrhage and died. Asked Dr. Chisholm as to the relative merits of Porro's operation over Cæsarean Section.

Dr. Buckley.—Recalled one case of partial placenta prævia. He thought that sometimes an early complete might be converted into a partial by gradual dilation of the os with little loss of blood.

Dr. Eagar felt he could sympathise with Dr. Morris in his experiences. Thought the Doctor's case of sudden death could be explained by internal hæmorrhage, relating a case of normal labour which nearly died in that way. Another obscure cause of death is rupture of the uterus.

Dr. Woodbury made reference to two cases in which craniotomy had to be performed, both of which, had it been practicable, could have been much more easily and safely relieved by Cæsarian Section.

Dr. P. A. McDonald.—Referring to Dr. Morris' case of sudden death, thought fair conclusion could hardly be drawn in the absence of post-mortem. In connection with Dr. Chisholm's paper, related four Cæsarean Sections which he had seen performed in Montreal hospitals.

Dr. Rankine had seen Cæsarean Section performed on a woman about 38 years of age, in which a cancerous growth obstructed the passage, delaying labour. The child was found dead and the woman died two days later. Had had two cases placenta prævia. Did not say of what variety. One was an eight-month's pregnancy, in which case the child died but the mother recovered.

Major Foster.—Referring to Dr. Morris' case of sudden death thought it a great pity that in private prac-

tice we do not more often have cases come to autopsy, as in such obscure conditions the cause of death would often come to light in that way.

Dr. Roach cited a case and asked Dr. Chisholm a question. A woman, after a long and tedious labour, had to be delivered by craniotomy. Two years later she came to labour again and was delivered with a face presentation. That woman had a contracted pelvis. What procedure would be justifiable in case of her again becoming pregnant ?

Dr. Morton reported briefly two interesting obstetrical cases which had complications. In one a severe and almost fatal hæmorrhage occurred in the later months of pregnancy; he found the cause to be a mass of hydratid cysts in the uterus. In the second the woman was taken suddenly in labour while alone and the child was born dead; the cord had been prolapsed.

Dr. Chisholm. Discussing Dr. Morris' paper he had had a large experience with placenta prævia in all its varieties. One thing which strikes him is the difficulties with which one meets in primiparæ. He thought the use of ergot harmful as it tends to retard dilatation of the os. Closing the discussion of his own paper, the point of interest in connection with the difficult conditions met with is the question of deciding upon the best measures for relief when death stares in the face both mother and child. As a young man his choice had been craniotomy. He had done it in cases where he would not, had he had then the knowledge which he has now. Particularly in the case of a primipara it does not do to perforate the child's head too soon; one must be very sure that the axis of the pelvis is too small for normal delivery. When sure then of the inability to give birth normally to a living child, what is the operation of choice? He thinks that in all these cases we should listen to the guiding voice of scientific teaching and employ the means which offers the best results. In a position such as Dr. Roach quoted, the fact of the woman's having delivered herself at the second labour, even under the increased difficulty of a face presentation, he thought conclusive evidence of her ability to deliver herself under favorable conditions in subsequent pregnancies. He would leave her alone.

Dr. Morris in closing said he had much enjoyed the discussion. He thought Dr. Trenaman's experience in regard to placenta prævia in so large a number of labours unique. Version and rapid delivery he considered dangerous; he would rather let the woman take her time, even at risk of losing the child; there is thus less danger of laceration or hæmorrhage, shock and death. He thanked the members for their courteous attention.

A motion to adjourn closed the meeting.

COLCHESTER ASSOCIATION FOR THE PREVENTION OF TUBERCULOSIS.

AT the recent annual meeting of this association, the President, J. B. Calkin, Esq., gave an interesting address which was referred to the Executive, with the result that two memorials were prepared by Mr. Calkin. One was presented to the Truro Board of Health, the other to Hon. Geo. H. Murray.

The one presented to the Board of Health was acted upon by that body in its entirety—the section regarding a Medical Inspector or Examiner in the Schools beng referred to the School Board. The following was the memorial to that body:

To The Board of Health
for the Town of Truro.

Gentlemen.—

As instructed by The Colchester Society for the Prevention of Tuberculosis, we the Executive Committee desire to bring before you several matters which our Society consider to be intimately connected with the health and well-being of the citizens of our town.

(1.) It is the opinion of the Society that the Public Schools should at regular intervals be carefully inspected by a medical officer and that such measures should be taken as will secure the proper sanitary conditions in the buildings and conserve the general health of the pupils, special care being exercised to guard against the spread of contagious diseases and to lessen the evils arising from abnormal conditions of the organs of sight and hearing.

(2.) It is urged that there be adequate inspection of the premises of all persons who supply our citizens with milk,—such inspection comprising stables, watering-places, food of animals and the handling and treatment of milk in every stage from the time it is drawn from the cows until it is delivered to the houses of citizens, taking note also of the condition of the cows as regards health and cleanliness.

(3.) Further, it is suggested and urged that his inspection extend also to butchers' stalls, to the animals slaughtered, and to the handling and care of meats and other foodstuffs on the streets and in the stores, with the view of protection against exposure to bacteria, and of maintaining thorough cleanliness.

(4.) That the Town By-Law regarding notification of cases of Tuberculosis be carefully observed, and that the Board require to be informed as to changes in residence of consumptives, and to be satisfied that proper disinfection of the houses of consumptives is made.

(Signed) J. B. Calkin, Pres.
S. L. Walker, Secy.
April 14, 1908.

The memorial to the Government was in regard to the Kentville Sanatorium. This memorial was in line with the addresses of Mr. Calkin and Rev. A. B. McLeod, and on the 29th of April the matter was somewhat briefly discussed by the Secretary of the Association with the Government. As the matter is one of vital interest to the people of this Province, and is not presented in a fault-finding manner, there can be no breach of etiquette in publishing the same in the columns of the News.

To The Honorable
The Executive Council of
Nova Scotia,
Halifax, N. S.

Gentlemen:—

As the Executive of The Colchester Society for the Prevention of Tuberculosis we have been instructed by our Society to memorialize your honourable body in regard to the Sanatorium at Kentville. It is the opinion of our Society that the institution named is not securing to the Province all the benefits that lie within the limits of its possibilities. Its organization does not appear to be consonant wth the findings of present day experience and the most approved methods of management of

such institutions; nor does the number of patients receiving its aid indicate that it enjoys full public confidence.

The general location and the situation is ideal, and the building seems to be fairly well suited to the purpose in view; but while many of our people suffering from Tuberculosis go abroad for treatment, the number of patients at Kentville is not equal to the capacity of the equipment. The Report of the Institution recently issued shows that for the past year the average number of patients was only 15.6, which is little over one-half what we have been led to believe it can accommodate. We submit to your honorable body that some radical measures are called for to secure the Sanatorium the full confidence of those needing such treatment as it is designed to afford. In our opinion there is a primary and imperative demand for a thoroughly trained and skilled expert physician at the head of this Institution. Let us not be understood as in any way reflecting on the character and general competence of the visiting physician. We know of nothing to his discredit, and we have no information that should lead us to suppose that he is not doing efficiently the work that is expected of him. Nevertheless we believe that the important interests involved, the character and reputation of the Institution, the confidence of our people, as well as the general custom of the day, call for the very highest expert management attainable. In this connection we may quote Sir James Grant of Ottawa, who says: "The days for the expensive and elaborate Sanatorium are about over. As a commencement the simple shack, erected at the expense of a few hundred dollars each, will be found most useful and practical. *Thoroughly competent medical attendants and nurses are what we require* and not expensive structures to overburden willing contributors to this noble and philanthrophic work."

With the idea fully established that we have an institution equal to the best to be found anywhere, the Sanatorium at Kentville, with its healthful situation and beautiful environment, will soon be filled to its utmost capacity, and more accommodation will be called for. To secure this we suggest a plan which we believe will be found adequate and yet will not draw very largely from public funds.

We have already at Kentville a good central building. Add to this such inexpensive cottages as Sir James Grant suggests as may be equal to the demand. We propose that the Government furnish sites for these cottages and invite the public to erect suitable buildings according to plans to provided. It is reasonable to hope and believe that various organizations, as churches, societies, clubs and municipalities will heartily respond to the invitation. In this way Nova Scotia will have, within a few years, an institution equal to anything of the kind on the continent and entirely adequate to our needs. Our people suffering from the dread malady of consumption will no longer need to go long journeys from home and friends in search of skilled treatment which they can find at their door.

We observe that over forty per cent. of the patients admitted to the Sanatorium are reported as "far advanced" in the disease at the time of admission. The reception of such patients is, we believe, quite the reverse of the course adopted by other similar institutions of the better class. It would seem to be in the interests of the institution as well as of

those desiring its aid that there should be a competent medical examiner in some central town in every County of the Province.

Respectfully submitted,
(Signed) J. B. CALKIN, Pres.
SMITH L. WALKER, Secy.
Truro, N. S., April 14, 1908.

It may be added that the Town of Truro voted $100 to the funds of the Colchester Association, to aid its work this year. This Association has at least the confidence and support of the Town of Truro and the County of Colchester.

ANNUAL MEETING CANADIAN MEDICAL ASSOCIATION.

THE forty-first annual meeting of the Canadian Medical Association will be held in Ottawa on June 9th to 11th inclusive. The provisional programme has been issued and appears herewith. The fee for membership in the association remains this year at $2.00. It is payable to the Treasurer, Dr. H. Beaumont Small, Ottawa, at time of registering. Those desiring to become members for the first time should get information as to procedure from the General Secretary, Dr. George Elliot, 203 Beverley Street, Toronto, who will also supply information to enquirers regarding transportation rates, etc.

PROVISIONAL PROGRAMME

Presidential Address—Dr. F. Montizambert, Ottawa.
Address in Medicine—Dr. Risien Russell, London, England.
Address in Surgery—The Surgical Rights of the Public—Dr. John C. Munro, Boston, Mass.

MEDICAL SECTION

Dr. John T. Fotheringham, Toronto, Chairman; Dr. Alex. J. MacKenzie, Toronto, Secretary.

Our Experience in Broncho-Pneumonia—Dr. C. S. McVicar, Hospital for Sick Children, Toronto.
The Differential Diagnosis of Some Forms of Mental Disease and a Note as to Treatment—Dr. G. J. Fitzgerald, Toronto.
Out-Patients' Clinics for the Tuberculous Poor—Dr. Harold C. Parsons, Toronto.
On the Choice of a Climate—Dr. Geo. D. Porter, Toronto.
Hæmoptosis in Pulmonary Consumption—Dr. J. H. Elliott, Toronto.
Spina Bifida Associated with Syringo Myelia—Dr. Colin D. Russel, Montreal.
Meningitis—Dr. A. E. Ranney, North Bay.
Some Interesting Complications of Pulmonary Tuberculosis and Their Treatment—Dr. J. K. M. Gordon, Gravenhurst.
Ergot—Drs. E. V. Henderson and W. H. Cronyn, Toronto.
Some Unusual Cases of Rheumatism—Dr. A. McPhedran, Toronto.
What Shall We Say To Our Neurasthenic Patients?—Dr. G. S. Young, Prescott.

Pernicious Anæmia, Report of Cases in Country Practice—Dr. James Baird, Hemmingford, Quebec.

Some Further Observations on Pneumo-Thorax—Dr. W. F. Hamilton, Montreal.

Myo-Cardial Change in Valvular Disease—Dr. H. B. Anderson, Toronto.

SURGICAL SECTION

Dr. Geo. E. Armstrong, Montreal, Chairman; Dr. Edward W. Archibald, Montreal, Secretary.

Title to be announced—Dr. James Bell, Montreal.

Congenital Pyloric Obstruction—Dr. F. J. Shepherd, Montreal.

Temporary Colostomy as a Curative Agent in Post Operative Fæcal Fistula of the Colon—Dr. J. M. Elder, Montreal.

The Administration of the General Anesthetic from the Standpoint of the Operator—Dr. H. A. Beatty, Toronto.

Reports of Two Large Abdominal Tumours with Remarks—Dr. A. B. Atherton, Fredericton, N. B.

Title to be announced—Dr. A. Primrose, Toronto.

Diagnosis and Treatment of Urethral Calculus, accompanied by Case Reports—Dr. A. E. Garrow, Montreal.

Exhibition of Cases to Show Result of Operations Reported at the London Meeting, 1903. Advanced Hip-Joint without Shortening—Dr. R. P. Robinson, Ottawa.

Calculus of Ureter Removed per Vaginam—Dr. Walter McKeown, Toronto.

COMBINED MEDICAL AND SURGICAL SECTION

Discussion on General Peritonitis.

Carcinoma of the Buccal Cavity, Etiology and Treatment—Dr. A. R. Robinson, New York.

Subdural Hæmorrhage and Its Surgical Treatment—Dr. E. W. Archibald, Montreal.

On the Use of the Ortho-Diagraph in Medicine—Dr. Robert Wilson, Montreal.

PUBLIC HEALTH SECTION

Dr. Chas. A. Hodgetts, Toronto, Chairman; Dr. Robert Law, Ottawa, Secretary.

Address by the Chairman, Dr. Hodgetts.

Title to be announced—Prof. Starkey, Montreal.

Title to be announced—Dr. J. D. Lafferty, Calgary.

Title to be announced—Dr. Seymour, Edmonton.

The Medical Inspection of Schools—Dr. John Hunter, Toronto.

LABORATORY WORKERS.

Dr. W. T. Connell, Kingston, Chairman; Dr. A. R. B. Williamson, Kingston, Secretary.

Anæsthesia in Laboratory Work—Dr. V. E. Henderson, Toronto.

Chorion Epithelioma in the Testis—Dr. C. B. Keenan, Montreal.

A Criticism of the Ammonium Nitro—Molybdate Method of Detecting Organic Phosphorus in the Tissues—Geo. G. Nasmyth, M.A., Ph.D., and E. Fidler, B.A., M.B., Toronto.

The Bio-Chemical Characteristics of Bacillus Influenza—Dr. Handford McKee, Montreal.

Title to be announced—Prof. J. George Adami, Montreal.

Title to be announced—Prof. J. J. McKenzie, Toronto.

Title to be announced—Dr. C. W. Duval, Montreal.

Contribution to the Pathology of Tumours of the Lung—Three cases of Sarconia: (1) Primary, (2) Secondary—Dr. E. St. Jacques, Montreal.

On the Technique of the Study of Complement Deviation—Dr. A. H. U. Caulfeild, Toronto.

COMBINED PUBLIC HEALTH AND LABORATORY WORKERS

Water Supplies and Water Analysis—Dr. J. A. Amyot, Toronto; Dr. T. A. Starkey, Montreal; Dr. Gordon Bell, Winnipeg; Dr. W. T. Connell, Kingston; and others will contribute to this discussion.

SECTION ON EYE, EAR, NOSE AND THROAT

Dr. H. S. Birkett, Montreal, Chairman; Dr. Hanford McKee, Montreal, Secretary.

New Therapeutic Notes—Dr. Wilfred Beaupre, Quebec.

Title to be announced—Dr. G. H. Mathewson, Montreal.

Title to be announced—Dr. Roy, Quebec.

Some Points in the Technique of Sub-mucous Resection of the Nasal Septum—Dr. C. M. Stewart, Ottawa.

Ulceration of the Cornea, Etiology and Treatment—Dr. Handford McKee, Montreal. (1) Calcified Fibroma of the Orbit; (2) A Case of Bilateral Lardaceous Infiltration of the Buccal Mucous Membrane, not hitherto classified—Dr. J. N. Roy, Montreal.

SECTION ON MENTAL AND NERVOUS DISEASES.

Dr. W. H. Hattie, Halifax, Chairman; Dr. J. C. Mitchell, Brockville, Secretary.

Some Clinical Considerations of Dementia Præcox—Dr. Elbert M. Somers, Ogdensburg, N. Y.

Hydrotherapeutics when applied to Mental and Nervous Diseases—Dr. A. T. Hobbs, Guelph.

The Differential Diagnosis of some forms of Mental Diseases, with a note as to Treatment—Dr. Gerald Fitzgerald, Toronto.

Title to be announced—Dr. E. W. Archibald, Montreal.

Title to be announced—Dr. Colin Russel, Montreal.

Some Points in the Etiology of Progressive Muscular Atrophy, with Especial Reference to Heredity—Dr. D. A. Campbell, Halifax.

A Study of Thomsen's Disease (Myotomia Congenita)—by a sufferer from it.

Insanity and the General Practitioner—Dr. Moher, Brockville.

Hysterical Manifestations Occurring after the removal of a Brain Tumour—Dr. D. A. Shirrers, Montreal.

SECTION ON GYNECOLOGY AND OBSTETRICS.

Dr. F. A. Lockhart, Montreal, Chairman; Dr. D. Patrick, Montreal, Secretary.

Title to be announced—Dr. Wm. Gardner, Montreal.

Somes Cases of Cæsarean Section—Dr. R. E. Webster, Ottawa.

Pregnancy and Heart Troubles, with Report of Cases—Dr. J. C. Cameron, Montreal.

Title to be announced—Prof. de L. Harwood, Montreal.

Cases of Vicarious Menstruation—Dr. Blakeman.

Uterine Inversion, with the Report of a Case—Dr. D. Patrick, Montreal.

The Role of the Gonococcus as a Factor in Infection, following Abortion or Full Term Delivery—Dr. Fraser G. Gurd, Montreal.

Report of Second Case of Chorio-Epithelioma—Dr. F. A. L. Lockhart, Montreal.

Thoroughness in Abdominal Surgery—Dr. A. Lapthorn Smith, Montreal.

Pubiotomy—Edward D. Farrell, Halifax, N. S.

Title to be announced—Dr. D. J. Evans, Montreal.

MILITARY SURGERY

Dr. G. Sterling Ryerson, Toronto, Chairman; Dr. T. H. Leggatt, Ottawa, Secretary.

Address by the President of the Association of Medical Officers of the Militia of Canada, Colonel Ryerson, M.R.D., Toronto.

On the Advisability of Forming a Canadian Ambulance and Red Cross Association — Lieutenant-Colonel Jones, D.G.M.S., Ottawa.

Title to be announced—Lieutenant-Colonel Cameron, A.M.C., to V. Field Ambulance.

The Territorial Army Medical Corps, and the Canadian Medical Services —A Comparison—Lieutenant-Colonel Sponagle, A. M. C.

Title to be announced—Captain H. A. Kingsmill, 7th Fusiliers.

Some of the Difficulties met with in Camp Sanitation—Captain G. M. Campbell, 7th C. A.

Title to be announced—Lieutenant-Colonel Maclaren, P.M.C., M.D., No. 8.

The Present Aspect of Military Sanitary Work—Major L. Drum, P.A. M.C.

Ready and Simple Tests for Water, Milk and the Detection of Disease in Animals—Captain L. M. Murray, A.M.C., No. 1 Field Ambulance.

The place of meeting will be in St. George's Church, Parish Hall, Metcalfe Street, and the Racquet Court, just opposite for exhibits and registration; also the Carnegie Library, close by, for any sectional meetings necessary.

Railway arrangements are completed for all points east of Fort William in the territory of the Eastern Canadian Passenger Association, and the standard certificate plan will prevail.

AMERICAN PROCTOLOGIC SOCIETY.

PROGRAMME.

MONDAY, JUNE 1.

Executive Council meets at 11 a. m.

First regular session at 2 p. m.

Annual Address of the President—
A. BENNET COOKE,
Nashville, Tenn.

PAPERS

1.—The Treatment of Choice of Stricture of the Rectum.
WM. BEACH, Pittsburg, Pa.

2.—Amebiasis: Its Symptomatology, Diagnosis, Sequellæ and the Use of Formalin and Copper Phenol Sulphonate in its Treatment.
JOHN L. JELKS, Memphis, Tenn.

3.—(*a*). Physiology of Defecation.
(*b*). Report of a Case of the Extraction of a Plate with False Teeth from the Sigamoid.
SAM'L. T. EARLE, Baltimore, Md.

4.—The Treatment of Chronic Constipation, Including a Consideration of Obstipation.
SAM'L. G. GANT,
New York City, N. Y.

5.—Dysentery.
Jos. M. MATHEWS, Louisville, Ky.

6.—Galvanic and Faradic Electricity in the Treatment of Hemorrhoids, Fissures, Prolapse, Ulceration and Non-Malignant Stricture of the Rectum.
WM. L. DICKINSON, Saginaw, Mich.

7.—The Choice of an Anæsthetic in Anal Surgery.
JEROME M. LYNCH,
New York City, N. Y.

8.—Chronic Multiple Punctate Ulcers of the Rectum.
J. A. MACMILLAN, Detroit, Mich.

9.—Benign Tumours of the Rectum.
T. C. HILL, Boston, Mass.

10.—Profound Peri-Rectal Abscess.
COLLIER F. MARTIN,
Philadelphia, Pa.

11.—Surgery of Special Diseases of the Rectum.
GEO. B. EVANS, Dayton, Ohio.

12.—(*a*). Report of Cases: Profound Secondary Anemia from Internal Hemorrhoids, (Six Cases). Gangrene of the Rectum from Self-Treatment of Internal Hemorrhoids (1 Case.)

(*b*). Presentation of New Examining Speculum.
DWIGHT H. MURRAY, Syracuse, N.Y.

13.—Spontaneous Intestinal Anastomosis.
JAS. P. TUTTLE,
New York City, N. Y.

14.—Mesosigmoidopexy, with Report of Two Cases
LOUIS J. HIRSCHMAN,
Detroit, Michigan.

15.—Carcinoma of the Rectum; Comparative Results of Operative Procedures.
J. RAWSON PENNINGTON,
Chicago, Ill.

16.—Primary Melanotic Sarcoma of the Rectum with the Report of Two Cases.
LOUIS J. KROUSE,
Cincinatti, Ohio.

17.—Some Colonic and Sigmoidal Conditions.
EDWIN A. HAMILTON,
Columbus, Ohio.

18.—Rectal Hemorrhage Due to Capillary Varicosity.
B. MERRILL RICKETTS,
Cincinnati, Ohio.

19.—Valvotomist and Valvotomy as a Fad and Fallacy.
LEON STRAUS, St. Louis, Mo.

20.—Rectal Diseases,—a Report of Three Cases:— Condylomata, Lipoma, and Dermoid Cyst.
LEWIS H. ALDER, JR.,
Philadelphia, Pa.

REPRINTS RECEIVED.

"SOME Phases of the Surgical Treatment of Cancer. A Clinical Lecture," by William Seaman Bainbridge, M. D., New York. Reprinted from the *American Journal of Surgery*.

"Metastases Following Incision of a Sarcoma." By William Seaman Bainbridge, M. D., New York. Reprinted from the *New York Polyclinic Journal*.

"The Land Laws of Canada and the Land Experience of the United States," by Ditlew M. Fredericksen. Chicago.

"A Clinical Study of Five Hundred Cases of Conjunctivitis," by Hanford McKee, B.A., M.D., Montreal. Reprinted from the *American Journal of the Medical Sciences*.

"La Phobie du Regard," by C. H. Hughes, M.D., St. Louis. Reprinted from the *Alienist and Neurologist*.

"Physicians and Publicity: A Study," by E. S. McKee, M.D., Cincinatti. Reprinted from the *Lancet Clinic*.

"The Hymen, Anatomically, Medico—Legally and Historically Considered, by E. S. McKee, M.D., Cincinnatti, Reprinted from the *Lancet Clinic*.

"The Course and Prevention of Consumption." Circular issued by the Illinois State Board of Health Seventh Revised Edition.

"The Bloodless Phlebotomist." This is the name of a neatly printed publication issued monthly in the interests of Antiphlogistine, but containing so many practical and useful hints that it has gained for itself much popularity amongst physicians.

BOOK ANNOUNCEMENT.

Messrs. John Wiley & Sons, of New York, announce the early publication of a comprehensive work on "Modern Baths and Bath Houses," by Wm. Paul Gerhard, C. E.

PERSONALS.

Dr. R. E. and Mrs. Mathers have returned from their trip to the Continent.

Dr. Samuel C. Primrose, of Lawrencetown, is seriously ill at the Victoria General hospital.

Dr. George W. MacKeen is now on a trip to the West Indies for the benefit of his health.

Dr. M. Chisholm has been re-elected chairman of the Board of Health.

Dr. J. S. Carruthers has been appointed a member of the Board of Health.

Dr. A. C. Hawkins was an unsuccessful candidate in the recent mayoralty election.

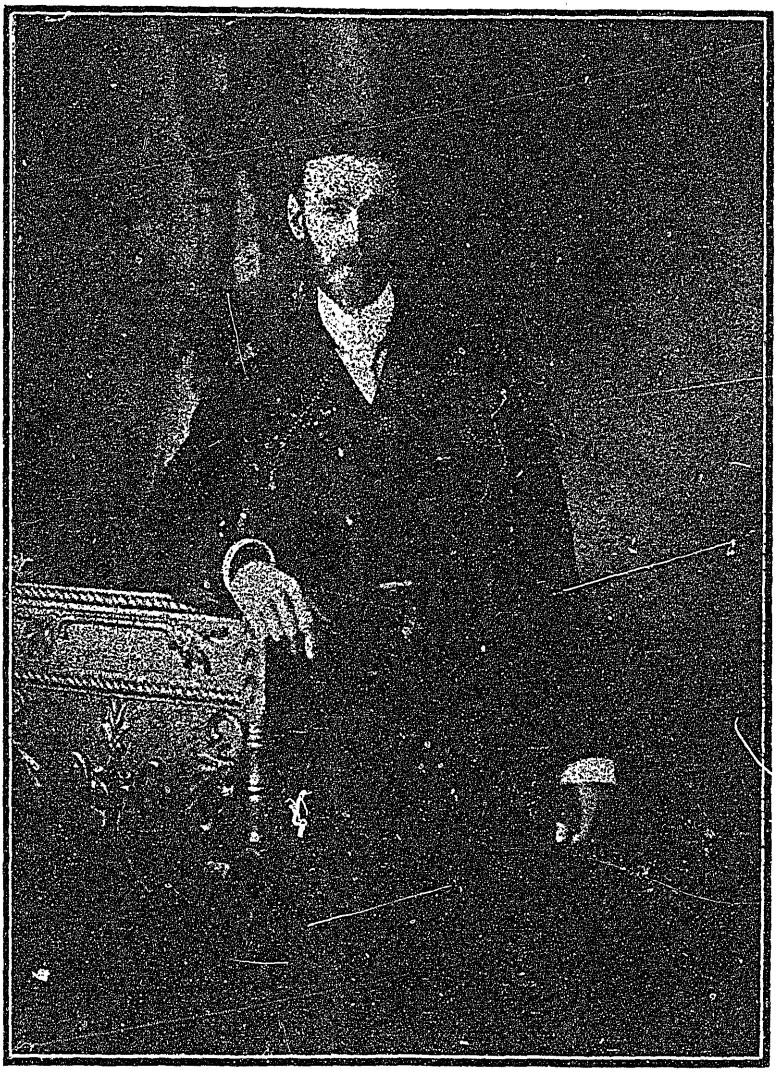
Dr. John Rankin is a candidate for alderman in the vacancy for Ward VI.

Dr. D. T. C. Watson is on a visit to his parents in Kingston, Jamaica.

OBITUARY.

EARLY on Saturday morning, April 25th, Dr. J. H. Scammell passed away after a brief illness of only three days duration. To a system not at all robust, pneumonia quickly proved fatal. His death was a great shock to the people of St. John, where he was so well known and respected.

Dr. Scammell was one of the most prominent and popular of the younger members of the profession; he was a man of upright character, of kindly and patient disposition,



THE LATE DR. J. H. SCAMMELL.

with great energy and capacity for work. His natural promptness and methodical habits enabled him to undertake many varied duties which otherwise would have been impossible, and none of these duties were ever slighted. He gave freely of his time to charitable objects, and indeed worked beyond his strength. His death will be greatly felt and regretted.

Dr. Scammell was the third son of the late Mr. Joseph H. Scammell, and was 38 years old. He graduated at McGill University in 1894, and in the same year began the practice of medicine in St. John. He was a member of the General Public hospital staff and of the governing board of The Home for Incurables, as well as attending physician at the Evangeline Home, and was deeply interested in all philanthrophic and charitable organizations.

He was a leading member of Trinity church, one of the vestry, a member of the Church of England Synod and a prominent member of the Brotherhood of St. Andrew.

In the masonic society, in which at the time of his death he was Master of the Union Lodge of Portland, The Sons of England, The Foresters and other fraternal organizations he took an active part, and was physician of No. 1 Salvage Corps. He was also deputy-quarantine officer, and during the time that elapsed between the death of Dr. March and the appointment of Dr. Ruddock, he discharged the duties of port physician in a manner that was commended by all.

Dr. Scammell is survived by his wife, formerly Miss Isabel Murdock, of Derby, Northumberland, and three young children, two girls and a boy.

At the morning service at Trinity church on Sunday, the rector in his sermon bore testimony to the excellence of the nature and character of Dr. Scammell, to his interest in many of the concerns of his fellowmen, to the earnestness with which he devoted himself to many of the organizations of the church, particularly to the Brotherhood of St. Andrew, and he especially emphasized the cheerful readiness with which on all occasions Dr. Scammell responded to the call of the poor and needy. The congregation was at times deeply affected by the warmth and tenderness of the rector in his references to the dead.

At a meeting of the Medical Society and members of the profession held on April 27th, feeling expression was given by Dr. Lunney, the President and others, to the loss the profession and city had sustained in Dr. Scammell's death. The President, Dr. Berryman and Dr. Bentley were appointed a committee to prepare a minute expressive of appreciation of Dr. Scammell. It was also decided that the profession should meet at Trinity church for the purpose of attending the funeral.

On Monday afternoon the funeral service was held in Trinity church, and that large edifice was filled to overflowing with those who came to offer a last tribute of regard to "The gentle physician."

The large attendance at the funeral representing all creeds and classes of the community, amply testified to the regard in which he was held and the general sympathy felt for his widow and children.

MUSKOKA SANATORIA MEDICAL STAFF.

W. B. Kendall, M.D. C.M., L. R. C. S., L.R.C.P., Physician-in-Chief of the Muskoka Cottage Sanatorium, has been appointed Physician-in-Chief of both the Cottage Sanatorium and the Muskoka Free Hospital for Consumptives, and C. D. Parfitt, M.D., M.R.C.S., L.R.C.P., Physician-in-Chief of the Free Hospital since its opening in 1902, becomes Resident Consultant of the two Sanatoria, each giving his entire time and effort to these institutions. The Medical Staff will also include a trained resident Pathologist and two Assistant Doctors, together with a staff of specially trained nurses.

❖ ❖ ❖

We meet with many cases in practice suffering intensely from pain, where because of an idiosyncrasy or some other reason it is not advisable to give morphine or opium by the mouth, or morphine hypodermically, but frequently these very cases take kind'y to codeia, and when assisted by antikamnia its action is all that could be desired. In the grinding pains which precede and follow labour, and the uterine contractions which often lead to abortion, in tic douloureux, brachialagia, cardialagia, gastralgia, hepatalgia, nephralgia and dysmorrhœa, immediate relief is not merely temporary and palliative, but in very many cases curative. The most available form in which to exhibit these remedies is in antikamnia and codeine tablets.

The physician cannot be too careful in the selection of the kind of codeia he administers. The manufacturers of antikamnia and codeine tablets guarantee the purity of every grain of codeia which enters into their tablets. This not only prevents habit and the consequent irritation which follows the use of impure codeia, but it does away with constipation or any other untoward effect.

❖ ❖ ❖

URETHRAL INFLAMMATION.

Usually the only treatment needed to cure urethritis is to administer sanmetto and alkalies, with an occasional purge, and very mild injections of chloride of zinc.

THE NEW SURGERY.

(In a short time, according to a prominent surgeon, it will be a common thing to transplant, with success, the vital organs of lower animals to man's body.)

Bill Smith was in a railroad wreck—
the cars were ground to matches—
And when the surgeons got to him
Bill Smith was mostly patches:
But soon with pair of rabbit's ears
Bill Smith was keenly harking,
While lungs from out a setter dog
had set Bill Smith a-barking.

The doctors solved most capably the
missing stomach question;
Two stomachs from a muley cow
built up Bill Smith's digestion:
And when a horse contributed (with
no thanks to the giver)
Bill Smith would not have taken
back his ancient faulty liver.

A pair of cat's eyes tickled Bill, and
fixed him up completely,
And he could see in blackest night,
and dodged his light bills neatly;
And when folks asked if he was
pleased with all his borrowed
tackle,
Bill Smith would just throw back his
head and give an old hen's cackle! —*Denver Republican.*

THE BOARDERS' RIDDLE.

Sing a song of sausage,
Unpretentious fare,
Maybe made of porker,
Maybe made of bear,
Have to on suspicion
Take it anyhow,
Sing a song of sausage,
Bow, wow, wow!

Man who fills the hopper,
Quiet and discreet,
Sees to it the mixture
Comes out sausage meat,
Many are suspicious;
Truth is known to few,
Sing a song of sausage,
Mew, mew, mew!

In its smoky jacket
Brown and steaming hot,
Who would guess the answer
Or suspect a plot?
Still the boarder doesn't
Know what's in the draw,
Sing a song of sausage,
Haw, he, haw!

—*Nashville American.*

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A Very Efficient Palatable, Hepatic Stimulant, Laxative and Diuretic.

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Valuable in the treatment of Biliousness, Sluggish Liver, Portal System, Deranged Stomach, associated with Constipation, Headache, Loss of Appetite, Nausea, Sallow Complexion, Gouty and Rheumatic Conditions. Uric Acid Diathesis, Auto-Intoxications, Relieving the Morbid Depression following the Over Indulgence in Alcohol, Congestion of the Pelvic Organs especially in Women.

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INGLUVIN A Specific for Vomiting in Gestation, In doses of 10 to 20 Grains.

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Indicated in the medical treatment of

Cholelithiasis, Cholangitis, Cholecystitis, Duodenitis, etc.

FORMULA: Acid Sodium Oleate, 1½ grains; Sodium Salicylate (from salicylic acid, natural), 1½ grains; Phenolphthalein, ½ grain; Menthol, 1/10 gram.

PILL CHOLELITH is a cholagogue and biliary antiseptic of exceptional value. It is successfully employed in the treatment of infectious catarrhal inflammations of the bile- and gall-ducts. It is indicated in bile-stasis unattended with calculi, as well as in actual stone-formation.

Bottles of 100, 500 and 1000.

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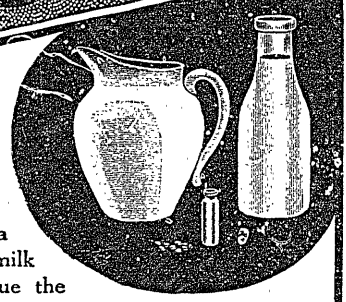

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A quart of pure, fresh milk, a Lactone Tablet, a little water and a pinch of salt produce a buttermilk that equals in flavor and excels in nutritive value the product of any dairyman.

LACTONE BUTTERMILK is commended to physicians as a wholesome food, a delicious beverage, a useful preparation in the treatment of gastro-intestinal maladies with digestive disturbance, and in malnutrition.

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