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(HALIFAX, NOVA SCOTIA.)

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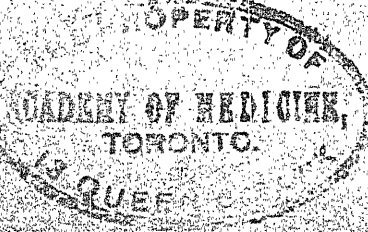
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The Collegiate Courses of this School are a Winter Session, extending from the 1st of October to the end of March, and a Summer Session from the end of the first week in April to the end of the first week in July to be taken after the third Winter Session.

The sixty-first session will commence on the 3rd of October, and will be continued until the end of the following March; this will be followed by a Summer Session, commencing about the middle of April and ending the first week in July.

Founded in 1824, and organized as a Faculty of McGill University in 1829, this School has enjoyed, in an unusual degree, the confidence of the profession throughout Canada and the neighbouring States.

One of the distinctive features in the teaching of this School, and the one to which its prosperity is largely due, is the prominence given to Clinical Instruction. Based on the Edinburgh model, it is chiefly Bed-side, and the student personally investigates the cases under the supervision of special Professors of Clinical Medicine and Surgery.

The Primary subjects are now all taught practically as well as theoretically. For the department of Anatomy, besides a commodious and well-lighted dissecting room, there is a special anatomical museum and a bone-room. The other branches are also provided with large laboratories for practical courses. There is a Physiological Laboratory, well-stocked with modern apparatus; a Histological Laboratory, supplied with thirty-five microscopes; a Pharmacological Laboratory; a large Chemical Laboratory, capable of accommodating 76 students' at work at a time.

Besides these, there is a Pathological Laboratory, well adapted for its special work. It is a separate building of three stories, the upper one being one large laboratory for students 48 by 40 feet. The first flat contains the research laboratory, lecture room, and the Professor's private laboratory, the ground floor being used for the Curator and for keeping animals.

Recently extensive additions were made to the building and the old one remodelled, so that besides the Laboratories, there are two large lecture-rooms capable of seating 300 students each, also a demonstrating room for a smaller number. There is also a Library of over 15,000 volumes, a museum, as well as reading-rooms for the students.

In the recent improvements that were made, the comfort of the students was also kept in view.

MATRICULATION.—Students from Ontario and Quebec are advised to pass the Matriculation Examination of the Medical Councils of their respective Provinces before entering upon their studies. Students from the United States and Maritime Provinces, unless they can produce a certificate of having passed a recognized Matriculation Examination, must present themselves for the Examination of the University on the first Friday of October or the last Friday of March.

HOSPITALS.—The Montreal General Hospital has an average number of 150 patients in the wards, the majority of whom are affected with diseases of an acute character. The shipping and the large manufactory contribute a great many examples of accidents and surgical cases. In the Out-door Department there is a daily attendance of between 75 and 100 patients, which affords excellent instruction in minor surgery, routine medical practice, venereal diseases, and the diseases of children. Clinical clerkships and dresserships can be obtained on application to the members of the Hospital staff. The Royal Victoria Hospital, with 250 beds, will be opened in September, 1893, and students will have free entrance into its wards.

REQUIREMENTS FOR DEGREE.—Every candidate must be 21 years of age, having studied medicine during four or six months Winter Sessions, and one or three months' Summer Session, one Session being at this School, and must pass the necessary examination.

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. VII.

HALIFAX, N. S., FEBRUARY, 1895.

No. 2.

Original Communications.

SYMPATHETIC OPHTHALMITIS.

By DR. KIRKPATRICK, Halifax, N. S.

Read before the Halifax Branch of the British Medical Association, January 10th, 1895.

CASE 1ST.

On December 1st, 1894, a little boy of 5 years was brought to my office by his parents who gave the following history regarding his ocular trouble: One day last June while the child was playing with a sharp pointed steel knife he accidentally pierced the left eye-ball at the outer sclero-corneal border. A physician from the nearest town was called, who examined the wound and prescribed a lotion. From the general behaviour of the child for the next five or six weeks as related by the parents I judge the resulting inflammation was of a moderate character and a favorable issue seemed to be promised; but after about eight weeks the photophobia, which had never entirely disappeared, began gradually to grow worse. Becoming dissatisfied with the treatment adopted the parents took the child on two different occasions during November to another physician in an adjacent town. In order to procure a thorough examination he very properly put the child

under chloroform at each visit, and appreciating the seriousness of the case he advised the parents to take the child to Halifax to consult one who had more experience in eye diseases. Two weeks after this the child was brought to the city, and to my office. Suspecting from the intelligent history of the case as presented by the father that I had a case of sympathetic inflammation before me I decided previous to the examination to call in Dr. Tobin. The consultation took place the next day, the child being under chloroform.

CONDITIONS PRESENT.

The left eye, that is the injured eye, deep cicatrix at the seat of the wound. Traumatic cataract and anterior synechia, vision nil. The right eye a typical picture of sympathetic inflammation in an advanced stage. There was extreme photophobia, the anterior chamber was shallow, the iris had lost its lustre, was muddy in appearance and new vessels had formed in its tissue. The pupil was contracted, and a membrane stretched across it. From these appearances we came to the conclusion that vision was almost nil. The case was entirely hopeless as the time for operative interference had long since passed.

CASE 2ND.

On April 13th, 1894, I was called to see a woman, who ten days previously

had injured the right eye by the breaking of a butter-dish, a piece having pierced the cornea. The family physician was called at the time of the accident and removed the fragment of glass, or at least a part of it. The wound did not heal however, and when I first saw the eye I found the cornea thoroughly disorganized, a mass of suppuration, painful, and no vision in the eye. I kept the patient in a dark room and used cleansing solutions, etc., and watched the eye carefully for some weeks, but the fellow eye became week and irritable. Dr. Farrell was called in consultation, and enucleation was decided upon. Almost immediately after the operation the sympathetic eye began to grow stronger and to tolerate light as before the accident, while the vision which had become somewhat reduced in this eye became normal.

CASE 3RD.

On June 22nd, M. E. F., age 50, from Bridgewater, consulted me because of a painful affliction of the left eye. About 15 years ago he met with an accident whereby the orbital ridge over the left eye was fractured, but no direct injury to the eye remembered. The vision however, since the accident has been very poor in the eye, but no pain or discomfort was ever experienced until the first part of May, 1894, when the eye, without any known cause, became inflamed and very painful. This condition continued and grew worse to the date of his visit to my office on June 22nd. The examination proved the existence of a well-marked irido-cyclitis in the left eye, with the fellow eye irritable, slight loss of distant vision, and remarkable loss of accommodation power. There was scarcely perception of light in the left eye, and considering there had been extremely poor vision in the eye for many years, and now the existence of a severe irido-cyclitis, with sympathetic irritation in the right eye, present enucleation was at once decided upon.

The offending eye was removed, and the patient returned home five days afterwards. The other eye from the time of the operation greatly improved so as to be as strong as usual in three weeks.

CASE 4TH.

This was a case where there was not the slightest hesitation about removing the eye, both from the standpoint of saving the second eye, and for its cosmetic effect. The eye was lost through an accident at mid-day, May 24th, 1894, and the eye was very badly damaged so that a part of the contents of the eye escaped and enucleation was performed that same afternoon.

Having these cases in my mind I thought it would prove of interest to this Association to call attention to the subject of sympathetic inflammation a name given to a disease which has been carried from the eye suffering from irido-cyclitis to its fellow eye previously sound. The disease is one of the uveal tract usually the ciliary part and develops after some injury or affection of the other eye which has been the seat of considerable destructive inflammation. In most cases such an inflammation is preceded by what has been termed sympathetic irritation, a prodromal stage in which there is an evident weakness of the eye for near work due to an impairment of the accommodation. During this stage there will be some photophobia and lachrymation, and perhaps pain in the back of the eye. This condition may exist for days or months, or even years, before passing into the dreaded inflammation. Most frequently, however, the inflammation supervenes after a few days or weeks. When sympathetic inflammation is actually declaring itself the symptoms of irritation become more pronounced. Increased tension, peri-corneal injection, contracted pupil, discoloration, and loss of lustre of the iris synechia and opacities in the vitreous are manifest. These changes may develop suddenly

with great pain, or be very insidious in their onset. Pressure over the ciliary region will reveal tenderness, and a close examination of the iris will show a formation of new blood vessels. The inflammation may possibly subside here and a little vision be retained, but probably in ninety-nine cases out of one hundred an opaque membrane develops in the pupil and detachment of the retina takes place. Perhaps in a larger proportion than one per cent the inflammation disappears before complete blindness ensues, but unfortunately recurrence of the inflammation nearly always takes place and ultimately vision is entirely lost.

It is almost universally conceded by the best authorities that the affection in the first eye is an irido-cyclitis and that almost always traumatic in character. The cases in which the ciliary border has been wounded, and those in which a foreign body has been left in the eye are considered as especially dangerous. To be sure it is a well known fact that foreign bodies have been carried in the eye for the remainder of the life of the patient and no sympathetic trouble has developed. These bodies doubtless have become encapsuled and thus rendered non-irritable. Such bodies however from a very slight accident or jar may escape from their protective environments and produce violent inflammation, and thus in turn cause sympathetic inflammation in the fellow eye, hence the necessity of advising patients carrying foreign bodies in the eye to seek advice immediately any tenderness may develop. The time for development of sympathetic trouble after an injury is very, very rarely less than three weeks and may be thirty years or more. It has never been known to develop if the injured eye be removed within twenty-four hours after the accident. The common time for its appearance is from four to eight weeks.

TREATMENT.

First, in regard to prophylaxis, which is the most important. In some cases it is exceedingly difficult to decide as to the proper course to pursue. One wishing to keep in line with conservative principles will find difficulties which scarcely have a parallel in the whole range of surgery. Take a case of a foreign body presumed to be lodged in the coats, or within the eye. Perchance some days have elapsed since the accident; the external wound is healed, and the patient gives you an uncertain and unsatisfactory history. Of course, if the foreign body has entered through the cornea a scar will be visible, but if it has entered through the sclera the wound is often difficult to find; and yet in the latter case a careful examination would reveal the superficial tissue bound down to the deeper, and trying to move the ocular conjunctiva over the sclera one will find it attached at the point of entrance. Furthermore a point will be ascertained where great tenderness is manifested. Haemorrhage into the vitreous is in favor of the foreign body having pierced the coats; while if no haemorrhage has taken place the vitreous may be thoroughly explored with the ophthalmoscope and as a reward view the body and locate its exact position. When the lens has become opaque the thorough examination of the field of vision will become valuable. Iron and steel are the common particles projected into the eye, and the introduction of the electro-magnet has rendered great service in their removal. The electro-magnet consists of a core of soft iron around which is placed the coil of insulated copper wire, and this again is inclosed in an ebonite case. To one end of the instrument are attached the screws to receive the battery connections, at the other extremity the core of the magnet projects just beyond the ebonite jacket, and is tapped, and into it is screwed a needle which fits closely on the end of the instrument

by a projecting cap. It is a powerful magnet, and when applied to five cells can raise 500 grms. * The following excellent rules for the use of the magnet when iron or steel lies in the vitreous, are given by Hirschberg. If the wound in the sclera through which the piece of metal has penetrated is still open the magnet should be at once introduced through it after it has been somewhat enlarged so as to admit of the easy removal of the metal adhering to the magnet and not risk its being rubbed off on withdrawal other openings may be made in two situations, either by means of a meridional cut through the equatorial part of the sclerotic coat or by section through the corneo-scleral margin, the vitreous being reached after the removal of the lens, or if it be absent after the perforation of the lens capsule. Hirschberg distinguishes three stages after the accident in which an operation may be undertaken. First, the primary stage—that is before inflammatory symptoms have set in. Second, the secondary stage in which such symptoms have more or less developed; and third, the tertiary stage, when fresh irritative symptoms have appeared after a longer or shorter period of quiescence. Careful probing with the magnet in the first stage, conducted with proper antiseptic precautions is safe enough and should be undertaken when the wound is in the sclera, even though there should be some little doubt as to the diagnosis. Otherwise when the diagnosis as to the presence of the metal in the vitreous is not absolutely certain, it is advisable to await the symptoms of the second stage before proceeding to make an opening. If the foreign body can be actually seen in the vitreous, the opening may be made at once, and such cases afford the best opportunities of obtaining satisfactory results. Patients however seldom present themselves until the second stage is arrived

at and the operation should generally at once be resorted to.

When the wound is in the dangerous region and especially if the vision is likely to be lost in the wounded eye enucleation had better be performed at once. This is a good rule particularly as such cases are not likely to remain under the eye of the surgeon. Evisceration of the globe, section of the ciliary nerves also of the optic nerve have been advocated as substitutes for enucleation but experience has proved them less safe as prophylactic measures. There is no doubt that many an eye has been enucleated which if permitted to remain in its socket would have proved a useful eye and never caused inflammation in its fellow and yet such a mistake is not to be compared to the one by which both eyes are lost as a penalty for procrastination in operative interference.

Concerning the treatment of the sympathising eye when once sympathetic trouble has developed there is little upon which to comment. The eye should be kept protected from the light and atropia used in most cases.

Mercury internally has been given a faithful trial but statistics do not prove it to be of much if any benefit.

MEDICAL MEN AND LIFE INSURANCE.

BY G. CARLETON JONES, M. D.

Read before Halifax Branch British Medical Association, Jan. 24th, '94.

The selection of lives suitable for insurance is a very important duty of the general practitioner. It is a subject the study and consideration of which is very much neglected. The student is not instructed on this point, nor is the matter often brought up before the societies. The literature on the subject is exceedingly meagre. I thought that it might be of interest if I were to bring up a few points on this question before this

* See "Berry on Diseases of the Eye."

Branch. The subject is a large one and there are many points to consider.

First, let us consider the relation in which the examiner stands to the company and its agents, is it satisfactory? I think that as things now are managed it is not. In theory everything is almost as it should be, in practice somewhat different. The examiner is supposed to be the appointee of the company, but we find in reality that he is at least the nominee of the agent, the too frequent plan is, for the agent to solicit business from practitioners by promising to have them appointed to an examinership, so that they will be enabled to more than pay the premium out of the fees received, one ought to see that appointments of this kind cannot be stable. Where this is done once, it will be done twice and so on indefinitely, and the examiner will find that perhaps at the end of the year, some one else has been appointed on the same terms. One cannot blame the agent, if he can find medical men willing to enter into a bargain of that kind. The first class company will not make appointments such as these and discountenance the practice on behalf of the agents. When an appointment of this kind is made, and in fact in other cases, the agent often seems to forget that the examiner is the employee of the company and it is to him that the company looks for protection. The agent often looks upon the examiner as a canvasser, the one who can put the finishing touch on the question, who can finally rope the somewhat unwilling victim into taking out a policy. The agent sends the examiner to finally run down the applicant, seize hold of him, examine him and when examined he is caught, the agent gets his commission and is satisfied. I fancy this is the reason that so many examinations are made at the applicant's places of business or office. It would be an excellent plan, if we did no work of this kind except at our own offices, or the applicant's residence or the

office of the company, if the proper facilities are available. It is utterly impossible to make a satisfactory examination at the applicant's place of business, amidst the noise, bustle and constant interruptions. We are very apt to slur over the examination and to do it in a hurried and perfunctory manner. I was very much impressed, a few months ago by hearing a patient remark, when a certain medical man of this city was suggested to him as a consultant. "He, the Dr., examined me twenty years ago for life insurance, at my place of business, he never even made me undo my waist-coat and did the whole examination in about five minutes." The man being a skilled workman and very thorough in all his doings was anything but impressed at the doctor's carelessness.

In our own offices, we can strip the proposer and make a thorough physical examination, and moreover can take our time over it. That is another important point. As a rule the solicitor is anxious to close the transaction with great haste, the applicant must be seen at once and examined, an opinion must be given without any hesitation or delay. If it is not done at once, the proposer may change his mind or may go to some other company. We have a very important function to perform, as Dr. Thorburn says, in this respect; for on the one hand the rejection of a candidate may prove most disastrous to him and his family, while on the other, the greatest importance attaches itself to a careful and searching examination as well as to the importance of preventing applicants from concealing facts that indicate depraved habits and tainted constitutions. And yet we are called to give this important decision as to the probability of this man living a certain length of time, a man perhaps whom we never have seen before and know nothing about, to give this I say in five minutes in order that the agent may catch the post.

To come to proper and correct ideas on many an individual life, we ought to watch the applicant, we ought to examine him not once but twice, and we ought to make further enquiries as to his habits, history and customs.

We are absolutely dependent on what the applicant tells us as regards his past history, unless we happen to be his medical adviser. Although the company as a rule demands the name of the medical attendant. How many men give a true and correct account of their past history. I have examined a good many risks even in the course of my limited practice, but I can safely say that I have never known one applicant, acknowledge to having suffered from syphilis or any venereal disease. If we happen to be or to have been the medical attendant, we are in a much better position. I remember examining a gentleman who was applying for a large amount of insurance, whom I had some time before attended for renal colic, I said so, as I was bound to do. He was refused although he a few weeks before had been accepted by another company, the medical examiner of course was unaware of this episode in the patient's history. I have reason to remember this, for the applicant thought that I had acted unmanly and has not looked upon me in a friendly manner since that examination.

Most of the companies, rightly demand an examination of the urine, but we often find, that the proposer is unable to pass a sample having perhaps recently done so. He sends it to us. Can we be sure that it is the urine of the applicant? Fraud could easily be committed, I don't think it often is, but still nothing could be easier. I had a specimen sent to me the other day, which puzzled me very much, for it turned out that it was ginger beer. On procuring another specimen, passed in my presence I found a trace of albumen and owing to certain other

circumstances refused the risk. I don't think this applicant attempted to deceive in this case. it being only one of accident and coincidence.

The companies or rather their agents do not protect their examiners sufficiently. It is the medical man who stands or ought to stand, between the company and loss. With careless and incompetent examining, the best of companies would soon be in a bad way. What passes between the applicant and the examiner ought to be absolutely secret, no one connected with the office should see the application paper, it should be mailed direct by the examiner to the medical reference. If it passes through the agents hands, we cannot expect to get an honest history on the part of the applicant, he does not want all the world to know what ills he has suffered from. Then also the medical man would be protected, and would not have to hear from the agent that he, the examiner, had done the agent or solicitor out of his commission, by refusing a doubtful risk, as happened to me not long ago, the solicitor ending by saying that he would bring me no more applications, because I had refused this one and protected the company.

It is possible that these grievances which I air, may not have a place in the experience of some members, but I rather fancy that all have felt, that things are not very satisfactory. We can remedy a good deal, and our position depends on pretty much what we make it. The agents and the companies are not going to go out of their way to improve our position, if we do not wish that position improved.

The selection of risks depends on a great many things in the patients personal and family history, and also his physical condition, but I will only refer to these points, which are probably the most frequent causes of refusal of proposers, namely some hereditary taint, organic heart disease, and some condition of the kidney or constitution.



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giving rise to albuminuria. The commonest hereditary taint is the tubercular, which is of the greatest importance, one authority says. "In life insurance, the claims result largely from Phtthisis, and it is here that the medical selection tells more according to the manner in which it is conducted than in any other disease. I do not think that the common belief that mortality from consumption decreases with age, will be born out by statistics, for we find from the statistics of the Mutual Life, that while the percentage decreases after thirty, it increases after fifty. Ought we to refuse every applicant who has a tubercular history? I think not, when a parent has died of the disease, and the applicant is under thirty, I think we ought to refuse him, but if he is over thirty I think we might be safe in taking on a short endowment. When a brother or sister has been phtthisical, I do not think that unless the applicant be very young we would be justified in refusing him, for many of these cases are accidental and isolated, but we ought to bear in mind that in many instances we are dependent entirely on the patient's own history, what he describes as congestion of the lungs may really be a case of acute phtthisis. Also the patient's figure, personal habits and employment, must be taken into consideration, so that we can lay down no hard and fast rules, but where we have tubercular history very apparent and close up, it would I think be the wisest plan to recommend the applicant for a short term policy only.

Disease of the heart. It is perhaps the rule with many practitioners to refuse all risks having valvular disease of the heart. It is perhaps the wisest course to pursue, but still there are some cases which could be taken on a limited system safely, if the occupation is taken into consideration, I know of a gentleman here, who was refused fifteen years ago for a systolic murmur which he has at present, but otherwise is in perfect health, his life being quiet

and healthy, I think at the time he might have been accepted with safety.

The relation of albuminuria to life insurance is of great importance, and has lately been attracting much attention. I do not think that any examiner is justified in refusing a risk, when a discovery of albumen is made, unless it be very pronounced, and unless there is evidence of advanced kidney trouble. It would be better to postpone judgment, and examine the urine from time to time in order to see if the albumen is not merely transitory. But even in these cases when it is found to be transitory, it would be advisable to recommend the acceptance on some modified plan, or increase of premium. It so often happens that albumen is discovered, where there is no indication of any trouble whatever till the urine be examined, that no risk should be accepted without an examination of the urine, most of the companies demand this, but there are some who don't, unless the amount applied for be \$2,000 or over. The same may be said as regards sugar, but not to the same extent. Beale says recently: "In cases of albumin we have not only to consider the consequences of possible renal disease progressing, but also to bear in mind that, should the patient be attacked by some acute malady, the prospect of recovery is not so good as it would be in the case of persons who were in ordinary health before the attack." These notes are somewhat rambling, but may serve to bring out something in discussion. The importance of the subject must be recognised by all who have anything to do with Life Insurance examination, and in conclusion I would quote an authority when he says. "No man in the business of Life Insurance fills a more honorable or responsible station than the medical officer, who is thoroughly trained to his work, and who should always do it without fear or favour. No one should accept the appointment of medical examiner who

has not given, or is not willing to give, care, time and study to it.

SPASM OF ACCOMMODATION.

BY STEPHEN DODGE, M. D.

In August, 1893, I was consulted by C— S— aged 14 years. His eyes had been troublesome for some years. He had been unable to go to school with anything like regularity, so great had been the discomfort from attempting to use his eyes for a length of time in reading. Two years ago his father, who was then living in Boston, had him to go on there, and he took him to a prominent oculist to be examined. He was given glasses to wear: and he appeared to have as much trouble in using his eyes for near work as before.

I found vision of R. eye 20/20, L. 20/200. With—30 spherical glasses he saw better for the distance, but not better for near work. From the history of the case I did not feel satisfied that myopia of that amount was the cause of his long history of discomfort—ever since he began his school days. Accordingly I introduced atropine in both eyes to suspend the accommodation and examine the refraction more thoroughly. I found, instead of myopia, that he had hypermetropic astigmatism, requiring a +48 cylindrical glass with the axis 90. I also injected strychnine into the arm with the view of ascertaining whether it would have any effect upon the sight of the L. eye. After half an hour, the sight was improved to 20/100: whereas before its use the letters of that line of Sneller's types were seen as mere dots.

As the eyes were very sensitive to light, with the vessels of the ocular conjunctiva much injected, and some phlyctenules at the corneal border, I directed him to wear London smoke glasses for a while and to use ungt. hyd. oxid. flav., a lotion of Boracic Acid, and internally cod liver oil emulsion, as his general health had

suffered from his being obliged to remain in doors so much in consequence of the photophobia from which he had complained. He was directed to avoid using the eyes for reading and study in the mean time, and to spend the most of his time during the day out of doors.

In the course of a month I saw him again. He was now much improved in general health and his eyes were very comfortable. The photophobia had disappeared. He brought his glasses that he had been ordered to wear two years before. They were simply myopic glasses, of the strength of 1.25 D., as the formula showed; as near in Dioptrics as possible to the glasses, I found on examining the eyes before using the atropine on his first visit to me. With these he still saw better for the distance than with the astigmatic glasses: though his sight for distance was much improved with the latter, after using the atropine on his first visit. Now that the eyes were not under its influence, he was able to read comfortably with the astigmatic glasses, which he could not do with the myopic glasses. He was an intelligent boy, and I explained to him the nature of his trouble, that he might understand the apparent anomaly caused by the two kinds of glasses. He has since been wearing the astigmatic glasses for all distances with complete relief, goes to school regularly, and his father reports on two different occasions that his son's eyes are all right now.

I do not wish the readers of the Journal to suppose that I am reflecting in any way upon the gentleman first consulted, nor do I wish to imply that he was unable to detect astigmatism. He has a well established position in the profession, has written a monograph on a subject which he has made high his own, and on account of which he is recognized as an authority in Europe as well as in America. He simply did not give the patient

sufficient time and consideration. It is quite possible that we can all draw a lesson from this case, and not take too much for granted.

I remember quite well an incident that occurred some years ago in the practice of the late Dr. L., of New York. He was considered unsurpassed by any physician of his day in questions pertaining to the refraction of the eye. His colleagues in that city were justly proud of him. He had a lady patient under his care who did not improve, she went to Philadelphia and consulted a distinguished oculist, who found that she had astigmatism, and when corrected she had complete relief. The facts were communicated to me by an oculist of the "City of brotherly love," between which place and New York a foolish rivalry had arisen among the oculists. I know the principals in this case, and I am sure that they had no sympathy with such school-boy like conduct.

The following case is different, though arising from accommodation, Miss———student at college consulted me in February, 1893. Had headache and aching of eyeballs during the winter of '92, but her eyes have caused her so much distress that for the past few weeks she is unable to do any study. Vision in each eye = 20/20. After examination under atropine she was found to have hypertrophic astigmatism, requiring + .60 cyl. glass axis 90°. With these she was able to prosecute her studies without any trouble, and she has been wearing them ever since. But about two months ago she came to see me complaining of her eyes very much. I examined one of them under atropine, thinking it possible, that there might be some change of refraction; but found the same glass needed as before, I tested the muscles but found no deviation nor defect in them. I then gave her strychnia to take though her general appearance was indicative of good health. In fact she looked much better than when I first saw her.

She began to improve almost immediately, and soon was entirely free of any trouble in attempting to accommodate for near work.

Selections.

CASTRATION IN HYPERTROPHY OF THE PROSTATE GLAND.—When Dr. J. William White first suggested to the profession the operation of castration for the relief of hypertrophy of the prostate gland (Address at the Annual Meeting of the American Surgical Association, June 1, 1893, *Annals of Surgery*, August, 1893) on theoretical grounds, although strongly supported by experimental evidence, it is doubtful whether any one appreciated the full value of the recommendation. Cases of prostatic hypertrophy are of extreme frequency. Sir Henry Thompson found that one man of every three over 54 years of age examined after death showed some enlargement of the prostate; one in every seven had some degree of obstruction present; while one in fifteen had sufficient enlargement to demand some form of treatment. In this country to-day, as shown by the last census, there are more than three millions of men over fifty-four; of these, according to Thompson's estimate, which genito-urinary specialists consider a conservative one, about two hundred thousand are sufferers from hypertrophy of this gland. This number seems very large, but the assertions of Thompson unquestionably express a general rule, and in fact every surgeon must have seen men in whom some prostatic overgrowth existed *before* the fifty-fourth year. The lives of such patients are threatened because, if the obstruction is not removed, the health is rapidly undermined by the retention of urine and the consequent fermentative changes, the deleterious influence of backward pressure on the kidneys, the frequent use of the cath-

eter, and the loss of sleep incident to the incessant demands to void urine. Heretofore the surgeon has been unable to afford distinct relief from the distressing symptoms of an advanced case of this affection. If the patient's general condition would warrant the considerable risk, some form of prostatectomy was performed. The suprapubic method was recommended for a time, but the difficulties encountered in its performance, the frequency of suprapubic fistula as a sequel, and the high mortality following the operation have led to its almost total abandonment. Perineal prostatectomy is also attended with considerable risk, on account of the free hemorrhage, which cannot be controlled during the operation, and the prolonged anesthesia which is necessary. In addition to this, the operation is a bungling one, in which the enlarged gland is removed by cutting, scraping, or gouging, while the instrument is out of sight, and much of the time it cannot be guided even by the finger. Combined suprapubic and perineal prostatectomy enables the operator to reach and enucleate the gland with greater freedom, but it is an operation of such gravity that it would be contraindicated in the very cases in which the demand for relief was most urgent.

Perineal prostatotomy is little more than a palliative measure, which does some good, temporarily, by draining the bladder and inducing slight contraction of the middle lobe of the prostate in the healing process. All of these operations confine the patient to bed for several weeks, which is, in itself, objectionable, and in addition require the use of the bougie for a long time afterward.

In view of these facts it is not strange that surgeons should have presented Dr. White's suggestion to patients suffering from the consequence of prostatic hypertrophy, nor is it unnatural that such patients accepted this chance for relief from a condition that in

many cases was rapidly and surely impairing the health of a person otherwise vigorous and, apparently, without this trouble destined to enjoy many additional years of life.

With the testes already or soon to become functionless, and with the contemplation of a long period of intense suffering which will be relieved only by death, sentimental objections pale into insignificance, and the problem of securing relief without placing the life in danger, is the only one entitled to consideration.

Cases of castration based upon Professor White's deductions, soon began to be reported. Ramm, of Christiania, Norway, recorded two in September, 1893; Haynes, Los Angeles, Cal., and White, Philadelphia, each report three cases; Finney, Baltimore, reports two cases; Smith, St. Augustine, Fla., Powell, London, Mayer and Haenel, Dresden, Moullin, London, Thomas, Pittsburg, Ricketts, Cincinnati, Swain, Bristol, England, and Bereskin, Moscow, each record one case. Thus far eighteen operations have been published. All have been more or less successful, and usually the relief from the distressing symptoms and the shrinking of the prostate have been marvellous. The least favorable cases have experienced infinitely greater relief than has been obtained by any method heretofore employed. At least as many unpublished cases have been operated upon with equally favorable results. There have been no deaths from the operation: of course, few would be expected in the hands of competent surgeons.

To those familiar with these cases, the rapid shrinking of the prostate and the simultaneous relief afforded the patient have been truly wonderful. The operation has therefore passed the experimental stage, and has legitimately established for itself a position among the most successful of operative procedures. Indeed, the results have been so uniformly favorable that cas-

tration may now be considered a specific for hypertrophy of the prostate.

It is necessary, however, to utter a word of caution here. Castration is not indicated in every case of prostatic enlargement or urinary obstruction. To secure uniformly successful results one must be certain that the condition from which the patient is suffering is appropriate for the operation. Cases of prostatic abscess, prostatitis, tumors of the prostate and of the region of the neck of the bladder, and other forms of obstruction in the neighborhood of the prostate must be distinguished from true prostatic hypertrophy. Without careful discrimination, both the surgeon and the patient will be disappointed, and the operation will unnecessarily be brought into discredit.

As it stands to-day, however, in appropriate cases, it appears to mark an advance in the surgery of the prostate, which, when the gravity and the frequency of the condition of hypertrophy are recalled, together with the more or less ineffectual and always dangerous methods of treatment which have prevailed, must be a source of congratulation not only to Professor White but to the profession at large, and to thousands of patients who, having outlived their sexual lives, and earned an old age of mental and physical repose and intellectual enjoyment, have had only a few short years of torment and misery to look forward to on account of this hitherto intractable disease.—*Editorial Univ. Med. Magazine.*

REFLEX COUGH DUE TO EAR DISEASE.—Lavrand calls attention to the fact that in many patients affected with ear disease, a blunt hook, curette, or speculum, when introduced into the internal auditory meatus, provokes cough, which disappears when the instrument is withdrawn. He has obtained this reflex in twenty-one per cent of all the patients that he has

examined. He states that at times, from disease of the auditory canal, the cough occasionally becomes very distressing and persistent. He cites a case reported by Percy Jakins in which there were all the signs of beginning tuberculosis, such as cough, exhaustion, night-sweats, occasional delirium, mucous rales throughout the chest. Both meatuses were plugged up with accumulations of wax, and when these were removed the pulmonary symptoms abated. The reflex cough is explained by the anatomical fact that the auricular branch of the pneumogastric has its origin in the jugular ganglion, or is given off from the trunk of the pneumogastric immediately below that situation, and proceeds by way of the jugular fossa and the Fallopiian canal to the posterior part of the external auditory canal. Observation has shown that this cough is produced only by irritation of the postero-inferior wall of the canal near the tympanum, and the reason that all do not suffer with auricular reflex cough when disease is present may be in part due to an anomaly of innervation in that particular individual. The author finds no relation existing between the more or less nervous condition of the patient and the occurrence of this reflex. The cough which is produced has no distinct characteristics; sometimes it is paroxysmal, resembling that of whooping cough; sometimes explosive, short, harsh, and barking, and, unless there is catarrh of the passages, it is not accompanied by expectoration.—*Medical and Surgical Reporter.*

DR. W. A. CROSS (*Med. News*) recommends stockinet cotton as an eligible material for bandages. It is soft, pliable and elastic, giving firm pressure and support, yet so yielding that it admits of comfort and motion, when motion is desired. It is especially useful for the treatment of leg ulcers, varicosities, sprains and dislocations.—*Ev.*

Maritime Medical News.

FEBRUARY, 1895.

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It is very desirable for practitioners to have within their reach, the means of positively determining cases of diphtheria and those which are not diphtheritic; to be able to have the question definitely answered, readily and in the early stages of the disease would be and is indeed a great boon to physicians and patients.

The bacteriological examination necessary for this proof, should be made by one familiar with such work and by one who is accessible and prepared to promptly carry out the investigations. The Provincial Board of Health of New Brunswick, at the meeting on the 18th January of this year, decided to move in the above indicated direction as will be noticed in one of the resolutions mentioned elsewhere. This is in line with the practice which has been adopted in other places and is an effort to keep abreast with the progress of science. It seems hardly necessary to enumerate

the great advantages to be gained from adopting the proposal to appoint a bacteriologist to carry out such work, they are many and great, such as, the determination of the disease or otherwise, especially in the early stages; and the consequent necessity for isolation and the requisite treatment or the reverse with its accompanying relief from anxiety. The more successful treatment and the diminished danger of the spread of diphtheria. The results of the use of antitoxin in diphtheria, so far, seem to be decidedly successful, unfortunately the supply at present is quite limited. The Board of Health is also endeavouring to supply the want. It is to be earnestly hoped that the efforts of the Board will meet with the active co-operation of the Government, so that practitioners will have at their command the means to combat diphtheria more successfully and to the great advantage of the public at large.

The following resolutions were passed at the Provincial Board of Health, at the meeting held on the 18th January, 1895.

Whereas,—"In the contagious form of diphtheria the Klebs-Loeffler Bacillus is invariably found, while in the non-contagious form of the disease it does not exist. This bacillus can only be detected by a chemical or microscopical examination, for which few medical men possess the appliances. *And whereas*, this bacillus can often be found in the throat and nose of a patient for weeks after he is supposed to be well, rendering it imperative that no child having had the disease should be allowed to enter school until the non-existence of this bacillus is established. We therefore respectfully suggest to the government the desirability of appointing an expert to carry out this necessary object, to whom portions of the membrane or secretions from the throat of the suspected patient may be sent for examination.

No. 2.

Whereas recent investigations have established the fact that the use of "antitoxine" has very largely reduced the mortality from diphtheria. *And whereas* antitoxine cannot be obtained from any reliable source in the Dominion. *Therefore resolved*, "That His Honor the Lieutenant-Governor in Council, be respectfully requested to obtain some for the use of the Board.

A PARAGRAPH has been making the rounds of the press, professing to give the results of some recent investigations into the comparative physiology of the sensory nervous system, and the bearing of these on racial development.

It has been made out by certain inquirers that marked differences in sensation exist between the various races of man, also that among various classes of the same race considerable differences may be found. It is, for instance, said that the sensation of pain is much less pronounced among the lower classes of such a city as Paris, than among the intelligent and cultured. It has also been stated that there is a higher degree of sensory reaction among the people of the United States than in those of other countries, and the diligent investigator has satisfied himself that the hand of the American physician has a more delicate tactile sense than that of his British confrère.

This increased delicacy of sensibility is held to prove a higher nervous organization, and the deduction is obvious.

We are aware that some American writers have claimed for the heterogeneous agglomeration of races in the Great Republic, the foremost place in the march of humanity, but it is something new to have the claim made on physiological grounds.

Before submitting meekly to take up our position in the rear-ranks, we would ask, not so much for new evi-

ence, as for more of it, and for a review of the inductive process based upon the alleged facts.

Much of the false science of the present day is due to hasty generalisation. The edifice is begun before proper material has been collected and selected, and so, after having attracted much attention, it comes to a standstill, or having been completed, it may be with much elegance and apparent strength, it topples over in the first gale of wind, and remains nothing but an encumbrance which must be cleared away before anything can be done to replace it. If psychological societies are to do good work, they must be content to go on accumulating facts for many a year to come before they can erect even a respectable milestone in the course of true progress.

We are not disposed to take exception to the alleged facts, but we may ask how many observations of this kind have been made; have they been made under all conditions of social life, of climatic distribution, of personal health; also, by how many observers, for the observation of facts is an interpretation of nature, and the personal equation of the interpreter must be calculated.

Then, why is so much made of mere tactile sensation; why are not visual, auditory and other perceptions also considered? If the tender hand of the American professional man is so many degrees more sensitive than the horny palm of the labourer, and if this argues that the former has reached a much higher plane of evolution, then the idea of evolution here must be something quite different from that ordinarily present in speaking of the Evolution of the Race, a slow majestic sweep of progress which "through ages" with "increasing purpose runs," for it is no unheard of thing that this great stride in development may take place in a single generation. But grant it: then if this increased tactile susceptibility argues a higher level of humanity,

what of the increased acuity of visual perception among some savage races? The keen dark eye of the Blackfoot following a trail where the bespectacled philosopher can see nothing to guide him must argue for the savage a higher nervous organisation. And why not extend the reasoning to the olfactory sense, and bow with becoming reverence before the retriever and the foxhound.

Then again, may we ask how is sensibility to pain estimated? The use of the *æsthesiometer* in defining tactile sensation is attended by many difficulties and must be rigidly corrected and verified. But in the estimation of pain the elimination of error is much more difficult. The physician who accepts the uncorroborated statements of his patient as regards pain is making trouble for himself. And it is here, in the danger of confusing the subjective with the objective; and in the inferential process that we venture to think there is fallacy in the conclusions of the psychological experimenter.

X. and Y. suffer from toothache: X. bears it in grim silence; Y. stamps about the house and makes loud outcry; therefore, Y. is more sensitive than X.! And, therefore X. is of an inferior nervous organisation! Preposterous logic! Suppose pain is more keenly felt: is our place in creation to be estimated by the number or size of our sensory nerves and their conductive power? What of the Will? What of our powers of inhibition or of self control.

Y. exhibits an increased susceptibility to pain, therefore Y. is of a higher grade of development. Is not this a *petitio principii*? Why not rather state the question thus: Y. shows a decreased power of endurance of pain, therefore the development of Y. is retrograde.

The fact is that many things popularly supposed to indicate a superiority of organisation, are really results

of degradation of function, if not of structure also. A curious fallacy centres round the idea of fineness of constitution. So-called delicacy of sensation may mean a development or a retrogression. Delicacy of touch may be acquired; it depends largely upon one's occupation, it may be an advantage, and therefore, on the lines of Evolution, an advance in development, but in itself it does not argue superiority or foretell social progress. It is possible to conceive of it as a defect. Fancy the condition of a man who should acquire tactile sensation throughout his alimentary canal! What is called delicacy of digestion is certainly no advantage: it is not an increased perception of what food is fitting and nourishing, nor a finer power of analysis and absorption, but a morbid reaction to the various influences, gustatory and otherwise, of ordinary food.

Indeed, this so-called delicacy appears to be in many cases a loss of those automatic processes which maintain the healthy equilibrium of the body, and are on their higher planes connected with volition and control, and any physical or mental acquirements which is not in harmony with a full-orbed development of the whole man, physical, intellectual and moral, is abnormal and pathological.

It is not to be denied that many of these abnormalities of sensation are found among cultured, intelligent and highly developed people, but their higher development does not depend on these abnormalities. And the physician, like the teacher has to deal with averages, not with exceptions.

The man who generalises as to mind and morals for an examination of the tactile sense, is trying to estimate the acreage of a field with a quart measure.

And any argument for advance in Evolution from increased susceptibility of the sensory nervous system or any other material element of human nature, and leaves out of account the

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In submitting to you my Canadian combination, Fellows' Compound Syrup of Hypophosphites, permit me to state four facts:

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Compound Syrup White Pine.

Messrs. WYETH desire to ask the attention of the medical profession to this invaluable expectorant, which after considerable experimental work and study, they have been enabled to perfect and present as a medicated syrup, which for beauty and efficiency they feel assured cannot be surpassed.

This preparation represents in each fluid ounce combined in the most palatable form the following ingredients:—White Pine Bark 30 grains, Wild Cherry Bark 30 grains, Spikenard 4 grains, Balm Gilead Buds 4 grains, Blood Root 3 grains, Sassafras Bark 2 grains, Morph. Sulphas 3-16 grain, Chloroform 4 mins incorporated into a syrup, which will preserve unimpaired their therapeutic properties. As an expectorant, it certainly possesses exceptional merit, and has proven of invaluable service in allaying those distressing symptoms so apparent in laryngeal troubles.

Practical physicians need hardly be told how frequently ordinary cough remedies and expectorants fail; the agents that *relieve* the cough *disorder* the stomach. It is a misfortune of the action of most remedies used against cough, that they are apt to distress the stomach and impair the appetite. As in all cases of chronic cough it is of vital importance to maintain the nutrition, the value of a remedy acting as Wyeth's Syrup White Pine can be readily appreciated.

Its efficiency is likewise manifest in relieving that obstinate and persistent irritation that frequently accompanies the development of pulmonary affections. The quantity of Morphia Sulphate is just sufficient to exercise a calmative effect, and yet so minute as to be free from objections.

In coughs, colds, and similar affections, such as hoarseness, sore throat, etc., whether recent or of long standing, it will be found to give immediate relief.

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WYETH'S COMP. SYRUP WHITE PINE.

A most valuable remedy in chronic or pulmonary affections of the throat or lungs—relieving obstinate coughs, by promoting expectoration—and serving as a calmative in all bronchial or laryngeal troubles.

Each fluid ounce represents White Pine Bark 30 grs., Wild Cherry Bark 30 grs., Spikenard 4 grs., Balm Gilead Buds 4 grs., Blood Root 3 grs., Sassafras Bark 2 grs., Morph. Sulph. 3-16 gr., Chloroform 4 mins.
Per doz. 16 oz. bot., \$9.00.
Per. Winch. 80 oz., \$3.50.

Wyeth's Glycerole Chloride of Iron.

(NON ALCOHOLIC.)

THIS preparation while retaining all the virtues of the Tincture of Iron Chloride, so essential in many cases, in which no other Salt of Iron (the Hydrochloric Acid itself being most valuable) can be substitute to insure the results desired, is absolutely free from the objections hitherto urged against that medication, being non-irritant, and it will prove invaluable in cases where Iron is indicated. It has no hurtful action upon the enamel of the teeth, even after long exposure. Each fluid ounce represents 21 minims Tinct. Chlor. of Iron.
Per doz. 16 oz. bot. \$9.00.
Per. Winch. 80 oz., 3.50.

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imponderable and immeasurable factors of endurance and self-control, has lost sight of the true forces which "lead life to sovereign power."

CANADIAN MEDICAL ASSOCIATION.

To that large part of the medical public interested in the Canadian Medical Association, it will be gratifying to learn that the meeting in 1895 promises to be the best yet, and after St. John in '94, that is saying a great deal. We have learned that from all parts of the Dominion the Secretary is hearing of medical men who intend to be present at the Kingston meeting.

We are glad to see that some of the suggestions in our issue of Sept., '94, are being acted upon, namely, as to the length of the meeting. This year it will last three days—August 28th, 29th and 30th.

No doubt many men from the maritime provinces will be present to renew the pleasant acquaintances formed last year, and to profit by the interesting discussions. The question too of Inter-provincial Registration should take a large contingent from our end of the Dominion.

THE fifth annual meeting of the Maritime Medical Association will take place this year in Halifax on July 3rd and 4th. The officers of the association are:

Dr. Edward Farrel, Halifax, President.

Dr. G. E. Coultard, Fredericton, Vice-President for New Brunswick.

Dr. R. McNeill, Stanley, Vice-President for P. E. Island.

Dr. G. E. Buckley, Guysboro, Vice-President for Nova Scotia.

Dr. G. M. Campbell, Halifax, Secretary.

Dr. G. E. DeWitt, Wolfville, Treasurer.

The committee of arrangements in Halifax are Dr. Wm. Tobin, Dr.

Curry, Dr. Carlton Jones, Dr. Kirkpatrick and Dr. C. D. Murray.

All communications with regard to reading of papers to be addressed to Geo. M. Campbell, 407 Brunswick Street, Halifax, N. S.

SOCIETY PROCEEDINGS.

HALIFAX BRANCH OF BRITISH MEDICAL ASSOCIATION.

Stated Meeting December 20th, 1894.

Routine business was first transacted.

NEW OPERATING TABLE.

Dr. J. F. Black exhibited an operating table which he had recently designed. His plans had been well executed by the parties undertaking the work. Cheapness, simplicity and convenience were aimed at, and had been fairly well attained. He explained very clearly the details, and after pointing out its advantages for ordinary work showed how readily it could be altered to secure the advantages of the Trendelenburgh and Sims position.

CASE OF EXCISION OF THE EYE, FOR INJURY.

Dr. John Stewart said: The patient was struck on the left eye by a splinter of steel which penetrated the upper lid near its outer end and then entered the eye in the upper and outer quadrant. Vitreous escaped, and on ophthalmoscopic examination blood was found in the vitreous, but no foreign body could be seen. On the ninth or tenth day inflammation set in; there was intense congestion of the conjunctiva, with irido-cyclitis and dimness of vision. Dr. Hector Mackay, of New Glasgow, under whose care the patient was, advised enucleation. On the patient's arrival in the city the symptoms had greatly abated, and as there was fair vision it was decided to wait. In three or four days,

however, there was an aggravation of the inflammatory condition, with severe pain, headache, great tenderness on pressure, photophobia and dimness with contraction of the field of vision, and the eye was removed, on the fourteenth day after the receipt of the injury.

A small sharp scale of steel, about the size of a flax-seed, was found lodged in the outer margin of the ciliary body. It had entered the eye very obliquely, and was lying behind the choroid, having penetrated the conjunctiva, sclerotic and outer part of the ciliary body.

Dr. Kirkpatrick thought it would have been better to have waited longer and that a search with the electric magnet might have been of value. Dr. Tobin concurred in this view.

CHOREA.

Dr. M. Chisholm reported a case of chorea occurring in a young man aged 20, very severe in character. The movements were so strong and incessant that the patient was with difficulty nourished and a gag had to be kept between the teeth to prevent him from biting the tongue. He had tried arsenic in large doses by the mouth and hypodermically without advantage. Other agents of repute were also tried but the patient seemed to grow worse. He then tried a magnetic belt. Very soon improvement was noted, and in two weeks the patient had so far recovered that he was able to leave the hospital. He did not go so far as to claim that the magnetic belt had effected a cure, but the result surprised him, as he had in two other very severe cases obtained precisely the same results. All these cases had been treated in the V. G. Hospital and the results were known to many members of the staff.

Dr. C. D. Murray remarked that chorea was a self-limited disease, and cases treated by the expectant method recovered about as quickly as those where drugs were freely given. He was

sceptical about the influence of the magnetic belt, particularly as it had been used after weeks of treatment and at a time when recovery would occur under any circumstances. Subject cases in the early stage of the disease to the treatment and then we will be in a position to estimate its value.

Dr. G. L. Sinclair thought that suggestion played an important part in the cure of many diseases, particularly nervous affections. He cited many instances from his own experience where *suggestion* was of great value. The general practitioner was disposed to overlook the value of the procedure. Drs. Jones, Black and the president took part in the discussion.

DIABETES ASSOCIATED WITH MARKED NERVOUS SYMPTOMS.

Dr. D. A. Campbell reported three cases of diabetes observed during the past year, associated with nervous disturbance. Dr. Smith in the very interesting case of crossed hemianalgesia reported at last meeting noted the presence of sugar in the urine, which might be expected on account of the proximity of the lesion to the diabetic centre. The cases observed do not admit of an easy explanation.

Case I.—P. S., aged 22, farmer, admitted to Victoria General Hospital Nov. 24, 1894, stated that he had lived on a farm all his life and had been exempt from sickness except the ordinary diseases of childhood. Eighteen months ago had suppurative inflammation of the right ear, which came on without apparent cause, and continued for some time, leaving with a thrumming sensation on that side of the head and some vertigo. Seven months after this he was suddenly seized with intense pain in right ear; ten minutes later convulsion followed by coma, which lasted for some hours. For ten days after this attack he was confined to bed, severe headache being the chief symptom. Shortly after this he noticed thirst, inordinate appetite, and an excessive flow of urine. He came to

hospital in April last, and had well marked symptoms of diabetes. He also complained of buzzing in the right ear. On May 3rd he had a convulsion followed by coma, and on May 5th another seizure. Prior to these attacks he was passing on an average 150 oz. of urine daily. For a short time after these the urine voided did not exceed 26 oz. daily. Soon after he returned to his home, and during the summer months he improved very much. The urine passed did not exceed the normal quantity and he gained in flesh and strength. Within the past month the diabetic symptoms have returned. He has been free from ear trouble and convulsions for some time. Has taken very little medicine, but has followed up closely the diet recommended. A careful examination had been made of the nervous system, and the only point noted was diminution of the patellar reflexes. It seems quite probable in this case that the diabetes was secondary to some injury of the nervous centre.

Case II.—T. S., aged 44, shoemaker, a robust, hearty man, but rather a heavy drinker, consulted me on June 28th, 1894. He stated that he had been feeling wretched for the past ten days, being tormented with unusual thirst. He had to urinate frequently, especially at night, and thought he was passing double the usual amount of urine. Urine was examined at once. Sp. G. 1044 sugar present. No albumen. Was placed on an anti-diabetic diet and codeine given in medium doses.

June 30th worse, and not able to work.

July 3rd, is exceedingly nervous, irritable and unable to sleep. Thirst less, urine diminished in amount, bowels acting freely. Codeine discontinued and diet modified.

July 7th, feels alarmed about his condition, and still unable to sleep. Has noticed a twitching of the muscles of the left forearm. Nervous system ex-

amined and nothing special noted. Urine contains an abundance of sugar and is free from albumen and casts.

July 9th, decidedly worse; twitching of muscles of left arm almost continuous. Sedatives prescribed.

July 10th, had a series of convulsions, which in spite of active treatment proved fatal in three hours.

Unfortunately an autopsy could not be obtained. The brief duration and severe nature of the symptoms was the notable feature of this case. His urine had been carefully examined eight weeks before, and at that time was normal, except that the Sp. G. was rather high, so that the disease could not have been latent for any length of time. It is probable that the diabetes and convulsions were the outcome of some intra-cranial lesion, the nature of which can only be a matter of speculation.

Case III.—R. McN., aged 65, of stout habit, was under treatment for diabetes during the past eight years, taking on an average three-quarters of a grain of codeine daily, and an anti-diabetic diet. Some months ago he noticed a failure of his eyesight and consulted a specialist, who informed him that the change in the retina was identical with that observed in Bright's disease. The urine contained a trace of albumen as well as sugar. The codeine was discontinued and he departed to some extent from his customary diet, partaking rather freely of bread and potatoes. Shortly after this he became restless and irritable. In the course of a few weeks he became decidedly insane and so violent at times that the question of placing him in an asylum was contemplated.

A return to the old treatment was decided upon. Twenty-four hours after resuming the codeine he had a convulsion followed by coma, which lasted 12 hours. He woke out of this condition clothed in his right mind, and has remained so ever since. The withdrawal of the codeine was no-

doubt responsible for the mental disturbance.

Considerable discussion ensued.

Stated Meeting January 10th, 1895.

Routine business being disposed of, the scientific programme was proceeded with.

SYMPATHETIC OPHTHALMIA.

Dr. Kirkpatrick exhibited a young patient suffering from sympathetic ophthalmia. (Case I. in paper on Sympathetic Ophthalmia.) — The patient was anesthetized and the salient features of the malady very clearly demonstrated. A report of a series of cases was then given, which is published on another page.

Dr. M. A. B. Smith read some additional notes on a case reported by him at a previous meeting, also a letter from Dr. M. Allen Starr, of New York, embodying his views on the subject. Some discussion followed, in which many present took part.

Book Reviews.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES. A yearly report of the progress of the general sanitary sciences throughout the world. Edited by Charles E. Sajous, M. D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators and correspondents. In five volumes. Published by F. A. Davis Company, Philadelphia.

Through the courtesy of the publishers, the 1894 Annual is now before us. The Annual furnishes a revision of some 1,163 medical journals and 176 books, monographs, theses, &c. Everything is written in a brief and concise way and represents whatever advances have been made in medicine and surgery the world over. Every department of medicine and surgery is dealt with. There is an index at the end of each volume and a combination index

at end of Vol. V. The general index at the end of Vol. V. is a very valuable feature. It is arranged in three columns, one for subjects, one for remedies and one for authors quoted. By means of the general index one may readily determine all that has been written during the year upon any given subject. This makes the work of value to teachers and busy practitioners. Good work, wherever it may be done, can be first published in the local journal, and subsequently find its way into the Annual, and thus be made known to the profession at large. We heartily recommend the Annual to our readers, not as a text book, but as a means of keeping in touch with advanced ideas in medicine and surgery.

SEXUAL NEURASTHENIA. By S. M. Beard, M. D., and A. D. Rockwell, M. D. Fourth edition. Published by E. B. New York.

Sexual disorders are so frequently met with in practice and the symptom complex is so varied that a work dealing with the subject is sure to obtain a wide circulation. The monograph by Beard and Rockwell has reached a fourth edition, which is perhaps the best test of its value. The subject is dealt with from every standpoint, and a new chapter is devoted to sexual erethism.

SAUNDER'S QUESTION COMPLENDS—Essentials of Diseases of Eye, Nose and Throat. Part I.—Essentials of Refraction and the Diseases of the Eye. By Edward Jackson, A. M., M. D. Part II—Essentials of Diseases of the Nose and Throat. By E. B. Gleason, L. B., M. D. Second edition, revised; 124 illustrations. W. B. Saunders, publisher, Philadelphia.

This is a volume of some 290 pages. It does not pretend to be a complete exposition of the subjects treated of. It is intended as a manual for students. The work of all concerned with this volume has been well done.

THE PHYSICIAN'S VISITING LIST FOR 1895.
Philadelphia: P. Blakiston, Son & Co.

The Visiting List before us is certainly a very compact and convenient little book for the pocket. It is the regular edition for 25 patients per week, with pencil and pockets. Many facts of great service to the physician and surgeon are given. We note in the table of contents: The Metric System of Weights and Measures, Posological Table, Dose Table corresponding with new U. S. P. in both English and Metric Systems, List of New Remedies, Incompatibility, Poisons and Antidotes, Disinfectants, Examination of Urine, Differential Diagnosis of Brights Disease, Diagnosis and Treatment of the Simpler Diseases of the Eye, Eruptive Fevers, Apnoea and Asphyxia, Calculation of Period of Utero-Gestation, Comparison of Thermometers. There are blank leaves for Visiting List, memoranda, addresses of patients, nurses, &c., obstetric engagements, cash, &c., &c. All in all this is a very compact little book. A perpetual edition may be obtained, to begin at any time, 2,000 names, for \$1.50.

CANADA MEDICAL REVIEW. This is the title of a new medical journal published in Toronto, and edited by a number of gentlemen formerly connected with the *Dominion Medical Monthly*. We wish the new enterprise every success.

E. B. Treat, publisher, New York, has in press for early publication the 1895 International Medical Annual, being the thirteenth yearly issue of this eminently useful work. Since the first issue of this one volume reference work, each year has witnessed marked improvements: and the prospectus of the forthcoming volume gives promise that it will surpass any of its predecessors. The price remains the same as before, \$2.75.

Selections.

CYCLING AND HEART DISEASE.—Sir Benjamin Ward Richardson.—I have been a practical cyclist for sixteen years or more. Having ridden with numberless riders, of different ages and sexes, under the most varied conditions, I now venture to lay before you certain of the effects I have observed. I may divide my observations under the following heads: (a) the immediate effects of the exercise on the rider; (b) the after effects as observed in the consulting room, and the conditions in regard to the heart and circulation under which cycling is favourable or unfavourable; (c) summary of the more salient medical considerations.

With regard to cycling and its effects upon the body at large, the exercise tells primarily and most distinctively on the heart, in which it differs from other exercises. In all riders, at all ages, it produces at once a quickened circulation, though riders themselves may not be conscious of the phenomenon. The effort may be so extreme as to cause the pulse to rise from 65 or 75 to 200 beats per minute: and, although after a longer time it sobers down, there is always a quickened action, which continues so long as the rider is at work. This act of quickened movement accounts for the astounding journeys a fully trained cyclist can undertake; journeys lasting two or three days and nights, when the cyclist is in his prime. The same probably accounts for his endurance as against sleep, the circulation through the brain being one continued series of waves, by which the molecular change of the brain occurring during natural sleep is suspended.

I have, however, never once seen a rider embarrassed by cardiac overstrain, faintness, breathlessness, angina or vertigo, so as to be obliged to dismount. Indeed, I have known a prac-

tical rider, who could climb a hill on his machine, but could not mount a flight of stairs on his feet without breathlessness and slight palpitation; moreover, I have never seen a sudden death from cycling.

Under the second head I may remark that I have met with instances in which, after some years of cycling, there was evidence of cardiac disease, with general languor and inability to sustain fatigue, if exercise were again tried on the machine. On the other hand, I know of an octogenarian who has kept up the exercise in a moderate degree, apparently with benefit to the circulation, and who in one journey had ridden from London to Bedford. In certain instances I have seen what appeared to be benefit arising from cycling, even when there was indication of some disease affecting the circulation. I have noticed good results from it in cases of varicose veins, fatty degeneration of the heart and unquestionably in conditions of anæmia.

I may now pass to the third head in the following summary:

(1) Cycling, when carried on with moderation may, in so far as the healthy heart is concerned, be permitted, or even recommended by practitioners of the healing art:

(2) In all cases of heart disease it is not necessary to exclude cycling: it may even be useful in certain instances where the action of the heart is feeble, and where signs of fatty degeneration are found, since increased muscular exercise often improves the condition of muscles, and of no muscles more than the heart itself;

(3) As the action of cycling tells directly upon the motion of the heart, the effect it produces on that organ is phenomenally and unexpectedly great, in regard to the work it gets out of it:

(4) The ultimate action of severe cycling is to increase the size of the heart, to render it irritable and hyper-sensitive to motion, the cycling acting upon it like a stimulant;

(5) The overdevelopment of the heart under the continued and extreme overaction affects, in turn, the arterial resilience, modifies the natural blood pressure, and favours degenerative structural change in the organs of the body generally:

(6) In persons of timid and nervous natures, "neurotics," the fear incidental to cycling, especially in crowded thoroughfares, is often creative of disturbance and palpitation of the heart, and ought to be taken account of as a piece of preventive advice:

(7) In advising patients on the subject of cycling, it is often more important to consider the peripheral, than the central, condition of the circulation, inasmuch as enfeebled or worn-out arteries may be more dangerous than the feeble heart, and, when connected with a heart that is overactive, are seats of danger. This same remark would, of course, apply to cases where there is local arterial injury as in aneurism;

(8) Venous enlargement seems rather to be benefited than injured by cycling, and conditions marked by sluggish circulation through veins are often greatly relieved by the exercise;

(9) There are three things which are decidedly injurious in cycling, viz.: (a) straining to climb hills and to meet head winds; (b) excessive fatigue; (c) the process of exciting the heart, and wearing it out sooner, by alcoholic stimulants, and the omission of light and judiciously selected meals at frequent intervals;

(10) The time has arrived when practitioners of medicine everywhere should make observations for themselves that confirm or confute these observations and add to them so much more which I, of necessity, have omitted.—*Medical Week.*

THE RELATION BETWEEN STERILITY AND UTERINE FIBRO-MYOMATA.—The influence of fibroid tumours of the uterus on conception, pregnancy, and

the puerperal state has been recently considered by Hofmeier in a paper an analysis of which appeared in the *Annales de Gynecologie* towards the end of last year. The question as to whether there is any etiological relation between fibroid tumours of the uterus and sterility, either absolute or relative, is one of considerable interest. The current impression undoubtedly is that the relation between them is casual rather than accidental. As in the case of so many other accepted views, the accuracy of this one is now called in question, and a careful consideration of the statistical evidence adduced by Hofmeier makes it clear that even if we cannot unreservedly accept his conclusions, there is at least sufficient ground for doubting the views hitherto commonly accepted as correct. Hofmeier's figures are based on a total of 213 cases of women with fibroid tumours of the uterus. A review of the details in this series of cases enables him to say that about 25 per cent. of women affected with uterine fibroids and seeking medical treatment are not married, 75 per cent. are married, and of these from 25 to 30 per cent. are sterile. Now, before drawing any conclusion from these figures, it is necessary to know what the percentage of sterility is among the whole class of married women. Probably further information is needed before we can state this exactly, but in the meantime, if we take the percentage of sterility among married women generally, as given by Matthews Duncan, at about 15 per cent., it will be seen that while there is a difference between this percentage and the percentage of sterility among married women affected with uterine fibroids, it is not so great as one might have expected. Still, at first sight—and we are not prepared to say at present that the conclusion is wrong—these figures would seem to justify the opinion that women with fibroids are about twice as likely to be sterile as

as other married women. Looking carefully into the matter it appears, however, that there is some reason to doubt whether the sterility should be ascribed to the presence of fibroids, or to some other cause. The duration of the sterility in each case, and the date of the first appearance of the symptoms of the fibroid tumours, are important points requiring consideration. Thus the average age of thirty-eight married sterile women was 41.4 years, and the duration of the sterility about sixteen years. Here, if the sterility is to be put down to the presence of fibroid tumours, we should have to suppose that when the patients were about twenty-five years old the tumours were already exerting an influence unfavorable to conception; whereas, clinically, we know that uterine fibroids are not commonly met with till later in life. It is, however, conceivable that they might at an early period of their development, before giving rise to symptoms, and before attaining a size that would enable them to be recognized clinically, nevertheless have an effect in rendering conception less likely to occur. It should be mentioned that inquiry showed that in some of the thirty-eight cases referred to the patients had been under gynaecological treatment ten or fifteen years before the fibroids appeared. We cannot follow the writer's thoughtful and suggestive paper further in detail, but we may just say that he considers that in most sterile women with fibroids the sterility must not be ascribed to the presence of the fibroids, but to some other cause, chiefly because the sterility always dates back to an age when in all probability there were no fibroids present. We have indicated a possible fallacy in this argument above. While the writer does not go so far as to say that fibroid tumours in themselves favor conception, yet in so far as their presence frequently prolongs the period of activity of the whole generative apparatus, and especially

of that of the ovaries, they do in that sense increase the chance that pregnancy may occur.—*Lancet*.

PREGNANCY AND LABOR COMPLICATED BY BRIGHT'S DISEASE.—Dr. G. E. Herman, obstetric physician to the London Hospital, reports to the London Obstetrical Society upon the careful study of numerous cases of Bright's Disease in connection with pregnancy and labor, and summarizes his conclusions as follows :

"There are at least two kinds of renal disease of which a pregnant woman may be subject, and to which pregnant women seem specially liable. One of these is a very acute disease, coming on either without any premonitory symptoms or with premonitory symptoms of very short duration, *i. e.*, usually measurable by days. It attacks chiefly primigravidae. It often causes intra-uterine death of the child. It is attended with extreme diminution in the quantity of urine, and the small quantity of urine passed is greatly deficient in urea, but contains enough albumen to make it solid in boiling. This is the disease which is accompanied with rapidly recurring fits. If the disease runs a favorable course, the fits cease, then the urine increases in amount, and the percentage of urea in it rises. If the excretion of urea is not re-established the case quickly ends fatally. Such cases seldom if ever pass into chronic Bright's disease.

"The other is a disease which attacks older subjects, chiefly those who have had children before. Its premonitory symptoms are gradual and slow in onset, *i. e.*, usually measurable by weeks or months. It less often leads to intra-uterine death of the child. It is generally accompanied with increase in quantity of urine, with copious loss of albumen, but not so much in proportion to the urine as in the more acute disease. In these patients delivery is followed by temporary in-

creased diuresis, and by increase in the excretion of urea. When this increase is only slight the albuminuria persists, and the case becomes one of chronic Bright's disease. This form of disease is sometimes attended with fits, but generally not. The presence of albuminuric retinitis affects prognosis unfavorably. When the pressure within the abdomen is greater than usual the amount of urine may be diminished; but in such cases the diuresis and the augmented excretion of urea after delivery are proportionately greater. In the acute disease, which causes eclampsia, and in the chronic disease when it is associated with excessive intra-abdominal pressure, much of the albumin is paraglobulin. The cases in which the albumen is mainly serum-albumen generally either die or pass into chronic Bright's Disease."—*Pu. Med. Journal*.

MANNER OF USING ANTITOXIN.—In order to arrive at any satisfactory conclusions, it is all important that in every instance where antitoxin is used there should be a bacteriological examination of the throat. It is also important that the urine of the patient should be examined for albumin before and after the injection. The dose for procuring immunity, according to some observers, is 1 cubic centimetre (15½ minims) for any age over three years, and half that for younger children. For a cure of the disease during the first two or three days, under two years of age, 2 to 3 cubic centimetres (31 to 49 minims); from two to ten years, 5 cubic centimetres (1½ fluidrachms); over ten years of age, 10 cubic centimetres (2½ fluidrachms). After the third day, in a severe case, twice as much may be used with positive advantage. If the disease does not seem to be ameliorated by the first dose, a second should be given in twelve hours. The question of dosage is one that can only be decided by a

more extended use of this agent. In the account of the cases treated there is no evidence of any distressing or annoying symptoms caused by the injection. One advantage of this treatment is that, after the injection into the back or abdomen, there is no interference with the patient; no swabbing of the throat; no tearing of the mucous membrane. It is stated that even in the worst cases that proceed to a fatal end there is a marked amelioration in the suffering; that the dyspnoea is relieved to a certain extent. If the patient dies, his death is comparatively painless. In regard to the kind of syringe that should be used, it must be said that the common subcutaneous syringe is not adapted for the purpose, because it cannot be properly sterilized by heat. Koch's syringe, which consists of a detachable rubber bulb, a glass barrel and a needle, is the most satisfactory instrument for this purpose. The barrel and steel needle can be put into a test-tube, in the bottom of which a little cotton is placed, the tube plugged with cotton, and then put in the oven of a cooking stove and kept at a temperature of 150° C. (302° F.) for half an hour or more, or until the cotton is slightly singed. A syringe prepared in this way will remain sterile for four or five days.—*Boston Medical and Surgical Journal*.

BICHRIMATE OF POTASSIUM AS A REMEDY IN GASTRIC AFFECTIONS.—

We offer the following synopsis of a paper on the above subject, which was read at the International Medical Congress by Prof. T. R. Frazier: Notwithstanding the assertion made in 1883, by so high authority as Vulpian, of the value of bichromate of potassium in the treatment of several forms of gastric disturbance, this substance has not yet gained a position among the many substances that are used in the treatment of these affections. Having, in 1884, treated with gratifying success

a case of persistent gastric disorder by the administration of small doses of bichromate of potassium, I have since that time administered it in a large number of cases, and the results have been so favorable that I feel myself justified in now stating my opinion of the therapeutic value of the substance. The cases have been recorded in two groups, the first group comprehending 18 cases of various forms of dyspepsia unassociated with evidence of gastric ulcer, and the second group, 18 cases in which distinctive symptoms of ulcer had been present at some previous time. The doses administered in the above cases have varied from $\frac{1}{2}$ grain to 1.6 grain, twice daily, and in most instances the smaller dose was found to be sufficient. The dose should be given during and on an empty stomach as possible. The administration was effected in the form of pills or an aqueous solution which may be flavored with tolu or orange. An examination of these cases shows that bichromate of potassium is capable of relieving, and often in a short time of removing, the entire group of symptoms—if we except constipation and anemia—encountered in dyspepsia, and especially pain, nausea, vomiting and gastric tenderness. In a few cases of acute gastric ulceration, with hematemesis, in which I have given bichromate of potassium, the results were not favorable, as it did not succeed in checking the bleeding. Bichromate of potassium possesses a strong anti-putrefactive power, which is exhibited in albuminous, saccharine and phosphatic urines, even with a 0.01 solution. This action probably constitutes one of the causes of its anti-dyspeptic therapeutical value, but there are undoubtedly other causes, such as direct or indirect analgesic action, and probably a selective action on the nutrition or function of certain histological structures, which I am now engaged in endeavoring to determine.—*Lancet*.

THE VALUE OF NUCLEIN AND NUCLEINIC ACID—Dr. Victor Vaughan gives this very modest statement of the therapeutic value of nuclein and nucleinic acid (*Medical News*.) After confessing that it is practically useless in advanced phthisis, he says: "In initial cases of pulmonary tuberculosis, when there is no secondary infection, and when the area involved is small and the resistance of the patient not too much reduced, the proper employment of this agent may produce at least a temporary cure. I say 'at least a temporary cure,' because none of these cases has been under observation a sufficient length of time for me to say that the bacilli will not reappear. In the few cases of urinary tuberculosis that I report in this paper the results have been remarkably satisfactory. The results that I have secured so far encourage me to continue the work.

I must not close this paper without mentioning another point: I am convinced, especially from my experiments on animals, that nucleinic acid, improperly used, may do harm. It acts, as I have elsewhere shown, by stimulating the organs that elaborate the polynuclear corpuscles, and these may be over-stimulated. Nucleinic acid fails to be of service unless these cell-forming organs respond. They may fail to respond on account of lowered vitality, or they may be paralyzed, as it were, by an excessive dose of stimulant. The agent is not one to be used indiscriminately. Already some physicians are supplying tuberculous patients with hypodermic syringes and solutions of nucleinic acid, and telling them to go ahead and treat themselves. Such practice as this may make the study of this subject result in a misfortune."—*N. Y. Med. Record*.

dyscrasia be recognized it must, of course receive appropriate treatment. When the skin lesions are acutely inflammatory the use of antimony seems beneficial, and the author gives ten or twelve minims of wine of antimony, repeating the dose in an hour, and, if necessary, in two more. Gradually the interval is increased and the dose lessened until six minims are given three times daily, and this is continued until the inflammation subsides. Arterial tension is an indication for the use of this drug, and depression a positive contra indication. Deficient strength and nerve force may call for strychnia, arsenic, belladonna, phosphorus, quinine, etc., but the author thinks diet has only an indirect influence, through its effect on digestion, the general health, etc.—*Pac. Med. Jour.*

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MANAGEMENT OF ECZEMA.—Dr. Malcolm Morris thinks that, as a general rule, the less internal remedies we use the better, but that if a constitutional

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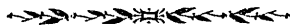
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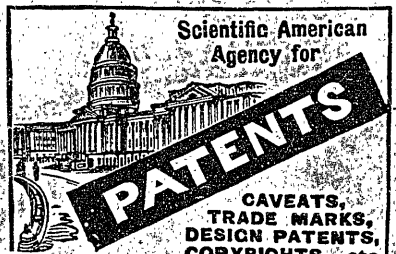
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