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THE Canadian Medical Review.

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Vol. I.]

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[No. 1.

Original Communications.

Recent Electro-Therapeusis of Goitre, with Improvements in Apparatus.

BY DR. CHARLES R. DICKSON, TORONTO,

*Electro-Therapist to Toronto General Hospital, Hospital for Sick Children, St. John's
Hospital and St. Michael's Hospital.*

[Abstract of paper read before annual meeting of American Electro-Therapeutic Association,
in New York, September, 1894.]

ABOUT five years ago I formed the opinion that for the treatment of goitre we had at our disposal an agent which, properly and rationally employed by competent operators, should prove safer, more efficacious and acceptable than any other in a majority of the various forms of this trouble. Electricity had been on trial with very varying results, but it seemed to me that the discrepancies were attributable to the apparatus employed or to the operator, and that we did not fully appreciate its value.

The literature on the subject was conflicting, misleading and most disappointing. Electricity was discredited, and other methods advocated fraught with gravest menace to the patient's future health, usefulness and happiness, in the event of recovery, from the immediate results of the procedures, and recent literature shows little improvement.

Here, surely, was a promising field for research, and I determined upon a careful investigation.

The immediate vicinity of Toronto is not goitrous, yet as a regularized medical and surgical centre it draws many cases from an extensive territory around, and in the great majority of these cases the best-known therapeutic measures adopted by the general profession have already been resorted to. My connection with Toronto hospitals places me in a most favorable situation with regard to the supply and character of this clinical material, and a number of our prominent practitioners have very kindly referred to me their private as well as their hospital patients, thus testifying to the unsatisfactory state of the therapeusis of the thyroid as well as to the success of my labors. This is most gratifying to me, and greatly to the credit of my professional brethren, well illustrating their broad and progressive spirit in contrast to the opposition to methods electrical manifested in other quarters. Improved apparatus and methods have retrieved past failures, and rendered possible results hitherto unattainable.

The discussions elicited by my former papers disclosed a decided variance of opinion as to the value and range of applicability of electrical treatment, and demonstrated the need and incalculable usefulness of our Association. I have again to report progress and state the deductions from a year's further experience. My aim has been to shorten the period of treatment, while extending the interval between *séances*, to improve technique and to discriminate the treatment most appropriate to each case.

The percutaneous method, using strong currents by means of flexible clay electrodes, has received considerable attention. I have found it very tedious, and have come to the conclusion that its chief utility lies in combating the hyperæmic condition, in reducing simple hypertrophy, in stimulating liquefaction and absorption of recent fibroid growth, and lessening the œdema of older cases preparatory to more active measures. It may also be employed where puncture would not be well borne, and occasionally to alternate with puncture treatments.

Thyroid hyperæmia occurring at the menstrual period or during pregnancy, and disappearing at their termination, does not call for interference unless there be accession of size at each period or gravid state. Galvanization of the sympathetic should then be resorted to, with occasional clay pad percutaneous treatment if necessary. This remark also applies to goitrous cases of amenorrhœa, whether primitive or secondary.

In the slighter forms of hyperplasia, the clay electrode treatment is indicated, the positive electrode at the back and the negative over the goitre, starting with 20m.a. to 30m.a. The patient will, after a few

sittings, gradually tolerate 100m.a. to 150m.a. for ten or twelve minutes two or three times a week.

In vascular forms, by diminishing excessive blood-supply and stimulating absorption, we induce a process of partial atrophy. The negative electrode, a large clay pad, is placed at the shoulders, while the active surface of the positive (a properly insulated platinum needle) is introduced within the capsule of the gland alongside a tenotomy knife. Of course, a local anæsthetic is first used. From 50m.a. to 150m.a. should be employed for eight to ten minutes every ten or twelve days.

In distinctly fibroid forms, the nutritive process may be lessened by the positive puncture, with occasional resort to the negative needle to hasten absorption. In some advanced fibroid cases where, owing to the small proportion of healthy tissue left the process of absorption and atrophy was slow, I have hastened matters by the formation of a central cavity or artificial cyst. This I have done by large negative needles, treating it as an ordinary cyst and maintaining drainage. It requires specially careful manipulation. In very large fibroids, I frequently discard the clay pad and use instead a second needle in another portion of the growth.

Thin-walled unilocular cysts are the most amenable to treatment. The positive pad is placed at the shoulders, while the negative electrode is an insulated canula, through which the cyst is aspirated and a solution of chloride of sodium introduced. From 50m.a. to 100m.a. is employed for ten minutes, the cyst again emptied and firm pressure maintained by broad adhesive straps. A single treatment may suffice, but frequently in the thick-walled and multilocular varieties drainage must also be kept up to permit escape of the fluid effused subsequent to the operation. The aim is thus to obliterate the sac by exciting adhesive inflammation of its walls.

Thick-walled fibro-cysts are often very rebellious. Following the above treatment, I have introduced a solution of zinc sulphate through a tube which carries a positive platinum wire, and employed 50m.a. to 75m.a. for ten or twelve minutes. I have also used a zinc positive electrode.

When the contents of a cyst are not sufficiently fluid to pass through the canula, some of the saline solution should be forced in, and currents of 50m.a. to 100m.a., or if the patient will tolerate it, and it is necessary, 150m.a. to 200m.a. employed. This will liquefy the contents, which may be withdrawn immediately or at the following *séance* eight or ten days later.

Puncture of the thyroid, apart from electrical treatment, is not

devoid of danger. Considerable dexterity is required, and a slight error may prove disastrous. When in addition to this we consider the power of the agent employed, it will easily be understood that great care is requisite both during and subsequent to the operation. Cleanliness and strict antisepsis are imperative. Drainage should not be unnecessarily prolonged.

With regard to exophthalmic goitre, I have nothing novel to offer. I meet very few genuine cases, and think that the Fellows fully appreciate the value of galvanization of the sympathetic and other electrical methods.

I have modified the canula and attachment of the Potain aspirator by enlarging the lumen to permit the easy passage of No. 3 drainage tubing. I have had the tube of the canula constructed of platinum. It may thus be used with the positive pole; and I have added a second stop-cock, which renders it independent of the reservoir.

As the use of chemical solutions corrodes metal parts, I employ for injection a second bottle, with tubes of glass leading to and from it. I have also furnished it with a third tube to facilitate the introduction of the solution. Provision is also made for emptying the sac after treatment without polluting the contents of reservoir.

The possession and care of the necessary apparatus, and the ability to employ it skilfully, minute acquaintance with fundamental laws, and a proper estimation of the power of this agent, are only a few of the factors which militate against the electrical treatment of goitre by the general practitioner, and he will be wise if he resist the temptation to use it.

Finally, the keynote of success is discrimination.

Treatment of Colles' Fracture.*

BY W. BRITTON, M.D., TORONTO.

PROBABLY this injury, more frequently than any other, is the bone of contention in vexatious litigation, and unscientific treatment has far less to do with it than a too sanguine prognosis.

The community at large is not slow to force upon our daily attention the obligations devolving upon us; but the first law of nature, that of self-protection, is quite as applicable to the medical profession as to the rest of mankind, and he deserves just a little touch of legal scorching who, when about to be burdened with a case of Colles' fracture, omits provision for future contingencies by neglecting to state in the presence of a witness the most disastrous outlook warranted by the circumstances.

So vividly has this been impressed upon my mind that some time ago, when summoned to a case of the kind, and finding on my arrival that the patient and her spouse belonged to that irresponsible caste which rakes up the majority of malpractice suits, before even asking for a shingle I draw up in "whereas" and "wherefore" form a stringent document holding me harmless financially in case of an imperfect result. To this formulated profession of absolute confidence in my skill and integrity were appended their signatures. The case followed the usual course satisfactorily—nothing of consequence transpired until some weeks afterwards when, having rendered a modest bill for attendance, I received from the husband a gentle intimation, in language outside the vocabulary of modern drawing-rooms, that the fingers were imperfect in their movements and were doomed to grow worse instead of better. It is needless to add that I awaited in vain a gratuity, while I fondly treasured the little scrap of paper securely locked away as a souvenir of my narrow escape from the clutches of judge and jury.

This subject has been worn almost threadbare in the text-books; therefore I dare lay claim to no special originality, and can only hope to emphasize the salient points in dealing more especially with the difficulties that so frequently occur.

The trio "reposition, rest and rigidity of fragments," which has become classical as the abbreviated indications in the treatment of fractures generally, deserves, in relation to Colles', the addition of another member—prevention of ankylosis.

* Read at the meeting of the Toronto Clinical Society, December 12th, 1894.

Analysis of the causes of deformity is necessary in order to arrive at a scientific method of correction.

The hand is abducted not only by the supinator longus and extensor proprius pollicis, but also, owing to the fact that, excepting in young subjects where the epiphysis is often separated, a certain degree of radial shortening ordinarily occurs through impaction.

The continuance of that force, which drives the inferior fragment upwards and backwards and lacerates the triangular cartilage, drives the ulnar portion of the carpus away from the ulna, whose styloid process finds its way forwards and inwards amongst the meshes of the annular ligament.

This is easily accounted for: the fibro-cartilage, the direct bond between radius and ulna, is already severed, and both anterior and posterior radio-ulnar ligaments passing downwards and inwards do not offer the same opposition to separation of the bones as though they were transverse; therefore the ulna has nothing to encounter in the way of luxation excepting the superficial structures.

In a recent instance with which I met there existed an additional deformity. The patient was a child and the radius was fractured at the epiphyseal line; therefore the opposing surfaces, being comparatively smooth, considerable flat pressure was required over the muscles to prevent the upper fragment from approaching the ulna. This tendency is caused in part no doubt by the pronator quadratus, but chiefly by the elastic stringency of the surrounding fasciæ.

Considering the difficulties attending perfect reduction, I do not think that any but the most simple cases should be attempted without an anæsthetic, and under its influence, while extreme adduction with extension are made, the most delicate manipulation should be observed in order that the operator may fairly conclude that the fragments are so accurately adjusted as to bring compact tissue in contact with its kind, otherwise it will enhance the difficulty of obviating radial shortening and consequent deflection of the hand to that side.

Subsequent circumduction of the hand with firm pressure will often restore the ulna to its proper position; but, should the dislocation be extreme and irreducible, although I cannot speak from experience, I imagine it an open question as to whether or not subcutaneous section of the offending fibres of the annular ligament would be less objectionable than a badly-deformed wrist.

A thousand and one splints have been devised and christened. I am well aware that in offering suggestions I run the gauntlet of being set down as another crank; and, in the way of excuse, express the conviction that the plan of treatment meets as far as possible every

indication in a simple manner, while at the same time I hold myself open for criticism and possibly for conversion.

At the first visit I am contented with placing and retaining the limb in an easy position, deferring perfect reduction for the short time required in the preparation of a permanent splint.

On a strip of pasteboard I secure the radial and ulnar outlines of the sound forearm and adducted hand, which, reversed, is the pattern for a pistol-splint made of a thin, flat board and extending from the elbow as far as the metacarpo-phalangeal joints. With a large flattish gouge, a few seconds suffice for the formation of a concavity for the base of the thumb. A convex piece of wood to fill the palm and elevate the knuckles to an easy position, together with a strip of galvanized iron one and a half inches by three or four, completes the anterior splint.

Each end of this strip is doubled in the form of a hem to increase its strength. It is then nailed to the ulnar edge, its distal extremity just below the position of the styloid process and its anterior edge flush with the upper surface, which leaves about an inch and a quarter in width projecting.

If the contrivance possesses any special virtue it consists largely in the use of this small piece of metal; but why?

Even after complete reduction of the ulna there often exists a tendency to more or less displacement inwards, with a corresponding carrying of the carpus and attached fragment of the radius outwards. This disposition is largely augmented by effusion into the *membrana sacciformis*, which is naturally opposed by pressure; therefore, a prime object is to maintain the ulnar extremity as closely as possible in contact with the sigmoid cavity of the radius.

In using the ordinary pistol-splint the arm and hand may be represented as a lever—the fulcrum, the radial side of the second metacarpal bone; the power, the fixed splint above near the elbow, and the weight, the pressure exerted outwards anywhere around the inner side of the wrist, wherever the bandage happens to be the tightest, and which may occur over the carpus instead of the ulna.

The very opposite is that which must be accomplished if the radius and ulna are ever to be brought into contact; and, by introducing the strip of iron well padded, the force is concentrated and limited to the very part desired—the lower ulnar extremity—while the counter-pressure forces the carpus inwards.

A flat posterior splint extending to the carpus, with the routine arrangement of padding and bandage, completes the dressing.

It cannot be called complicated or troublesome in construction, for

it may be made in almost as little time as I have taken up in the description ; and, so far as my experience goes, it fulfils every requirement.

No amount of care will prevent some stiffness of the wrist and fingers ; but, as the extensor tendons are much nearer the radius than the flexors, and, therefore, in the region of provisional callus, I am fully persuaded that rigidity is due more to the former than the latter, and that passive movements of the fingers are often deferred too long. I do not hesitate to employ them as early as at the end of the first week ; and, should fibrinous effusion take place into the tendinous sheaths, it is well that motion should anticipate its organization.

It is to be taken for granted that the wrist is to remain at rest until fair union is secured, and that more or less permanent ankylosis is to be looked for should there be cleavage into the radio-carpal articulation.

The splint which I present for ocular demonstration was hurriedly made this evening, and, therefore, will not strike one as the work of a Phidias ; but it will answer the purpose as well as though it were shining with polish to suit the æsthetic tendency of those who are able and willing to pay for the artistic.

Clinical Notes.

A Case of Infantile Spinal Paralysis, with Severe Resulting Deformities.

BY W. W. BREMNER, M.D., TORONTO,

Late Assistant Surgeon, New York Hospital for Ruptured and Crippled, etc.

J. M.—, age 25 years, suffered from myelitis of the anterior horns when he was five years old. He was very kindly referred to me in the autumn of 1894 by Dr. Geikie. There was very severe talipes equino-varus of the right foot and about three inches of knock-knee of the same limb (that is to say, there was an interval of three inches between the internal malleoli when the internal condyles touched each other). This state of affairs is seen in Photos 1 and 2. Every muscle on the front of the leg and foot seemed to have been permanently paralyzed, although it is quite possible that some of them, especially the short dorsal muscles of the foot, may not have been involved originally, but had just suffered atrophy from disease, as three weeks after the foot was rectified he was able to flex and extend some of the toes. The inversion and flexion of the foot were so great that he walked on the ends of the tibia and outer side of the

cuboid. Large bursæ had developed over these bones, which are well shown in Photo 1 before operation and in Photo 2 after operation. The planter, muscles and fasciæ were also greatly contracted, so much



PHOTO 1.



PHOTO 2.

so that the great toe was brought within four to five inches of the heel. See Photo 1. The man had suffered very much and very frequently from severe pain in the bursæ on which he walked; but being of a very determined disposition, he had persisted in going about and had often worked at heavy laboring, at one time acting for a considerable period as a driver to a coal dealer and having to carry the heavy coal bags in which coal is frequently delivered in this city. The affected limb was $1\frac{1}{2}$ inches shorter than its fellow and considerably atrophied, as can be seen in Photo 2.

With the assistance of Dr. A. J. Geikie, the correction was made on September 15, 1894. Every precaution was taken to prevent sepsis, the limb having been scrubbed and shaved the previous night, and wrapped in absorbent cotton, saturated in a carbolic acid solution 1 in 20. An open incision two inches long was made over the posterior tibial artery, midway between the internal malleolus and the tendo-Achilles. Through this the tibialis posticus and long flexor tendons were divided, the tibialis anticus and plantar fascia were cut subcutaneously and an attempt made with a powerful wrench to bring the foot into position, but the resistance of the short plantar muscles and of the deeper ligaments was so great that it was found necessary to cut every tendon on the plantar surface near its insertion, and many of the deep ligaments were also incised. This was all done subcutaneously with a very small, blunt-pointed tenotome, great care being taken to avoid the plantar arch, which, fortunately, we succeeded in doing. Before these short muscles were cut, it was very interesting to see how the toes were contracted like hen's claws as the wrench

was applied. After all these structures were divided, the tendo-Achilles was cut and the foot brought into a position of over-correction by means of the wrench. Very considerable force was necessary to do this. Iodoform gauze was applied to each puncture, the incision closed and a plaster of Paris dressing applied.

The result forty days after operation is seen in Photo 2. The sole of the foot is flat on the ground. The toes are straight and freely movable, and the range of motion in the medio-tarsal and ankle joints is very nearly normal. The buræ on which the patient walked now adorn the dorsum of the foot, but, as their usefulness is ended, they will gradually disappear. There is little doubt the patient will have a very useful foot. A light ankle brace, fitted with a check-action joint, will be worn for a little time to prevent recurrence.

The knock-knee was corrected on Nov. 9, 1894, by cutting through the femur subcutaneously just above the joint. There was no rise of temperature after the operation, nor any symptom to cause anxiety.

In treating these cases of infantile paralysis in their early stages, it is important to remember that deformity can usually be prevented by suitable orthopedic treatment. There is no doubt that all the very terrible deformity of this patient could have been prevented by suitable massage, passive motion and electricity, combined with a very simple walking brace with an elastic band to supply the place of the deficient peroneal and extensor muscles. The knock-knee I consider to be a secondary result of the neglected foot, an attempt by Nature to correct the centre of gravity.

A Peculiar Fracture of the Clavicle.*

BY DR. J. J. CASSIDY, TORONTO,

Consulting Surgeon, Toronto General Hospital.

LAST October 23rd, 10 p.m., Mr. B—, aged 17 years, presented himself at my office with a fracture of the right clavicle. The accident had been caused by direct violence during a game of football, in which he was one of the participants. The game was played at night, the field being lit up by the electric light. The bone was broken into three fragments—an acromial and a sternal piece, each of about equal length, and a central piece an inch in length. This central piece had been wrenched from its bed, and could be felt beneath the skin like a sharp fragment presenting in a vertical direction. No efforts that I could make, assisted by Dr. W. H. B. Aikins, who kindly responded to my call for counsel and assistance,

* Read at meeting of Toronto Clinical Society.

succeeded in restoring the fragment to its proper position. The advisability of operating immediately and removing the fragment was naturally discussed. Finally we decided to treat the fracture in the usual way for twelve or fourteen days, until union would take place, and then to trim or remove the central piece. The principal reason for this course of action was that the fragment was large, and if removed by immediate operation the gap between the acromial and sternal ends of the clavicle would cause considerable shortening of the bone and deformity of the shoulder. The fracture was therefore dressed with figure-of-eight bandage to the shoulders, the right arm being placed in a sling and the patient sent to bed.

November 2nd.—This bandage was removed, and the blade of the right scapula was fixed to the back of the thorax with a pad and adhesive straps, which encircled the chest from the spine to the sternum, the arm being sometimes placed in a sling or occasionally extended by the side. This was done to avoid the irksomeness of constantly having the forearm lying on the chest, while the patient was in bed. I also tried to relieve the tension of the skin over the fragment by using strapping in such a way as to cause wrinkles over the front of the fragment. My efforts to prevent perforation of the skin were in vain, and November 6th, fourteen days after the accident, the point of the fragment appeared through the skin.

November 10th.—Assisted by Dr. H. H. Oldright, who chloroformed the patient, and by Dr. Aikins, I cut down on the injured clavicle and exposed the fragment. At first it seemed that, owing to its firm attachment to the other pieces of the bone, I would be obliged to smooth the surface of the fragment, and leave whatever was sound bone in its unnatural position. By manipulation, however, the fragment became loosened, and I finally drew it out, exposing an opening which extended to the posterior surface of the bone. The fragment, which I now exhibit, was about $1\frac{1}{2}$ inches in length, and appeared to belong to the anterior surface of the bone, but did not include its whole thickness. It was denuded of periosteum. It had become united by callus at one spot to the sternal fragment.

The subsequent treatment, which was uneventful, consisted in keeping the wound clean, dressing it with rubber tissue and Gamgee tissue, the whole retained by strapping. The wound was quite healed December 6th when he returned to his work. The callus thrown out was considerable, the clavicle at the seat of fracture measuring about $1\frac{1}{2}$ inches in width, the opposite bone being about $\frac{3}{4}$ inch in diameter.

Society Reports.

TORONTO CLINICAL SOCIETY.*

(NOVEMBER MEETING.)

Pathological Specimens.

Colloid Cystoma.—Dr. J. A. TEMPLE, in presenting a large colloid cystoma, said—The patient, since confinement, had been tapped three times; the fluid accumulated very rapidly indeed. The last tapping was done on Saturday week. I operated on her yesterday, assisted by Dr. Macdonald. On opening her, we found a large quantity of ascitic fluid and a large ovarian tumor. The first appearance made us think it was a malignant growth, but I have had it examined by Dr. Anderson and he pronounced it of benign origin. She is progressing favorably to-night. The main object I had in showing it was because of its peculiar appearance. It will no doubt not be new to men of large experience, but perhaps it may be to some of the others. It is very soft; breaks down very easily. The great distinguishing character, and what makes it unique, is that there was not a single proliferation. These colloid cysts are rapid in their growth. The reason that I operated was because the woman was in such a terrible condition. She measured fifty-four inches around the abdomen. She had been tapped only ten days ago and had all the fluid taken out there. She had been tapped seven times in four weeks. On visiting the woman to-night, I found the temperature normal, the pulse ninety, and doing remarkably well. There was nothing to account for the ascites, except the peritonitis, which was caused, I think, by the rapid growth of the tumor.

Meningitis—Dr. SHEARD—A boy, nineteen, perfectly well until two weeks ago, was then taken with a tendency to sleeping, drowsiness and muttering of a low kind. He was in the hospital under my care for ten days. During his wakefulness, he would snatch at imaginary objects; would look at a distant point, and would make a snatch at it. He was also inclined to get up, and opposed any efforts to soothe him or confine him to bed. He had no distinct convulsive seizure, although the nurse reports that he had slight convulsive attacks. He had spasmodic contraction of the right cervical muscles. The head was drawn over to the right shoulder. This was a pretty constant symptom. It seemed to me that he had some congestion of

* Reported by Dr. J. N. E. Brown.

the right hand and forearm, and also slightly above the elbow, as was shown when the nail was drawn over, a feature which is noticed in basal meningitis. He had no ptosis. But he had a tendency to divergent strabismus. The eyes were drawn outwards, and held in that condition, until attempting to talk with him, when he would then move his eyes and look at you : but I do not think he could see or understand, because he did not appear to notice a light or any object put before his eyes. The pupils showed no change. They were not sluggish. There was marked retention of urine and feces as well.

Kyphosis.—Dr. SHEARD—The patient, from whom this specimen was taken, eight years ago met with an accident, receiving a severe blow in the lower dorsal region. After this he suffered a good deal of pain and tenderness, even after getting up. This persisted for several years, when an abscess developed, which presented itself at the iliac crest in the lumbar region, and was opened up by Dr. Bryans, and a small amount of pus escaped. After a week it healed up kindly, and the symptoms practically disappeared. His occupation was a sailor, and he worked a couple of years when he began to develop a kyphosis. This was accompanied by a small amount of tenderness and pains. He was placed in the House of Providence. On the 4th of November he began to have acute symptoms, marked by weakness in the legs, which soon became paralyzed in feeling, but he could move them and there was no increase of reflexes. He had also a marked tendency to semi-coma, and died comatose on the 12th of November, after four days' sickness. He had strabismus and ptosis, the lid covering the upper half of the cornea. In both of these cases there was general tuberculosis. In case number one the diagnosis was meningitis. Adhesions were found in the pons, and the upper medulla was thickly coated with lymph and congested. Examining the sylvian fissure and the sylvian artery, a quantity of lymph will be seen deposited there. Looking very carefully at the meningeal membrane, you can scarcely see the tubercle.

In connection with number two, I have one or two very interesting specimens. First, the kyphosis. You will see a softened condition of the vertebral body. It is perfectly carious, and can be easily broken down, and there are adhesions between the spinal meninges and vertebræ, and also inflammatory deposits. The most interesting thing was the caseous condition of the prostate. It shows a central caseous condition, which is very rare in it. The lungs of that patient showed cavities in the apex of the left lung. Then the brain shows basilar changes. The deposit of lymph unites the convolutions all through, especially in the sylvian fissure separating the tempero-

sphenoidal and frontal lobes. The lymph is unbroken, and shows the old adhesions in that way. In reply to question, Dr. Sheard said the age of the first patient was nineteen, that of the second, thirty-eight. There was no traumatism in the first case.

Fatty Tumor.—Dr. ALBERT A. MACDONALD—The peculiarity of this specimen is more in its situation than anything else. It was situated in the perinæum, about an inch in front of the anus and about an inch to the right of the medial line. It had the appearance of a hernia, and the history of the case rather led one to suppose that it might be a perineal hernia. The patient was a male, aged 32 or 33, in good health and an active man. He said that after a strain from lifting a roll of carpets he felt this protrusion, and that he had felt it ever since. He was in the habit of riding a bicycle, which interfered with the lump. When he presented himself to me, I discovered a pedunculated tumor, which was already in the position I have described, and on pressing it I was able to press it upwards, and seemed to reduce what might readily be considered a hernia, and at the same time it had not the feeling of a hernial sac; it seemed thicker and harder. It felt as though it could easily be reduced. For that reason I was led to believe it to be such possibly, though I was not sufficiently clear on the subject to give a positive diagnosis. I reserved that until after it was cut out. Drs. Temple and Baines assisted me to remove it. I cut down on the tumor, which was much larger than it is now, and removing it we found it to be a fatty tumor, and, fortunately for the patient, not a hernia.

Dr. CASSIDY—Had it a pedicle?

Dr. MACDONALD—Yes. I mentioned that it was distinctly pedunculated.

Dr. MACFARLANE—This is an interesting case—its situation, and the fact that it was taken for a hernia. I think it is very unusual. I never saw a hernia in the position this is described to have been in, and I would like to ask Dr. Macdonald if he got any of the symptoms usually accompanying hernia—any impulse on coughing, and the mode of growth of the tumor; in what way did he come to the conclusion that it was a hernia? We could easily understand, if the growth appeared in the neighborhood that was liable to rupture, how a mistake of that kind could occur; but in the location this tumor appears to have been, I would like to learn the peculiar symptoms that led him to have drawn the conclusion that it was hernia or like a hernia. Dr. Sheard asked if the doctor thought that riding on the bicycle had anything to do with it. Friction will cause a fatty tumor. They appear in the line of the braces, in the

line of the waist-band. That continued pressure, combined with the friction, would produce the origination of a fatty tissue growth, and taking this rather peculiar seat for a tumor, together with the habit of bicycle-riding, surgery may develop a new field.

Dr. ALLEN BAINES—One thing struck us all which was not mentioned—the skin over the tumor had become thinned and the covering of the tumor beneath seemed very much like mucous membrane. It felt like gut. It was very easily replaced. The doctor asked me to see this case with him and give him assistance. We supposed that it might be perineal hernia. As perineal hernia was a condition I had never seen, I fortified myself by reading up the subject, and found that perineal hernias are not very uncommon. They do occur frequently in this region.

Dr. TEMPLE said—When I saw this case with Dr. M——, I could verify what Dr. Baines says. There was the history of the sudden appearance and it had a most peculiar feel which simulated the feel of omentum. On manipulating it and squeezing it you could force it away out of sight, and then one could feel nothing but a loose bag. One might easily make a mistake in diagnosis.

Dr. MACDONALD—Regarding Dr. MacFarlane's remarks, I did not say that I had made a diagnosis of perineal hernia; I distinctly stated that I was unable to make an accurate diagnosis, and Drs. Temple and Baines have both given you the reasons why we could not. The fact of its coming on suddenly rather led me to the idea that it might be hernia. Then it was somewhat constricted at the base. It was in the region where we know perineal hernia may come down, passing through between the levator ani muscles, it was reduced by pressing it up into the cellular tissue; and I could not tell but what it might have been forced back into the abdominal cavity. The question of obturator hernia was also one that occurred to me, but that was easily disposed of; I had examined per rectum. I may say that before the operation the idea of hernia had almost disappeared from my mind. Then with regard to the question Dr. Sheard has raised as to bicycle-riding and as to whether that had anything to do with the causation of the tumor—I am not prepared to answer that question; it was in the situation likely to be pressed on by the seat of the bicycle, provided that the front part of the seat was a little wide and tilted upward. That would be more the case if the seat were high and the handles were low, as in the custom of those who imitate fast riders. I have not come across any other injuries or growths that might be said to be caused by riding. Whilst our minds are directed to this subject I may say that I believe on the whole that bicycle-riding is healthful,

though like any other form of exercise harm may be produced on the heart-muscle and may produce strain or rupture. Like other forms of exercise carried on injudiciously, it may cause disease.

Gastric Ulcer, with Perforation and Operation.—Dr. A. B. ATHERTON—Synopsis. Patient, servant girl, aged 20, suffered from dyspeptic symptoms, vomiting being one of the principal symptoms. Could not eat meat without pain; lost flesh. After dinner, on September 19th, four hours later, she complained of severe pain in the epigastrium and also in the right shoulder, accompanied by vomiting of a thin serous fluid. When seen in an hour, Dr. A—— found her lying on the back, with the knees straight, hands clammy, temperature 99.4, respiration 28, breathing thoracic, upper abdomen tender and the wall tense and hard. Morphine was administered until the next day, when the operation was done. Incision in the medial line above the umbilicus. A few ounces of turbid serum escaped. Traction on the stomach walls caused the adhesions to give way. Ulcer was found on the anterior surface near the pylorus. Approximation of the edges was made by two fine silk sutures, and outside of these five or six sutures (Lembert's) several times they cut through. Abdominal cavity wiped out and closed up without drainage. There was some vomiting after the operation. Patient made a good recovery.

Dr. TEMPLE said that he was much interested in the history of the case. He said Dr. Atherton deserved great credit for his success in the case and his good diagnosis. He (Dr. Temple) had never seen the operation performed. Dr. Davison asked if there was any theory to account for the pain in the shoulder. He had two or three cases of gall-stones in which the patient had very severe pains in the shoulders, accompanied with cramps and vomiting. She required two grains of morphine to keep her quiet.

Dr. CASSIDY—Is there any rule with regard to the incision in these cases? Some advocate the incision in the side. Mr. Callahan advocates the incision to be L shaped. Some advocate the central incision. The L shape can be made from this by making an incision to the right. In regard to the diagnosis, these ulcers are found most in maid-servants and middle-aged men. Why are maid-servants more exposed to this than young ladies? I have often thought of this, and can give no satisfactory reason for it. Why is it not found in other walks of life? As regards the operation, is there no means to tell whether the ulcer is anteriorly or posteriorly situated, near the pyloric or cardiac orifices? Is there anything to show except the shock and localized pain after previous dyspeptic symptoms (and

sometimes they have none at all). Regard to the suturing, Dr. Atherton used silk. Did he pare the edges of the wound, or did he stitch the wound as he got it?

Dr. POWELL.—It seems to me that it is worth while considering, where the ulcer is large, the advisability of forming an anastomosis between the stomach and the small intestine by means of the button or plate, rather than trusting to union taking place through the use of the Lembert's sutures. I simply throw out the suggestion. It seems to me that a puckering string would bring the parts together, and if there were any circumferential thickness or hardness in these cases there would not be that approximation that would ensure safety to the patient.

Dr. MACDONALD.—Dr. Atherton said he did not consider that there was any escape of the fluid from the stomach, or but little, and he did not wash out. I suppose if there had been much escape, it would have been wise to have washed out. If you make the diagnosis and decide to operate, the choice of operation can only be that of stitching up. If the stomach be dilated, I suppose it may be overlapped: they are taking reefs in stomachs now.

Dr. ATHERTON.—As to Dr. Davison's question regarding the pain in the left shoulder, I leave it to the anatomists: I suppose it is due to reflex action. I cannot give any other explanation. Regarding Dr. Cassidy's question as to the incision, it was in the median line. I made it here for one or two reasons. One is that the incision here holds more satisfactorily, and you are less likely to have a hernia follow afterwards. Another reason is that many of these cases of perforation can be reached more easily from the incision in this place. If the ulcer is near the cardiac region you can make a cross cut through the rectus and integument and get at it in that way. Many recommend the incision to the left side a little, near the median line. But personally I think the median line is very satisfactory. If the point could not have been got at without a cross incision, I would not have hesitated to have made it. As Dr. Cassidy says, undoubtedly in female servants we are most likely to find this condition rather than in young women in other walks of life. Many of these have more or less anæmia. This girl had somewhat of that aspect. It was markedly present in a young woman I had with gastric ulcer two years ago, and who died from perforation. Then I decided never to have another pass through my hand in that way—where they have anæmia and gastric ulcer. Men beyond middle age are apt to have it. I have seen two or three in men. With regard to re-vivifying the edges, I did not find it necessary. They healed perfectly well without it.

Regarding Dr. Powell's suggestion of making an anastomosis with the intestine, I cannot see how that would better matters. I think you would be more apt to have a bad result than if you turned the ulcerated surfaces inside and covered with peritoneum. I do not think the suggestion has been carried out. Another thing recommended is: If you can get at the perforation, to suture, pass the drainage tube into the stomach and pack around with iodoform gauze and drain off externally the contents of the stomach. I did not wash out the abdominal cavity because there seemed to be but little escape of the contents. I sponged it slightly around the parts where there seemed to be a turbid serous fluid. That seemed sufficient. I think this procedure is wiser in these cases, because if one attempts to wash out there is danger of spreading infection from one or two pockets to the entire peritoneum.

Editorials.

The Canadian Medical Review.

NEARLY all those who are interested in the promotion of the REVIEW a short time ago were associated with another periodical. We shall endeavor to make the REVIEW a first-class medical journal. Original articles shall be selected with care, and we shall carefully sift the best medical literature for our readers.

Medical Ethics.

ON December 13th, at the meeting of the Toronto Medical Society, reference was made to the fact that some members of the Society had been made unduly prominent in the public press in connection with their cases. Whilst it is true that medical men, as a rule, are more thin-skinned in this respect than are either clergymen or lawyers, we must not forget that the doings of those in the professions last-named are more of a public nature, and so are, in the natural course, more open to comment by the press. Though medical men cannot control the papers, and though the names of medical men may be dragged into print without their knowledge and consent, and even to their detriment, we believe that much can be done to discourage such actions, and that by keeping the harrowing details of operations to ourselves we will do much to uphold the honor and dignity of a profession which holds a good position in every civilized country.

Antitoxin Diphtheriæ.

So far as this new remedy has been tried there is some good ground for regarding it as of substantial use. Judging by the reports of cases so treated, about ninety per cent. has recovered. By the very best care without the antitoxin the results are about seventy per cent. of recoveries. Under five years the mortality is over forty per cent.

A pure diphtheria bacillus culture is obtained. This is injected into the animal that is to yield the serum. Very small doses are injected at first, and gradually increased until the most powerful doses are administered. It requires considerable time to reach the point of immunity. The animals generally selected are sheep, goats, dogs, cows and horses.

After immunity in the animal has been reached, the serum of the blood is taken as the antitoxin, to control and counteract the diphtheria

toxines. In a cool place this serum is supposed to keep for two or three months.

One of the features of this treatment is that paralysis appears to be less frequent than after the usual methods. It seems to control the toxines of the disease and lessen the tendency to paralysis. It does not appear to have much influence in controlling the membrane or the bacillus. Its power seems to be directed against the toxines of the disease.

Before definite conclusions can be drawn from its use, a large number of cases must be treated. Medical men will be glad to hear further from such men as Aronson, Behring, Roux, Yersin, and others. So far it appears that the remedy has come to stay.

The Patrons and Public Appreciation of Our Profession.

IN these days when rampant Radicalism and class prejudice threaten to overthrow the safeguards which have been thrown about our profession, and free trade in medicine is held up to the public as the ideal condition, when columns of vituperative misstatement of fact are taken as the very Gospel, when to be a member of the profession is to be at a political disadvantage, it is gratifying to observe in the *Illustrated London News*, of November 10th, a double-page portrait-group of the leaders of the profession in England. The accompanying letterpress is sympathetic and appreciative: "There is no profession," says the *News*, "requiring a higher degree of intellectual culture and proficiency in special studies not within the comprehension of ordinary laymen, the practical utility and even necessity of which, for the social welfare and for the preservation of families and of individuals, will be universally admitted. Modern physicians have found means to preserve for many years the lives of invalids who would, in former generations, have died early." And much more in a similar strain. It is passing strange that the *News* considers that there are medical subjects "not within the comprehension of ordinary laymen," while the *Farmers' Sun* "knows it all!" The editor of the *London News* must be a very "ordinary layman." He should come out here to get pointers. We may be pardoned if we remark that we do not know how to run a farm, not having been brought up to the business. But it strikes us as singular that those who presumably do have also to wrestle with mortgages first; second, and chattel in abundance. It appears to us, and we desire to express ourselves

humbly, that it might be well for the farmers to devote a little of their great and versatile ability to the study of agriculture, and to the commonplace but somewhat necessary art of making ends meet, before they attempt to practise medicine and to reconstruct everything in sight.

Diphtheria.

THIS is not a modern disease. It was known to the ancients. Its study, however, dates back to Bretonneau. He gave the first account of the disease that really separated it from other conditions.

As to the origin of diphtheria there is now no doubt. The Klebs-Loeffler bacilli are the *fons et origo malorum* of this dread disease.

Is the disease local or constitutional? All good pathological teaching at the present goes to prove that it is a local disease. The germs attack some broken cutaneous or mucous surface, and there multiply and manufacture their deadly toxins.

Then, again, there is some dispute as to the existence of a membranous croup that is not diphtheria. That there is a laryngitis that is not diphtheritic there can be no two opinions, but that there is a membranous croup without the specific bacilli is still a contested point.

The poison is a toxine of great virulency, and possesses extremely depressing powers on the living tissues of the body. This toxine enters the system at the seat of infection. On nerve-matter its action is specially potent.

The question of immunity is now to the front. The work of Behring, Aronson and others have given the profession the anti-toxin. By such efforts the time may not be far distant when perfect immunity may be produced through these culture methods. Hydrophobia, tetanus and anthrax are good examples of the work so far done.

This whole problem is in its infancy. Much may yet be expected. As our knowledge of the life-habits of the bacilli increases, and further experiments are made with culture preparations, the laws that govern immunity will no doubt be discovered.

It is clear from the local origin of the disease that its local treatment ought to be most painstaking and thorough. To destroy the bacilli is to lessen the toxins and improve the chance for recovery.

Electricity.

Few remedial agents are attracting more attention or being investigated more thoroughly and scientifically at the present time than is electricity.

Long shrouded in mystery, it has been left in the hands of the charlatan and the unskilful, but it is gradually emerging from its hazy surroundings, and is being accorded its rightful place among rational modern methods of combating disease.

It occupies the entire attention of a vigorous young society—The American Electro-Therapeutic Association—most enthusiastically devoted to its interests, and composed of the engineer and expert, who study its laws and not its action upon inert matter; of the physicist and biologist, who follow up these results in their laboratories and investigate its effects on living tissue, and, finally, of the physician and surgeon, who put to a practical use the deductions of their co-laborers in this most interesting field, and determine the palliative or curative properties of the agent.

Our own city is to be congratulated in that it has not been backward in according to electricity the dignity of a special department in all the public hospitals, thus openly acknowledging its value, and electricity plays no unimportant part in many of the smaller institutions of Toronto.

Perhaps in no field has it made its presence felt more than in gynæcology; here it has joined hands with conservative surgery in sparing from mutilation many a suffering female. It has been grossly misunderstood and misapplied, consequently its failures have been as marked as its successes; but to-day its position is more secure than ever, even though its range has been narrowed beyond what was anticipated for the measure when first it claimed the attention of the gynæcologist.

In surgery it is often an alternative to more severe proceeding, and has the advantage that, properly used, it does not prejudice the case for future more radical interference where necessary. In the field of medicine it plays an essential rôle, and here its range of applicability is very wide.

Recognizing the value of electricity in these and other fields, more definite allusion to which is not possible here, we hope to place before our readers from time to time short articles on electricity of interest to the general practitioner by acknowledged authorities.

QUININE AS AN OXYTOCIC.—Dr. E. A. Edlen (writing in *New York Medical Journal*, November 24th) claims that quinine is a good oxytocic. He states that, in utero inertia, ergot often fails to stimulate contractions. In one case where the pains were poor he had given ergot without results. He then gave eight grains of quinine. In half an hour the pains began in an active manner. He regards quinine as much safer and surer than ergot.

COD LIVER OIL.—Dr. E. F. Billings, of Boston (*St. Louis Medical and Surgical Journal*, November), directs attention to some of the uses of cod liver oil. 1. In wasting diseases it holds a well-merited reputation. Great care must be taken, however, to secure its digestion. The writer is not in favor of the extracts of cod liver oil. 2. In some forms of neuralgia cod liver oil is of the greatest value. When all other remedies have failed, some brilliant triumphs have been obtained by this remedy. When given with extract of wild cherry, extract of malt and syrup of hypophosphites, very excellent toning effects are obtained.

CONGENITAL ANNULAR STENOSIS OF VAGINA.—Dr. H. N. Vineberg, of New York (*Medical Record*, November 17th), describes a new method of operating on these constricting rings. Instead of making incisions in them and then keeping up dilatation, he incises the mucous member along the entire length of the constricting band. He then dissects out the band. The mucous membrane is carefully replaced and sutured. No dilatation is necessary in this operation. As soon as the mucous membrane has united the result is complete. By this operation, all the constricting tissue is removed. There is much less irritation in this method than that by forced dilatation. When the incision has healed, no rigidity or constriction remains.

TRICHINOSIS.—Dr. Frank J. Thornbury, of Buffalo (*Cincinnati Lancet-Clinic*, October 13th), reports on five hundred cases of trichinosis in swine. Of these cases, the parasite was found in four hundred; in the loin in two hundred and ninety, in the neck in one hundred and seventy. All three parts were affected in two hundred of the cases; two parts in one hundred and thirty-six cases; and one part in one hundred and sixty-four cases. The diaphragm, therefore, appears to be the favorite point of attack. The trichinæ bore into the muscles in the region of the digestive canal. When the hog was extensively infected they were found in the hams, shoulders, sides and

almost every part of the body. In twenty human cases, the trichinæ were found in the muscles of the extremities, the diaphragm, intercostals, abdominal muscles, etc. In some cases the trichinæ were calcified, in others alive and active.

HYPERTROPHIC AND ATROPHIC RHINITIS.—Dr. Albert Pick, of Boston (*New York Medical Journal*, November 17th, 1894) states as follows: In hypertrophic the first thing to attend to is that of thoroughly cleansing the nasal cavity. When this has been thoroughly done, some application like Sieler's tablets may be employed. The hypertrophied tissue may be removed by chromic, nitric, glacial acetic acids, or the cautery. Bony spurs may be removed by the saw. Deviated septum must be straightened by same method. Vegetations removed as you would polypi. Good constitutional treatment is needed in most cases to restore the due balance of health. In atrophic cases atomizers are of great value. They throw in the solution in such a manner as to have a stimulating effect on the mucous membrane. The Sieler's tablets, or sod. bi-carb., gr. xx; listerine, ʒss., aquæ ad. ʒii. are good sprays. Tincture iodine and glycerine, equal parts, applied on the cotton-tipped probe, do good; when treatment is continued the outlook is good.

CHOLÆMIA.—Dr. J. H. Clayton, of Birmingham (*Birm. Med. Rev.*, October), divides cholæmic conditions into two groups: The first, where the elements of the bile are circulating through the body in the blood, and the second, where they pass through the vessels into the tissues. This latter form is jaundice or icterus. The writer claims that these two conditions should be carefully distinguished. In many cases there are changes in the liver, and the bile is found in the blood and urine, and no jaundice present. On the other hand, all the conditions may exist for some time, and the bile be found in the blood prior to the appearance of jaundice. The cholæmia, in other words, precedes the jaundice for a time. In many of these cases, with muscular weakness and *molaise*, a saline laxative affords great relief. In some cases this cholæmia is caused by close business application or mental application during the week, then taking some brisk exercise on Saturday. This throws a large amount of bile into the blood, and causes much distress on Sunday. Brisk salines on Saturday corrects these cases. Thus the keynote to the treatment of these cases is purgation, so as to evacuate the intestinal canal and prevent the absorption into the blood of the bile lying in the canal.

The liver is torpid during the week, and the active exercise of Saturday causes a free excretion of bile, hence the utility of the purgative. The best are mercurials and salines.

GUAIACOL EXTERNALLY IN TUBERCULOSIS.—Dr. J. Solis-Cohen, of Philadelphia (*Medical News*, November 24, 1894), states that he has had great benefit from the external employment of guaiacol in the elevated temperature of tuberculosis. At first he used as much as ℥40, but found this too depressing. Doses varying from ℥10 to ℥25 are usually sufficient. He selects that portion of the surface over the seat of disease, washes it off well with soap and water, and then dries thoroughly. The guaiacol is painted on with a brush until it is all absorbed, the part is then wiped with the hand and covered with cotton wool and oiled silk or paraffin paper. Sometimes the temperature will drop three or four degrees in a short time. When the temperature falls much below normal, the patient feels uncomfortable and chilly. This is readily corrected by a warm drink and a warm bag to the body. The results are best when the application is accompanied by free perspiration. In one case the temperature was maintained at normal for six weeks. Free perspiration is favored by giving the patient some hot milk, or a warm drink, and applying warm bags to the sides. In no other way can the temperature in these cases be reduced so readily and with such good results to the patient. The applications can be repeated as the temperature rises. After an application of ℥20 the temperature usually remains normal for two days to nearly a week. The reduction is usually accompanied by a feeling of comfort.

[We have used guaiacol in cases of typhoid fever, but discontinued its use owing to the great depression following. The effect appeared to be transient; temperature was only lowered for a few hours.]

THE HYGIENE OF THE EYES.—Dr. L. W. Fox, of Philadelphia (*Diet. and Hyg. Gazette*, November), remarks as follows: "A woman with leucorrhœa should be ordered an antiseptic injection before confinement, and the child's eyes should be treated with nitrate of silver, gr. 1 to the ounce. During the first six months of the child's life, its health should be well looked after. It should be much in the air. Its eyes must be guarded against sudden bright lights and objects. Children should not be allowed to do much with printed books till they are ten. Kindergarten work up to this age is far better for them in more ways than one, but specially with regard to their eyes. Myopia is one of the direct results of school life and

education. Savages are all far-sighted. As people begin constantly to look at near and small objects, near-sightedness is produced. This is greatly obviated by not allowing the child the use of books too young; and, when reading is allowed, only for a limited period each day. Hyperopia, or far-sightedness, is the natural condition of the eye. Savages are all far-sighted. When a person with this condition is put into an office, and begins close work on books, eye-strain soon follows. Headaches, pain about the eyes, a languid feeling, are prominent symptoms. Suitable glasses must be obtained in these cases, though the person be quite young. Adults employed much at reading, etching, engraving, book-keeping, type-writing, etc., should take special care over their eyes. The nature of their occupation is sedentary. There is usually insufficient daylight in most offices. This is supplanted by artificial light. A pure white light is not good. In many cases a reflector is used. This focuses the light on the white paper, whence it is reflected into the eye. This causes contraction of the iris and constant eye-strain. The reflector should be removed from the light, and a shade worn over the eyes. Gas light diffuses round a room better than electric light. Reading in railway and street cars is hard on the eyes. Owing to the swaying motion, the paper is held too close to the eyes; this keeps up much eye-strain. When book-keepers are adding up columns of figures, they should place behind the sheet a tin plate colored green, blue or black; this color penetrates the white paper, and they are then working on a neutral tint: when this cannot be done, glasses of some tint, such as the arundel. Blank walls should be decorated with scenery paper, or pictures on which the eyes will rest when raised from the white paper of a ledger.

Book Notices.

Essentials of Diseases of the Skin. Including Syphilodermata arranged in the form of questions and answers, prepared especially for students of medicine. By HENRY W. STELWAGON, M.D., Ph.D., Clinical Professor of Dermatology in the Jefferson Medical College. Third edition, revised and enlarged, with seventy-one letter-press cuts and fifteen half-tone illustrations. Philadelphia: W. B. Saunders, 925 Walnut Street. 1894.

The very flattering reception given to the first edition of this compend when it appeared three years ago, was the best indication of its worth. That a third edition has been called for so soon, shows that it is still popular, and rightly so, with both students and practitioners.

Diagnosis and Differential Diagnosis and Treatment of Diseases of the Eye. By Dr. A. E. ADAMS. New York: G. P. Putnam's Sons. 1894.

This little book gives the diagnosis and treatment of eye diseases in a clear and concise manner, and should be of use to students and general practitioners as a work of ready reference. The design of the book is novel.

Difficult Labor: A Guide to its Management for Students and Practitioners. By G. ERNEST HERMAN, M.B., Lond., F.R.C.P., Senior Obstetric Physician to the London Hospital; Physician to the General Lying-in Hospital; President of the Obstetrical Society of London; Examiner in Midwifery to the Royal College of Surgeons; Late Physician to the Royal Maternity Charity. Crown octavo. 442 pages, 162 illustrations, muslin, price \$2.25. New York: Wm. Wood & Co.

This is a work which, to the busy practitioner, commends itself at once. The arrangement is good, and the matter, though somewhat arbitrary, is excellent and very correct. Page after page is not consumed in the recitals of the history of operations and statistics. The author has plunged into his subject apparently with the determination of assisting his readers and giving them the advantage of his vast experience in as brief but comprehensive a manner as is possible.

The book is a handy size, well printed and profusely illustrated with easily understood cuts. We believe that the active physician will find it indispensable, and we can recommend him to purchase it, as he will get more than the value of his money in return.

Practical Uroanalysis and Urinary Diagnosis. A Manual for the use of Physicians, Surgeons and Students. By CHARLES W. PURDY, M.D., Queen's University; F.R.C.P.S., Kingston; Professor of Urology and Urinary Diagnosis at the Chicago Post-Graduate Medical School. Author of "Bright's Disease and Allied Affections of the Kidneys"; also of "Diabetes: Its Causes, Symptoms and Treatment." With numerous illustrations, including photo-engravings and colored plates. In one crown octavo volume, 360 pages, in extra cloth, \$2.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

Dr. Purdy had a good reputation before this work appeared. It was therefore with considerable expectation that the volume before us was opened. This expectation has not been disappointed.

The first part of the work deals with the analysis of the urine. The subject is handled in a very clear and full manner. In this day of accurate diagnosis and life insurance work, we hardly see how any physician should not have such a work of reference.

The second part deals with urinary diagnosis. There is much valuable matter in a condensed form in this section. The work is well illustrated. Both publishers and author are to be congratulated upon their work. We can cordially recommend the book.

The Popular Science Monthly. New York: D. Appleton & Co., 72 Fifth Ave.; Toronto Agency: N. G. Morang, 63 Yonge Street.

This valuable journal maintains its well-earned position as the best popular scientific periodical published in the English language. The December number is replete with interesting papers contributed by scholarly and well-known writers.

Psychopathia Sexualis, with Especial Reference to Contrary Sexual Instinct. A Medico-Legal Study. By Dr. R. VON KRAFFT-EBING, Professor of Psychiatry and Neurology, University of Vienna. Authorized translation of the seventh, enlarged and revised, German edition. By CHARLES GILBERT CHADDOCK, M.D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis; Fellow of the Chicago Academy of Medicine; Corresponding Member of the Detroit Academy of Medicine; Associate Member of the American Medico-Psychological Association, etc. In one royal octavo volume, 436 pages, extra cloth, \$3.00 net; sheep, \$4.00 net. Sold only by subscription. Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street.

Whether this work will become an authority in the study of perverted instinct or not, remains to be seen. It contains in its 436 pages an unvarnished recital of the depths of human depravity, such as can best be familiar to the alienist. To the general practitioner it discloses material for sad reflection.

The work has been sold extensively throughout the country; fortunately, for the most part, to physicians. It is not easy for the general practitioner to review this book. We would almost be disposed to think it should be confined to the library of the alienist.

PROFESSOR ZAKHARIN has been presented by the Czar with a valuable snuff box bearing a portrait of the late Czar Alexander III.

THE promised "Life of Sir Andrew Clark" is being prepared by Canon MacColl, with the co-operation of Dr. W. H. Allchin. An introduction will be contributed by Mr. Gladstone. The book, which will be published by Messrs. Longmans, is not expected to be ready for some time yet.

Correspondence.

The Editors are not responsible for any views expressed by correspondents.

Reflections.

The Expression "Doc." . . . The Drug Store "Doctor" . . . Patent Medicines . . . Wealthy Physicians . . . Tariff of Fees.

To the Editor CANADIAN MEDICAL REVIEW.

SIR,—The expression "Doc." is becoming more and more common in this Province, and no medical gentleman of any pretensions or worth, who has respect for the exalted title of "Doctor," which he during the best few years of life worked zealously to obtain, can otherwise regard himself than humiliated when addressed as "Doc." "Doc" is by the rough element of every country town or village applied to such who obtain a certificate as V.S., or to some sport about town. It is really an expression that should be stamped out by every physician.

It has been my sad experience to have lived in places wherein the really licensed M.D. has secured his stronghold in a drug store. His position is such that he dispenses his drugs, advice and skill at rates which his fellow-practitioners, relying on their practices, cannot adopt and keep their families. As a rule, no greater stumbling-blocks as regards adherence to the Divisional Tariff of Fees exist greater than these "condition powders" doctors. He reads but little medicine, frequently criticises your prescriptions, and, among several faults, is doing quietly a lot of good work for the patent medicine man, and frequently that same man is the doctor himself.

So much has been written about patent medicines condemnatory of their sanction by medical men, that I will state that it is my opinion that in recommending or prescribing such preparations as "seng," "H.V.C.," "broncholine" and the hundred or more of such preparations, we are to a great extent but endorsing patent medicines; yes, encouraging a company probably composed of really qualified M.D.'s, who, not wishing to undergo the toils of professional life, probably rich or backed up in the enterprise by a few rich loafer-companions, push a medicine or preparation before our notice, and being recommended as specifics by many who like to see their "names in print" — by J. Smith, M.D., Alligator Creek, Florida, to W. H. Brown, M.D., Hudson Bay P.O., Manitoba; or by Peter Physic, M.D., Sc.B., Orange Grove, Cal., or some Blue Nose M.D., of Blue Nose P.O.,

Halifax, N.S.—it is no wonder that some of us older ones should be tempted to play the fool and buy a ticket.

Once I was young, and I now claim many years of active service in practice, and yet I have seen very few of my fellow-practitioners acquire any great wealth; in fact, the wealthiest among them have become so by marriage or by being remembered in the will of a hayseed father. Recently, in an address to the members of a graduating class in medicine, I told them that the surest course to acquire wealth in practice would be to marry it. However, I did not adopt this mature thought, yet for the first year I thought I had; but, for the score of years since, those newly then-formed relations have struggled to consume and eat up their first year's offerings. Rich in having a noble wife and several children, and the most ordinary comforts of life, I am satisfied, like the majority of my fellow-practitioners, with my lot, but expecting, with every assurance, a legacy. I will build greater, and the world will say, "Another doctor has made himself rich."

In *re* tariff of fees, such a schedule we have for our Division, but it fails most decidedly in being adopted, and I have recently written our member to make efforts to secure the endorsement to said tariff (without mental reservation) of each licentiate in the district, and to have each M.D. supplied with a good-sized copy, with the names of the Division's men added as subscribers as proof of general adoption of the fees named. As our own and United States medical journals are giving space to discussions or articles on subjects actually pertaining to the business part of the profession, it is desired by the writer that short articles on this and other subjects of this writing be written on by fellow-practitioners in medicine.

"Qui non liberè veritatem pronunciat proditor est veritatis."

"JUNIUS."

December 13th, 1894.

Hon. G. W. Ross' Address at the Medical Banquet.

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—At the late dinner of the "meds." of Toronto University, the Hon. G. W. Ross, in his *post prandium* address, foreshadows an attack to be made upon the medical profession at the coming session of the Provincial Legislature. While warning the profession that their claims to special legislation will be questioned, severely criticised and even opposed, he at the same time declares himself in favor of

the Medical Council, and of maintaining the standard of medical education as a protection to the public.

This announcement of his views by the Minister of Education will no doubt be pleasing to the majority of the profession in Ontario, as it will be regarded as the index of the mind of the Government regarding the matter. I must say, however, that Mr. Ross does not give any definite grounds for hope that the views expressed at the "meds." dinner will necessarily bind the Ontario Government to a policy of medical protection in the approaching session of the House. The fact is, the Patrons are after our scalp, and if they are strong enough they may get it.

The question may be asked here, Why should the Patrons of Industry or the representatives of any section of the people of this Province, desire to destroy a profession so useful and necessary to the public as that of medicine? I fear it must be admitted that the cause is to be sought for mainly within the profession itself. There are registered traitors, whose sole object is to make money, and secretly desire to remove every obstacle, ethical and legal, in order to satisfy their lust for gain. These men will use the Patrons, or even the devil himself, to gain their ends. The honor of the profession is of no account to these licensed quacks. There is another class in the profession who, though not actually plotting with any political iconoclasts, are more destructive because more numerous—I mean the club or contract doctor. They make themselves the slaves of their employers, and are gradually reducing the already meagre average income of our profession, so that now a good mechanic enjoys an income more certain and more remunerative than the average doctor. In time, our men who are conscientiously striving to live up to the ethical standard will get tired of fighting against these dollar-a-year men, and be driven in the struggle for existence, to sink all scruples of professional conscience and take up the job of the fakir. Indeed, it is to be feared that we are fast drifting into fakirism as it is.

To return to the well-meaning utterances of the Minister of Education, I would ask Mr. Ross how he accounts for the noticeable deterioration in the moral of the profession *pari passu*, with an advancing curriculum and all the efforts of the Ontario Medical Council to stamp out quackery and maintain the dignity and honor of the profession. Is our modern medical student a mere mercenary, with no regard for high and noble aims, and a worshipper of the great god "Get there" no matter how, or are there too many medical schools interested in manufacturing for an already over-supplied market?

Now, I wish it to be understood that I have no desire to make any radical changes in the laws which, with great labor and heroic struggle on the part of a few men, have been enacted in the interest of the public as well as the profession. My object is to point out vices within the professional body politic, so that we may set to work to reform and bring about a change before the diseases have become incurable.

Yours,

"PHILO MEDICUS."

Weston, Dec. 13th, 1894.

Selections.

FAUVEL WRITES: "Yes, odors have an injurious influence on the vocal cords, and I have obtained from several directors of singers, managers of opera, a rule forbidding any bouquets or flowers being sent to dressing-rooms or presented on the stage. There is, following the inspiration of strong odors, such as violets, pinks, lilies of the valley and mignonette, a vibratory struggle between sonorous undulations. The vocal cords, at contact with odors, go into a state of paresis, from default of contraction; they become halting, or crippled." —*Cincin. Lancet*.

APPENDICITIS.—*Food* quotes Swain as saying ninety per cent. of cases recover spontaneously, and that therefore early operative interference is not justifiable. The editor of the *Medical Arena* corroborates and asserts, as the result of personal experience, that every case is amenable to persistent conservative treatment. He would, however, advise an operation when abscess has formed. Nevertheless, the fact remains that too many continue to recommend the knife, and that indiscriminate cutting for pain in the region of the cœcum is the rule rather than the exception.—*Medical Age*.

MODERN SURGICAL TECHNIQUE.—Dr. Henry O. Marcy, of Boston, emphasizes the importance of a most careful bacteriological training on the part of him who would become proficient in surgical practice. In the preparation of the operating-room, Dr. Marcy pointed out the ease and safety with which an ordinary living-room, by preference the kitchen, is made comparatively sterile, when from necessity the surgeon is called upon to act promptly and suddenly. In abdominal wounds, where irrigation is not advised, he substitutes for it a slowly flowing stream of oxygen gas from a compressed

cylinder. This sterile gas is heavier than atmospheric air which it displaces, and as a consequence renders the wound less likely to infection from the products of respiration and atmospheric contamination.—From report of Mississippi Valley Medical Association in *Medical Record*.

FOR INTERCOSTAL NEURALGIA.—

R Linimenti belladonnæ	f ̄j.
Linimenti chloroformi	f ̄iv.
Linimenti opii	ad f ̄iij.

Misce et fiat linimentum.

To be well rubbed over the painful area.—*The Practitioner*.

THE MURPHY BUTTON.—Dr. Dawbarn said that about the time when the Murphy button was first used in New York, he sent to Chicago and got one which he used in a case of gall-stone, the diagnosis having been confirmed by the operation. The gall-bladder seemed remarkably friable, and at autopsy—death having occurred in forty-eight hours—a distinct tear was found at the edge of the button. There was also a diffuse form of cancer of the liver, and this had probably led to the friable condition of the gall-bladder, although this viscus was not carcinomatous. He had sent an account of the case to Dr. Murphy before the latter had reported a collection of one hundred successful cases, and had afterward written Dr. Murphy to learn why this fatal one had been omitted. The answer was that he did not suppose the author of the case would care to have it reported since it was unsuccessful, and also because it was an attempt to unite a cancerous gall-bladder with the duodenum, which was not true.—From report New York Academy of Medicine in *Medical Record*.

Miscellaneous.

DR. J. ALGERNON TEMPLE and DR. ALBERT A. MACDONALD, of this city, have entered into partnership in the conduct of "Bellevue House," 87 Bellevue Avenue, heretofore Dr. Temple's Private Hospital for Women. Dr. Temple, whose reputation as an operator is so well known, has carried on the work of the hospital with singular success. Increased accommodation has been provided, and in order to keep up with the work, Dr. Macdonald, who has also devoted special attention to gynecology, has become associated with him.

ALBERT NAPPER, the originator of cottage-hospitals, died on November 16th, at the age of seventy-nine years. He established the first cottage-hospital in 1859.

OUR MEDICAL STUDENTS.—England has but 552 medical students; there are 8,000 in the Germany universities, but the United States has 13,000. We could loan England a few thousand and have plenty to spare.—*Med. Record.*

CHARCOT, like Gull, physicked his patients very sparingly. If he did not, like Sydenham, recommend students to read "Don Quixote" as a part of their medical education, he thought the works of the so-called "naturalist" school of novel writers useful for other purposes. He used to prescribe certain chapters of Zola as the surest emetic known to him; other works of the same master and his disciples were, in his opinion, valuable as narcotics. He used to say the best shop for narcotics was at Medan (where the author of "Nana" lives); there an infallible "drowsy syrup" could always be got for 3.50 fr. To a student who, after a lecture in which erotomania had been touched upon, asked what was the best remedy for incontinence Charcot replied, "Anæmia—or, better still, apoplexy."

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