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THE  
Canadian Medical Review.

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Original Communications.

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The Treatment of Diseases of the Fallopian Tubes  
and Ovaries.\*

BY A. LAPTHORN SMITH, B.A., M.D., M.R.C.S. ENG.,

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(CONTINUED FROM LAST ISSUE.)

**Tubercular Salpingitis.**—This disease is more common than is generally supposed. Dr. Whitridge Williams, of Baltimore, states† that a careful microscopical examination of all the tubes and ovaries removed by operation demonstrates that a considerable number of cases are tuberculous, even when macroscopically they present no trace of tuberculosis. In his experience, about 8 per cent. of all appendages removed for inflammatory diseases are tuberculous. In other words, every twelfth case of adherent tubes and ovaries, or pus tubes, is of tuberculous origin. When the lungs are not affected, it is almost impossible to diagnose the tuberculous nature of diseased appendages, so that I have not made any special mention of them ;

\* Read at meeting of Canadian Medical Association, St. John, N.B.

† "Transactions, American Gynaecological Society." 1894, page 456.

but the fact that any given case of fixed or inflamed appendages may be tubercular, and that the disease when primary in the tubes may lead to tubercular peritonitis and death, is a strong argument in favor of operation, as this result might be avoided if the appendages were removed while the disease was limited to them. An instance of this was reported by me a year or two ago.\* This patient came to my clinic with pain in the pelvis, and the tubes and ovaries could be distinctly felt behind the uterus. Her temperature was elevated, and she had chronic diarrhoea. As she was becoming rapidly emaciated, her abdomen was opened, revealing the intestines, tubes and ovaries so thoroughly cemented together as to render it impossible to do anything of practical value. The peritoneum was saturated, so to speak, with miliary tubercle. The cheesy tube on the left side was dug out piece-meal, the cavity irrigated with hot water, and a drainage tube inserted. The patient improved somewhat, her temperature remaining down as long as the tube was left in, but she had a hæmorrhage of the bowels from tubercular ulceration two weeks later, and died in a few days from exhaustion. If this patient had had the appendages removed a few months earlier, her life might have been saved. Of course, it is useless to operate in a case in which the lungs are in an advanced state of phthisis, but infection of the peritoneum is not a barrier to operation, as recovery of many such cases has been recorded.

**Puerperal Fever.**--The relation of pus tubes and ovaries to puerperal fever is another very important question which has been pointed out by many writers. In 1862, Dr. Robert Barnes placed on record† a case of peritonitis caused by the escape of pus or putrillage from the Fallopian tube into the abdominal cavity following an abortion artificially induced. The patient was thirty-four years of age, and she died six days after delivery from peritonitis. A *post-mortem* examination was made on a coroner's warrant. Pus was detected in the uterus and Fallopian tube. In the left tube, pus was distinctly traceable into the peritoneal cavity.

Dr. Barnes, in reporting the case, refers to several writers who have observed and recorded instances of a similar mode of infection. One of the cases is briefly but graphically described. It is related by Vocke: "On the ninth day after labor, a young woman, her progress to that time appearing satisfactory, was suddenly seized with acute pain in the seat of the left ovary, and died in forty-six hours. In the

\* "Transactions, Medico-Chirurgical Society of Montreal," Vol. V.

† "Transactions, Obstetrical Society, London," Vol. III., p. 419.

abdomen were found several quarts of sero-purulent exudation. The peritonitic signs were all most intense around the opening of the left tube. This tube gave forth little streams of pus when it was squeezed towards its end."

Martin, of Berlin, says that "when the escape of pus takes place, sudden acute pain follows, then fever. The quickly ensuing tympanitis may obscure the signs of peritonitis."

The most conclusive proof of the relation of pus tubes to puerperal fever may be found in Bland Sutton's book.\* Delbert† mentions that Siredy, in a thesis published in Paris in 1860, states that in twenty nine autopsies made upon women who had died from puerperal affections, he found in twenty-two the tubes dilated full of pus and the ovaries purulent.

Dr. Chapman Greig, pathologist to Queen Charlotte Lying-in Hospital, states‡ that in five patients who died in that institution with symptoms of puerperal fever out of a total of 548 deliveries, extending over a period of nine months, four were due to antecedent disease of the ovaries and tubes. Believing, as did Barnes and the other writers mentioned, that many deaths from puerperal fever are really deaths from pus tubes and ovaries, and that the rest of them are deaths from the sinuses and lymphatics of the uterus, being saturated with streptococci, I have for some years advocated with all my strength a treatment for puerperal fever which is gradually gaining ground, namely, when all other measures have failed, and the patient's pulse continues to rise, to open the abdomen and remove the infected organ, if it can be removed, whether the pus be in the appendix, in the tubes and ovaries, or in the uterine lymphatics and sinuses. Removal of pus tubes and ovaries is one of the safest abdominal operations; removal of the uterus by the extra-peritoneal method scarcely less so. Then, why allow women to die, as so many do, when there is every chance of saving them by operation?

Coming now to diseases of the ovaries, by far the most serious are ovarian tumors, including in the general term tumors of the oophoron, the paroophoron and parovarium. Whether the tumor be a simple or a suppurating cyst, a hematoma, a papilloma, a fibroma, a sarcoma or an ovarian abscess, the best and only treatment is early removal. On this point among gynæcologists there is no difference of opinion: the earlier the tumor is removed the less dangerous the operation, and the more sure will be not only the immediate recovery

\* "Sutton's Surgical Diseases of the Ovaries and Fallopian Tubes," page 202.

† "*Des Suppurations Pélviennes chez le femme, Paris,*" 1891.

‡ *Journal of the British Gynecological Society*, Vol. II., page 264.

but the ultimate cure as well. Every day the tumor remains, the danger to the woman's life is increasing. Not only may the tumor rupture in the case of an ovarian abscess, causing fatal general peritonitis, but in the case of a papillomatous cyst the disease may extend to the whole peritoneal cavity causing matting together of the intestines, which renders the operation impossible. I once saw Olshausen open the abdomen of such a case; the intestines were so matted together and adherent to the abdominal wall, that the first incision cut through the bowels several times, and all that one of the greatest operators in Europe could do was to repair the intestines and sew up the incision. The path of even the most successful abdominal surgeon is strewn with the remains of women who have died, not from the operations but from delay in performing them. One of the simplest abdominal operations I have ever had was the removal of an ovarian tumor the size of a cocoa-nut, which was seen for the first time on a Saturday and was removed three days later. The day after the operation this woman was laughing and joking, while on the third day she was absolutely free from pain, and it was with the greatest difficulty that she could be kept in bed two weeks. At the end of that time she went home, only returning at the end of a month after the operation to have the silk-worm gut stitches removed. On the contrary, one of the most difficult cases I have ever had was a woman with an ovarian cyst who had delayed her operation for two years. And what was the result? The tumor was adherent to the liver, bowels, abdominal parietes, in fact to everything with which it came in contact, so that before it could be detached she had almost died of unavoidable hæmorrhage. The pedicle was very broad and required to be ligated in many segments. The contents were thick and would not run through a large trocar so that the incision had to be lengthened, and finally to make a long and sad story short, when the case of early removal above mentioned was sitting up in bed combing her hair, the case of late removal was lying dead in her coffin. And yet if she had been operated on just two years sooner she would not only have been saved two years of pain, but she would just as surely have recovered as her more fortunate sister.

Two years ago I was called to see a woman of fifty who was propped up in a chair with her abdomen distended, and gasping for breath. After the removal of two pails of ascitic fluid two ovarian tumors could be felt, and next day the abdomen was opened and two carcinomatous tumors of the ovaries were easily removed, weighing five and six pounds each. But it was too late; the liver was already full of cancer, and although she rapidly recovered from the operation

so as to go about, she died three months later of cancer of the liver. And yet, at one time the disease was a local one and could have been entirely removed with ease.

Not only does delay lead to adhesions which render the operation long and difficult and dangerous, but there are other evils hardly less great. Such are the twisting of the pedicle leading to gangrene of the tumor and incurable disease of the kidneys due to pressure. In the former case, by prompt action, we may generally save the patient; in the latter the operation is often followed by total suppression of urine and death. The treatment by tapping of ovarian tumors cannot be too strongly condemned. It never cures, which early operation almost always does: while by temporarily relieving the patient it induces her to allow the safe-for-operating stage to pass, and renders the operation much more dangerous by reason of the dense adhesions which it sets up. In multilocular cysts it does not even temporarily empty all the cyst, while if an error of diagnosis is made and a fibroid is mistaken for a cyst a fatal hæmorrhage may result.

What should be our treatment of an ovarian cyst when complicated with pregnancy? Should we wait until the woman is delivered or operate at once? Delivery in the presence of an ovarian cyst blocking the pelvis is a very dangerous affair. The removal of it during pregnancy has been proved over and over again to be devoid of danger, it being the exception for even a miscarriage to occur.

How small an ovarian tumor are we justified in removing? We can hardly say that the ovary must be removed whenever it is painful and large enough to be felt, but we certainly should remove it if it is the size of a lemon and still growing.

Ovarian abscesses are by no means rare, and they are greatly dreaded by experienced gynæcologists because of the virulent nature of their pus. Some recommend its aspiration before attempting to remove it in case it should break. This accident happened to me once, but the hole was covered with a sponge which was immediately discarded and the patient made a good recovery.

Functional diseases of the tubes and ovaries, including simple salpingitis and ovaritis, active and passive congestion and neuralgia. Fortunately all diseases of the appendages do not require removal, although, no doubt, many a hundred pair have been needlessly sacrificed. For such diseases as inflammation and congestion such a treatment is unjustifiable, while for neuralgia and pelvic pain it is irrational. I have seen a good few ovaries removed for no greater cause than inflammation and congestion, although the operators tried to justify their action by pointing to some small cysts and calling the

organs "cystic ovaries." These little cysts, however, were nothing more than ripe ovarian follicles and their removal was a blunder, which I frankly confess I have once or twice committed in my earlier years.

For removing normal ovaries for neuralgia there is certainly no excuse. Neuralgia is the cry of the nerves for better nourishment. The ovaries are richly supplied with nerves and are the most apt to feel the need of better food.

If we are not justified in removing inflamed and tender ovaries, is any other treatment satisfactory? We can answer, yes, decidedly. Rest in bed with the pelvis elevated, saline laxatives to remove fecal obstructions lying on the ovarian veins, the application of iodine to the vaginal vault and poultices to the lower abdomen, rarely fail to bring relief. In very severe cases a few doses of opium are necessary. In neuralgia, on the contrary, opium is contra-indicated, for the simple reason that by disturbing digestion it cuts off the only hope that leads to succor. On the contrary, instead of being paralyzed by opium the stomach should be toned up with strychnine and the appetite encouraged so that the patient may eat freely and digest well plain but nourishing food. As the blood of the best fed person becomes poor and anæmic without sunshine and fresh air, such patients must be urged to pass most of their waking hours in the fresh air and sun out of doors. Iron and phosphoric acid may be added to the strychnine.

In cases of congestion of the ovaries, we have in the galvanic current a valuable means of toning up the relaxed vessel walls which have ceased to receive their proper stimulus from the great sympathetic nerves. I have demonstrated the power of toning up dilated vessels in many cases of swollen and painful testicles as well as in the thyroid gland. If you place the two poles of the galvanic battery near the two sympathetic nerves in the neck and gradually turn on the current, you can make the patient faint every time owing to the contraction of the arterioles of the brain; while a lesser current made to pass through the enlarged thyroid gland will diminish its size enough to give the gasping sufferer from goitre immediate relief. If you pass the same current through a swollen testicle or varicocele you will diminish its size and cure the pain, and so I was led to employ the same treatment in congestion of the ovaries with very fair success.

For ovarian neuralgia and pelvic pain as well as for the exaggerated pain of hysteria, I have found the fine wire faradism of considerable benefit. After a seance of twenty minutes the pain will remain away for several hours and in most cases half a dozen applications on succeeding days will completely cure it, provided always that the general condition is being attended to.

The cure of constipation alone has cured the pelvic pain in more than half the cases, at least, that have come to me in a year, partly because a stop is put to the sapremia or faecal blood-poisoning which offers an insurmountable barrier to healthy nutrition and partly because the mechanical obstacle to the circulation of the ovaries, especially the left one, is thus removed, and the organ is no longer so heavy as to fall into Douglas' cul-de-sac during efforts at defaecation, and while there bruised by large hard masses of faeces. It is almost a daily occurrence at my clinic to have a patient suffering from pelvic pain to state that her bowels are moved but once in from ten to fourteen days. I need hardly add that excessive coitus must be prevented, many women having assured me that they have to submit to it several times a day all the year round with only a week's rest during their confinement every second year.

We are rarely justified in removing the ovaries for dysmenorrhœa, while their removal for insanity and epilepsy is only occasionally followed by relief. The following case is interesting :

Mrs. M——, twenty-six years of age, had been under my care for several years for menorrhagia and dysmenorrhœa. She had begun to menstruate at the age of seventeen, the flow always having been painful and profuse. She was married at the age of twenty-three, but had never been pregnant. Bowels had always been confined. Coitus was painful. On examining the pelvis the uterus was found to be sharply anteflexed. The tube and ovary on the left side appeared normal in size but painful to the touch. The right tube was felt to be decidedly enlarged. She stated that she suffered at every period, but at every second period the pain was terrible. I saw her on several of these occasions, and after trying many other things I had to give her morphine as a temporary expedient, but insisted on more rational treatment. Thinking that the anteflexion might be the cause of her suffering, I performed rapid dilatation, with the result that the next three periods were about half as painful. At the end of six months she was as bad as ever, and I dilated again with the same result. I therefore determined to remove the appendages, for which she was quite anxious, as she dreaded for weeks beforehand the arrival of every second period. Cœliotomy was performed at her own home on the 22nd March, 1894; the right tube being detached with great difficulty, the left one coming out easily. She had a remarkable convalescence. I had the greatest difficulty in keeping her in bed a reasonable length of time. I went at an unexpected hour on the tenth day and found her rocking herself in a chair before the fire. After a severe scolding, I could only keep her in bed fourteen days.

I did not remove the stitches for a month. No drainage tube was used in this case, as the adhesions did not bleed very much. On examining the specimens one tube was found to be very little larger than normal, and possessing a beautifully fimbriated pavilion. The other, on the contrary, is completely sealed up, the pavilion being withdrawn into the interior of the tube. There was a little pus in the left tube, but the mesosalpinx was not much thicker.

Why did this patient suffer so much more every second month? Is it because, alternately, each ovary produces a ripe egg, so that when the open tube had to swallow the egg the only pain felt was that caused by the squeezing of the egg and the menstrual blood through the stenosed cervical canal; but when the egg ripened on the side on which the tube was blocked and bound down, the additional pain was caused by the spasmodic efforts of the tube to pass the egg on to the uterus.

Another case of severe dysmenorrhœa due to diseased tubes was Mrs. A —, twenty-nine years of age, who gave the following history: Menstruation began at the age of fourteen, and was normal until her marriage at the age of nineteen. She had no children, but she had a miscarriage at five months nearly ten years ago, since which her periods have come on every two or three weeks and have lasted four days, accompanied by very severe pain. I saw her during several periods, and the pain was so severe that ordinary doses of anodynes had no effect whatever in relieving her. Coitus has been impossible the few times it has been attempted, causing her to cry for some hours afterwards. Her bowels are generally moved once in five days. On examination the uterus was found in normal condition and size, but in Douglas' cul-de-sac there are felt two round, hard masses very sensitive to the touch, which were thought to be enlarged tubes and ovaries matted together. As she was very anxious to have children and very loath to part with her ovaries, I took her into my hospital on the 5th February to see what a few weeks' rest in bed with systematic douching and catharsis would do for her. In addition the vaginal vault was painted with Churchill once a week. While in hospital she had a menstrual period, with which she suffered only half as much pain, and she was considerably improved otherwise. She was allowed to go home but returned much emaciated on the 17th April, stating that since I had last seen her she had steadily grown worse until life, she said, had become unbearable. She was now quite anxious to have the appendages removed. After a couple of days of careful preparation cœliotomy was performed on the 19th April, when these specimens were removed with a great deal of difficulty, the adhesions

being very dense. After flushing out the abdomen with very hot water a drainage tube was inserted and the tube was left in for only one day. Both this and the last case were allowed a hypodermic of a quarter-grain of morphine the first night after the operation, which gave them great relief and did not seem to do any harm. This patient also stated that the pain which she had suffered almost constantly all these years had entirely disappeared two days after the operation, and that the pain of the operation was as nothing compared with the pain of a menstrual period. She made a rapid recovery and went home on the 21st day. These tubes contained only a very little pus, but their walls were much thicker than in the previous case.

My experience has been, that whenever two or three months' treatment with constitutional measures, both hygienic and therapeutic, and local treatment such as painting the vaginal vault with Churchill's iodine and the use of boroglyceride tampons and very hot douches given with the patient lying down, and the use of fine wire faradism and galvanism,—when such a treatment, I say, has failed to cure, an operation has been necessary, and the operation has always proven that there was present advanced organic disease of the appendages, fully justifying, nay, more than justifying, the operation.

#### CONCLUSIONS.

1. We are never justified in removing tubes and ovaries simply for ovarian pain or neuralgia which can surely be cured by electricity and tonic treatment.

2. We are not justified in removing tubes and ovaries for active or passive congestion which can be easily cured by antiphlogistics and local depletion.

3. We are not justified in removing appendages for inflammation when it has not extended to the pelvic peritoneum.

4. We are not justified in removing even chronically inflamed tubes and ovaries until we have first given a thorough trial (six to twelve weeks) of the ordinary measures of local or general treatment.

5. We should not hesitate to remove chronically inflamed appendages when six to eight weeks' systematic treatment fails to relieve the patient so that she can enjoy life and fulfil her duty to her husband, and if not with pleasure at least without pain.

6. We should not hesitate to remove appendages so diseased as to set up recurrent attacks of inflammation of the pelvic peritoneum by leakage or continuity of infection.

7. We should not hesitate to remove a tube or ovary large enough to fill Douglas' cul-de-sac, no matter what the nature of the enlargement,

a simple cyst, a tubal pregnancy or pus tube. As long as it remains it is a source of danger and sometimes of suffering, and when the inevitable time comes when its removal is imperative, the operation will be the more difficult and dangerous the longer it is delayed.

8. The removal of both tubes and both ovaries should not be done when only one tube and one ovary is diseased. It is worth while leaving even the half of an ovary for the purpose of preventing the onset of the menopause before the usual time.

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## Notes on the Medical Services of the British, French, German and American Armies.

BY DEPUTY SURGEON-GENERAL G. S. RYERSON, M.D.

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### I. THE BRITISH ARMY MEDICAL STAFF.

THE late Sir James Simpson, whose remarkable erudition and industry will be the wonder of generations yet to come, wrote an interesting essay on the medical service of the Roman army. Until then nothing was known of it. It may now be said, without affectation, that almost as little is known of the British and other services by the practitioner of to-day. It is to supply this interesting chapter in medical annals that I write these articles. They are necessarily of the nature of compilations from official and other narrations. Up to the end of the fifteenth century military surgeons were in little demand, for it was considered cheaper to levy a recruit than to cure a soldier. During the war of the Revolution there was no regularly ordered system of medical aid, but the wars of the eighteenth century were attended by such bloody battles that surgical aid became absolutely necessary. During Marlborough's campaigns the service began to take on some semblance of order, and we read of regimental mate, hospital mate, regimental surgeon, apothecary to a general hospital, surgeon to a hospital, surgeon-general and physician-general. They served in the navy or army as they might be required—indeed, the combatant ranks of the two services were little more distinct. It is to the administration of Sir John Pringle, the senior medical officer to Marlborough's army, that the system of regimental, field and general hospitals is due. A general hospital was established at Ath, after the battle of Fontenoy, which received 600 wounded, and another at Ghent, a little later, which took 1,500 wounded. It was not until the Peninsular war that an assignment of medical officers and hospitals

to an army in the field was made in anticipation of active service. The scheme was carried out with remarkable skill by Sir J. McGregor, P.M.O., so much so that between the siege of Burgos and the battle of Vittoria (ten months) 95,348 sick and wounded passed through the hospitals. Yet so assiduous were the surgeons that only 5,000 sick were in hospital at the time of the latter battle. There was no ambulance service, in the modern sense of the word, country carts being used for the transport of the sick. In 1812, the Royal Waggon Corps was organized for transport and commissariat purposes. Special waggons with springs were constructed for the carriage of the wounded. This corps was disbanded in 1833. On the outbreak of the Crimean war the Hospital Conveyance Corps was started, and is in existence still under the name of the Army Transport Corps, under the orders of the Army Medical Staff. The Crimean war brought out the many weaknesses of the medical organization, and efforts were made to put it on a more efficient and satisfactory basis. Medical officers were attached to regiments. There was a general medical staff service, but there was no "chain of responsibility," so the organization would not work. The conveyance of the wounded from the field of battle on stretchers, and the attendance on the sick and wounded in hospitals was a part of the regimental system, and was performed by regimental orderlies under regimental surgeons. By Royal warrant, in June, 1855, the first Medical Staff Corps was formed. It consisted of nine companies, of 78 each, and was "employed in any way that may be required in the performance of hospital duties." The lack of military organization in this corps caused it to fail, and it was replaced by the Army Hospital Corps in September of the same year. The failure of the Medical Staff Corps was due to its anomalous position in relation to the combatant ranks. The medical officers had no military control over the corps, and therefore discipline could not be maintained. The new corps possessed a complete military organization. From this time there has been a great improvement in military medical matters. In 1873, the regimental system was abolished, and all medical officers were placed in a department. In 1877, medical officers were empowered to command the officers, n.-c. officers and men of the Army Hospital Corps, and all patients in the hospitals. In 1883, the medical officer in command of a hospital was given undivided control of the hospital and ambulance transport. In 1884, the Army Medical Department and the Army Medical Corps were designated the Medical Staff Corps, which name it still bears. In 1889, the medical officers were given substantive in place of relative rank, and medico-military titles, so that an assistant surgeon became a surgeon-captain; surgeon, surgeon-major; surgeon-major, surgeon-lieutenant-colonel;

brigade-surgeon, brigade-surgeon-lieutenant-colonel; deputy surgeon-general, surgeon-colonel; surgeon-general, surgeon-major-general. These titles carry precedence and other advantages, and relieve the friction as to relative rank. They moreover facilitate command and discipline, and give greater authority and respect to the office.

There is at present an establishment of 10 surgeon-major-generals, 24 surgeon-colonels, and 50 brigade-surgeon-lieutenant-colonels available for administrative work, also an average of 763 executive officers, as well as 35 quartermasters of the Army Medical Staff. The Medical Staff Corps consists of 3,000 officers, n.-c. officers and men, the whole under a director-general. There are also a militia and volunteer medical staff and staff corps, and a nursing service, both army and volunteer. The latter consists of lady superintendents, senior nursing sisters and nursing sisters. They are called on for foreign as well as home service, and are retired at sixty with a pension. The duties of the medical staff in peace consist of: The general treatment of the sick; the careful regulation of sanitation of the troops; the examination of recruits; invaliding of men unfit for service; management of various classes of hospitals; the command, discipline and interior economy of the Medical Staff Corps. Medical officers are rarely placed in charge of regiments now, the work being done by the station hospital.

In time of war the arrangements for medical service with an army in the field are: A medical officer is attached to every regiment or corps. To each brigade a bearer company and a field hospital is detailed. For each division an additional field hospital is allowed; for an army corps, ten field hospitals and six bearer companies. The entire medical service is under the command of a surgeon-major-general. When a soldier is wounded he is attended as soon as possible by the surgeon attached to his corps. He is carried to the collecting station by the bearers. He is then placed on transport vehicles and passed on to the dressing station, 2,000 yards from the fighting line. These two stages comprise the "first line of assistance." From the dressing station he is passed by road or rail to the field hospital, which is placed beyond the range of artillery fire. Here he remains for two or three days, if necessary. This forms the "second line of assistance." When the distance is great "hospitals on the line of assistance" are formed, and the wounded are carried by easy stages to the base hospital. This forms the "third line of assistance." Invaliding boards are held, and the men are either sent home or to the front. The last stage is embarkation for England, where he is received at Netley Hospital.

*(To be continued.)*

## Society Reports.

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### Toronto Medical Society.

THE regular meeting of the Toronto Medical Society was held on May 15th, 1895.

**Antitoxine.**—The postponed discussion on antitoxine was then proceeded with.

Dr. MACMAHON said that he had seen the remedy tried in a case since the last meeting, in which there were well-marked symptoms and the diagnosis confirmed by bacteriological examination. By the second day the membrane had disappeared, an event he would not expect to occur so soon under the old treatment.

Dr. MCPHEDRAN said that the general consensus of opinion on both continents was favorable to this method of treatment. It would, however, be disappointing in cases of mixed infection. He quoted statistics which, if credible, he said, were strongly commendatory of the treatment. He emphasized the necessity of its use in the early stages of the disease. Its action was that of a counter-stimulus to the tissues poisoned by the diphtheritic toxine rather than an antidotal one.

Dr. CLINGAN said that, contrary to the rule that the cases of mixed infection were the worst, the worst case he had seen was one in which pure cultures were obtained.

The secretary introduced Dr. ERNEST HALL, of Victoria, B.C., and moved that the courtesies of the society be extended to him. He said that in a visit to our isolation hospital he had learned that the antitoxine was looked upon with less favor than other treatment, particularly in the laryngeal form. He was struck with the large amount of calomel used for fumigation—gr. x. every quarter of an hour. In Berlin there were three cases in particular in which he had noted favorable results. The treatment there had met opposition from eminent men. He had had no personal experience with the serum. To give the best results it must be used early, and in large doses, and often repeated. As it was innocuous, enough should be used.

**Flat Foot.**—Dr. B. E. MACKENZIE read this paper. This term, he pointed out, was not a happy one for this condition. He described the anatomical construction of the two arches in each foot, showing how well provision had been made for its functions. The weight of the body was transmitted through a tripod. To maintain proper stability, the line of transmission must come within the triangle.

Falling without the triangle toward the median line as a result of tissue-relaxing diseases, such as rickets, etc., or trauma, the abnormal condition would obtain. In mild cases three bony prominences could be noted—the inner malleolus, the head of the astragalus and the tubercle of the scaphoid. He had seen such a condition diagnosed tuberculosis. The deformity presented three elements—an abnormal lowering of the arch, pronation and valgus. A scientific method of treatment aimed at the correction of all three. Probably the best method of replacement was with the hand or a Thomas wrench, and retention with gypsum for three or four weeks. After its removal the “developmental” plan of exercise and massage should be persistently pursued, with the object of strengthening the structures whose duty it is to maintain the correct position. The essayist then spoke of mechanical devices used. He showed modified lasts and shoes made on them, the shoes being shaped to suit the over-corrected foot, and reinforced or strengthened in those parts where support was needed. Dr. MacKenzie also presented drawings and a cast showing the various features of the deformity.

**Syphilis.**—Dr. DWYER presented a patient who five years ago had syphilis, and was under treatment for some months. About sixteen months ago he consulted a physician for a cold, when it was discovered that he had an aortic regurgitant murmur. Up to that time he had no subjective symptoms, except some palpitation. He was engaged in work in which there was heavy lifting at the time. The patient was admitted to the hospital recently for angina pectoris. He was suffering from dyspnoea, and was quite cyanotic. Morphine, hypodermically, relieved the pain. Pot. iodide in 25-gr. doses was also being administered. The patient was examined by the society. A double murmur could be heard at the base of the heart, and could be traced up into the neck. The cardiac impulse was very strong, its maximum of intensity being in the seventh interspace and to the right. Capillary pulsation could be seen, and the “water-hammer” pulse plainly felt. Dr. Dwyer was unable to say whether the regurgitation was due to disease or deformity of the valves, or enlargement of the aorta. The cause he attributed to the uncured syphilis.

Dr. MACMAHON considered that if the treatment had been kept up longer the patient would not have been in the condition he was. He believed there was dilatation of the arch of the aorta. He thought, along with the dilated condition of the ventricle, there was relative insufficiency of the mitral valve.

Dr. MCPHEDRAN asked if there was evidence to prove that the condition of the heart was due to syphilitic infection. If so, it was a

very rare case. He was disinclined to believe that was the cause. Had rheumatism been eliminated entirely as a causative element? He believed there was a marked mitral lesion, and that it was of older standing than the aortic, and it was that which had caused the major portion of change in the left ventricle, the enlargement of the ventricle being transverse rather than longitudinal, displacement being outwards, not so much downwards. The coronary valves might be diseased, and as a result a degeneration of the heart muscle, and consequent dilatation and partial hypertrophy of the heart muscle. There was some dilatation of the aorta. Pulsation could be felt to the right of the sternum. The cyanosis and dyspnoea referred to did not occur till the mitral orifice had given rise to very free regurgitation. The pulsation phenomena might be accounted for by the relaxed condition of the arterial system, often seen in neurotic women.

**A Case of Poisoning by Atropia.**—Dr. OLDRIGHT said that practitioners who had used atropia and belladonna in the maximum doses would find they were too strong. In a patient suffering from neuralgia and excessive perspiration he had ordered gr. 1-25 of atropia in  $\mathfrak{z}$ iv. mixture doses. The patient telephoned him that the medicine did not agree with her, that she had a good deal of stiffness about the neck and jaws, and that her face became flushed. Upon inquiry, he found that the druggist had used ℞ 25 liquor atropiæ (gr.  $\frac{1}{4}$ ), which was gr. 1-64 at a dose, almost the minimum B. P. dose.

**Ovarian Cyst.**—Dr. ATHERTON presented an ovarian cyst he had removed on account of twisted pedicle. The tumor had existed two years. A few days prior to operation the patient was taken with severe pains in the abdomen and vomiting. The pedicle was swollen and œdematous, and required to be ligatured several times. The sac looked dark in some places, as if it were nearly gangrenous. There were some ecchymoses in the sac wall, and some clots in the veins.

Dr. MCPHEDRAN moved that the sympathy of the members of the society be tendered by the secretary to the president in his present affliction, the early demise of his brother, Dr. Barker Peters, of Medicine Hat, late house surgeon at the Children's Hospital and the General Hospital.

Dr. MACDONALD seconded the motion, which duly carried.

The society then adjourned.

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FROM an examination of foreign medical journals, reports are seen of the successful use of the Murphy Button. It seems to be looked upon in general with favor.

### Toronto Clinical Society.

(MAY 8TH, 1895.)

*President DR. RYERSON in the chair.*

**Empyema.**—Dr. GRAHAM presented a patient, a young woman aged 26, who had suffered from an attack of pneumonia eight years ago, which was followed by an empyema. She had been coughing up pus ever since then, coughing up as much as a half pint in twenty-four hours. The one lung was in fairly good condition, somewhat emphysematous and enlarged. The other side was very much contracted. A peculiar feature about the case was that both in front and behind there was a musical bruit with each systole of the heart. What produced it he was not prepared to say. He had another patient, a young man suffering from the same condition of chest, in which a similar bruit could be heard, whom he presented to the Society for examination. He asked the opinion of the Fellows as to the advisability of an operation to relieve the condition in the two cases. In the first case there was exaggerated breath sounds on the upper part of the side affected. Vocal fremitus was absent in the lower portion, and the breathing was somewhat tubular. Dr. Graham read the history of the second case: In October, 1894, the patient was seized with severe pain in the region of the liver in the axillary line. Was treated for abscess of the liver in New York; lost flesh; was troubled with profuse sweating; two weeks after coughed up considerable matter of a reddish dirty color. In January, 1895, was admitted to the Toronto General Hospital. Temperature ran up to 100°, 102°, 104°, with morning remissions. About two months ago the chest was aspirated, but no pus found. Breathing is now regular; expiration prolonged; more expansion on the left than the right side; coughs a great deal, and expectorates a large amount of foetid matter; no tubercle bacilli are to be found in the sputa, but a good many pus organisms. In both cases the empyema had opened into the bronchus before he had seen the patients. He thought possibly the bruits might be due to the presence of a cavity filled with air in which the heart sound was echoed.

Dr. W. H. B. AIKINS asked how long the last case had run. He said about three months ago one of the servants at the General Hospital had come under his care, suffering from an attack of influenza. Pleurisy developed, with the accumulation of a large effusion in the chest. The heart was very much displaced, and there was great difficulty in breathing. Although in the acute stage, as the symptoms

were very distressing, he aspirated, drawing off about forty ounces of serous fluid. The distress was relieved. The patient improved in almost every way, but there was no further diminution of the fluid. About three weeks ago, with a hypodermic needle, pus was discovered and a second aspiration performed, when about thirty ounces were withdrawn. Patient began to cough, and coughed up a considerable quantity of pus. He thought there was now pneumo-thorax with pus in the pleural cavity. He asked for opinion of members as to operative procedure.

Dr. TEMPLE said that he had one case of chronic empyema in a man, a case of long duration. The man coughed up pus. It was decided to open the chest. Assisted by the late Dr. Fulton, they removed a portion of two ribs, opening into a large pus cavity. The walls of the sac were very thick. They drained and washed out, and an excellent recovery followed. We did not think any harm could be done by cutting down on the cavity.

Dr. GRAHAM said one difficulty was in locating the pus. It was often difficult in aspirating to strike the cavity, in trying to locate it. In the second case this had been tried, but pus was not discovered.

Dr. GREIG said that it might be well to remember that there was a great deal of thickening of the pleura in these cases, and for that reason it was difficult to aspirate, the needle not penetrating the tough tissue. It often required several attempts to reach the pus.

Dr. KING thought operation was perfectly justifiable in both cases, particularly in the girl's case.

Dr. J. N. E. BROWN presented some patches of skin which had been thrown off from a smallpox patient during desquamation. The portions from the sole of the foot were two inches square, and showed the pocks *in situ* very plainly.

**Disease of the Middle Turbinate with Pus in the Ethmoid Cells** was the title of a paper read by Dr. McDONAGH. The disease usually resulted, he said, from trauma or from extension from the nasal cavities. On examination there was to be found thickening of the anterior portion of the middle turbinate, and very frequently the presence of granulations. On introducing a probe, small spiculae of bone may be felt. The irritation of the mucous membrane by these leads to the formation of polypi. At the seat of granulation the bone may be found to be cleft and pus exuding. It causes symptoms of tightness over the bridge of the nose, headache and neuralgia. There were various reflex phenomena to be observed, which he would not refer to. By trans-illumination the wall of the face over that portion would be found to be opaque. Treatment in the early stage, before the involve-

ment of the ethmoid cells, consisted in the application of chromic acid or the galvano-cautery to the hypertrophied mucous membrane. If distinct cleavage has taken place and polypi are present, they must be removed. His plan was to remove the inner half of the bone, and thus open the ethmoid cavity and wash out antiseptically with pyrozone, or iodoform and glycerine.

Dr. RYERSON said in addition to the symptoms Dr. McDonagh had mentioned, he had found patients complained of pain and tenderness over the inner angle of the eye, and the appearance of swelling of the bone. In one case he had cut down and trephined. A large quantity of pus and broken down tissue were thrown off. That was probably in connection with the front of the sinus. The disease seemed to extend into the ethmoid. In another case he had attempted to perforate the ethmoid through the nose. In endeavoring to open it the drill broke off. It was afterward cast off. The patient did not seem to mind it very much. With a cannula he had washed out much in the same way as Dr. McDonagh recommended. He believed these cases were much more common than was generally supposed. Many cases of catarrh and polypi he believed were really disease of the ethmoid, and the only treatment that would be beneficial was the one described. He was in the habit of scraping with a curette with malleable handle. He reported a case where he had used pyrozone where symptoms of constitutional poisoning presented themselves. There were alarming symptoms for a few minutes. The patient felt severe distress in the head, the pulse was irregular and weak, but she soon recovered. He was not sure whether the symptoms were caused by the pyrozone or from extension of the disease to the brain cavity. Since then he had been cautious in the use of pyrozone in closed cavities.

Dr. McDONAGH said that when the disease extended into the sphenoidal or frontal sinuses, as it often did, the symptom referred to by Dr. Ryerson was often present. He thought there was no danger in using pyrozone. Where there was free exit made for the pus there would be an equal chance for the pyrozone to escape.

**Intra-Ocular Tumor.**—Dr. RYERSON reported two cases of intra-ocular tumor. The first case was that of a lighthouse keeper from the northern part of the Province, who had an attack of *la grippe* and suddenly lost his sight, apparently from detachment of the retina. Examination of the eye showed a distinct round growth or tumor in the left eye towards the lower portion. It was of a greyish-pink color, and it appeared to be either a growth or detachment. He was treated for a short time by hypodermics of pilocarpine as if for detachment.

Patient went home for a time, but on returning, examination revealed an intra-ocular tumor. The eye was removed. The tumor was found to occupy half the eye and was sarcomatous in character. It was now some eight months since the operation, and the patient had suffered no further trouble. The second case was that of a young man who had been referred to him by a medical friend in New York State. A tumor could be easily detected by the ophthalmoscope. There was some bulging of the sclera. The optic nerve seemed healthy. On examining the orbit nothing could be seen or felt of further growth. The patient did well after the removal of it, making a good recovery. Three months after, he came back. There was slight swelling of the orbit. He suffered also from gastric disturbances, indigestion, etc. The patient went home. Dr. Ryerson had since heard from the medical man in attendance that there was a tumor in the neighborhood of the stomach, growing very rapidly. It apparently had some connection, he believed, with the tumor of the eye, occurring as it did so soon after it. This was an example of those cases where the recurrence was not in the orbit, where it usually occurs, but in a distant part of the body. It was wise, therefore, in such cases to warn the patient of danger of recurrence.

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HEPATIC COLIC.—Alfred S. Gubb, in a recent number of the *British Medical Journal*, reports the cure of a case of hepatic colic from the administration of eight fluid ounces of pure olive oil, following a five-grain dose of calomel.

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OBLIQUE FRACTURES OF THE LOWER EXTREMITY.—W. Arbuthnot Lane recommends, in oblique fractures of the lower extremity, particularly those below the knee, cutting down and securing the ends with steel screws, in view of the difficulty of securing a correspondence of the axes of the fragments by the old methods, and of preventing the interposition of tissues between the ends in many cases.

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CASTRATION FOR HYPERTROPHIED PROSTATE.—Alexander says (*N. Y. Medical Journal*, May 11) in regard to castration for hypertrophied prostate that, in cases where sclerotic changes have taken place in the vesical walls, atrophic changes in the prostate would not cure the condition. In vesical atomy it would not restore the tonicity of the vesical muscle. The sudden lessening in the size of the organ may be due in large part to rest, fluid diet, and careful catheterization.

## Editorials.

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### Electrical Progress.

THE application of electricity to therapeutic purposes is attracting much attention at the present time. A serious obstacle, however, to the more general use of this agent in therapy is the great lack of uniformity in the construction of appliances and the means of connecting electrodes with their source of current. Thus, the instrument of one maker can rarely be used with the apparatus of another, and repair is often a difficult matter.

These difficulties are being considered by the Standing Committee on Electrodes of the American Electro-Therapeutic Association, which, through its chairman, Dr. Charles R. Dickson, of Toronto, is in communication with manufacturers throughout the world with the view of securing the production of efficient, durable, interchangeable electrodes, the universal adoption of uniform connections for instruments, and a standard gauge of screw in the construction of apparatus; and manufacturers have been requested to submit their electrodes to the Committee for testing.

The medical journals, home and foreign, have been asked to accord their hearty co-operation in securing these results, and we are sure it will not be withheld, as the accomplishment of this somewhat formidable undertaking can result in nothing but advantage to maker and customer alike in increased sale, facilitation of repair, and the avoidance of many existing annoyances.

Dr. Dickson is ably assisted in this important work by Dr. Hall Brown, of Brooklyn, N.Y., who will test gynæcological electrodes, and Dr. Riggs, of St. Paul, Minn., who will look after neurological electrodes; while Dr. Dickson will devote his attention to surgical and other electrodes and to connections for instruments.

We hope the labors of the Committee will meet with merited reward, and that a most favorable report will be forthcoming.

The American Electro-Therapeutic Association will meet in Toronto on September 3rd, 4th and 5th, 1895, and members of the medical profession are welcome to its sessions, all of which are open to them. A most interesting programme of papers will be presented, and we bespeak a cordial reception to the Association on this its first visit to Canada.

### Specialism Gone Mad.

THE tendency of the age to run to specialism in all branches of business is perhaps more noticeable in the profession to which we belong than in any other. For instance, laparotomists, laryngologists, rhinologists, ophthalmologists, otologists, pædeologists, and so on, contend for public favor. Now we have "Doctors of Refraction." Pretty soon we will have "Doctors of Eczema," and "Doctors of Scabies." Could anything be more farcical? Of course such degrees are not recognizable by law, and are meant to delude the unwary by giving the impression of having had a medical education. It is a question if the Legislature should not take some action to protect the public against the spectacle fakirs who are overrunning the country. Their *modus operandi* is to offer "scientific examination free," and to charge for the glasses only. They discover that every other person has astigmatism, and load the people up with cylindrical lenses at three times their normal value to the detriment of the eyes and purses of the purchaser.

### The Diagnosis and Treatment of Abdominal Injuries and Hæmorrhages.

DR. JOHN B. DEEVER recently read an able address upon the above subject before the Philadelphia Academy of Surgery. He first of all directed attention to the fact that severe intra-abdominal injury, either with or without hæmorrhage, may occur, and yet no external marks of violence. This is important, as most medical men have met with cases where the stomach or bowels have been ruptured, or the spleen, kidney or liver lacerated or comminuted into a pulp, without the slightest external mark of injury.

The mortality in these cases of intra-abdominal rupture or hæmorrhage is very high. In laceration of the liver or spleen, where the patient does not die of hæmorrhage or shock, a violent peritonitis ensues, to which he is almost certain to succumb. In those cases where the stomach, bladder or intestines are ruptured, and their contents poured into the abdominal cavity, a rapidly fatal peritonitis is the result. In the case of rupture of the mesentery the great danger is from hæmorrhage, but even should death not occur from hæmorrhage, peritonitis is produced by the blood-clots in the abdominal cavity. When the lesion is a ruptured extra-uterine pregnancy, death results from the hæmorrhage or peritonitis.

With the exception of extra-uterine pregnancy, the history of these cases is that the patient has received a direct injury to the abdomen. These injuries may be caused in many ways, as kicks, being caught between cars, spent balls, railroad accidents, etc.

The most prominent symptoms are pain and shock. These, of course, vary with the extent of the injury, and the temperament of the patient. The Americans are far more liable to suffer from shock than the Germans.

The pain is peculiar and difficult to describe. It is mentioned by patients that there is the sensation as if something had given way, or ruptured, and a feeling of impending death. There is usually tenderness, more or less localized, but, if the shock is extreme, this may not be pronounced. When vomiting occurs there is generally pain, but rarely blood.

There is often marked rigidity of the abdominal walls, due to intra-abdominal irritation. This is sometimes so great as to cause the checker-board appearance of the walls. Consciousness is usually retained, and restlessness is not frequent in the early stage, unless there be severe hæmorrhage. When peritonitis develops, it is not an uncommon symptom.

The pulse and temperature vary with the degree of shock. The former is weak, and runs from 100 to 160, and the temperature sub-normal. If reaction takes place the pulse becomes less frequent, and the temperature reaches normal. After reaction, peritonitis is always the rule where there has been laceration and hæmorrhage. The pulse becomes accelerated and of high tension. The temperature is unreliable, as it does not correspond to the degree of inflammation or septic infection. High temperature with a slow pulse is less ominous than a rapid pulse with a low temperature. The abdomen may be full of pus, and yet the temperature normal throughout the attack.

In injury to the abdominal cavity, with and without visceral lesion, the following points are important. In the former the pain is severe and characteristic, there is often constant and persistent vomiting, the anxious expression of the patient is very remarkable, there is a feeling of impending death, and there may be the evidence of internal hæmorrhage, showing that along with the lesion there is bleeding.

Rectal and vaginal examination may yield important information by revealing the presence of blood in the pelvis. Percussion shows dulness in the iliac regions if there be much hæmorrhage. When solid viscera are the seat of the injury, rapid bleeding is the great danger, and the speedy exsanguination of the patient gives the clue. The organs are usually injured in the order, liver, uterus, spleen, kidney and stomach.

In all cases of severe injury to the abdominal organs, with evidence of laceration or hæmorrhage, if the patient does not improve within a comparatively few hours, recourse should be had to operative treatment.

In all cases of extra-uterine pregnancy, as soon as the diagnosis is clear, operation should be undertaken. The rupture is sure to take place in these cases, compelling an operation under very unfavorable conditions, often on a collapsed patient, and in a hurry. It is much better to operate in advance of the rupture, when the advantages are on the side of the surgeon and patient.

While abdominal section is not advocated as a means of diagnosis, there are obscure cases with very severe symptoms where such is justifiable to clear up the ground. The almost universal fatality of intra-abdominal lesions of traumatic origin is so well known that there would hardly seem to be any question as to the wisdom of opening the abdominal cavity.

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### Ontario Medical Association.

THE following is the provisional list of papers to be presented at the Ontario Medical Association, which convenes in the Council Buildings, Toronto, June 5th and 6th :

#### DISCUSSIONS AND PAPERS.

The President's Address, R. W. Bruce Smith, Hamilton. Papers by Guests: "Intestinal Complications in Gynecic Surgery," J. B. Murphy, Chicago; "Embryonic Remains in Cases of Eczema of the Navel," Robert T. Morris, New York; "Operative Treatment for Bronchocele," Francis J. Shepherd, Montreal; "Laryngeal and Tracheal Tuberculosis—the Importance of their Early Recognition and Treatment," F. W. Chappell, New York. Discussion in Medicine—"Diphtheria," W. J. Wilson, Richmond Hill, followed by G. M. Aylsworth, Collingwood, and J. T. Fotheringham, Toronto. Discussion in Surgery—"Delayed Union in Fractures," Geo. A. Peters, Toronto, followed by I. H. Cameron, Toronto, and A. McKinnon, Guelph. Discussion in Therapeutics—"The Physiological and Therapeutic Action of Iron, with a discussion of its newer Pharmaceutical Compounds," H. A. McCallum, London, followed by J. H. Sangster, Port Perry, and A. T. Rice, Woodstock. Discussion in Obstetrics—"The Primary Repair of Genital Lesions of Child-birth," K. N. Fenwick, Kingston, followed by H. Meek, London, and H. T. Machell, Toronto. "The Present Position of Antitoxine in

the Treatment of Diphtheria," Chas. Sheard, Toronto. "Antitoxine in the Treatment of Diphtheria—with clinical notes of cases," J. D. Edgar, Hamilton. "Calomel Fumigation in the Treatment of Diphtheria," T. F. McMahon, Toronto. "Phlegmasia Dolens—report of cases," J. Campbell, Seaforth. "Constipation," H. Arnott, London. "Treatment of Pulmonary Tuberculosis," D. Marr, Ridgetown. "A Few Remarks on Home and Foreign Climate in Consumption," E. Playter, Ottawa. "Science in Medicine," F. Oakley, Toronto. "Hydrotherapy in the Treatment of Exanthematous Fevers," A. K. Sturgeon, Petrolia. "Inflammations of the Optic Nerve—their Causes and Prognosis," G. S. Ryerson, Toronto. "Cataract," R. A. Reeve, Toronto. "A Case of Pneumo-Peritoneum," C. J. Hastings, Toronto. "Puerperal Insanity," N. H. Beemer, Mimico. "Narcotic Addiction," S. Lett, Guelph. "Notes on Paresis," Ezra H. Stafford, Toronto. "Use of the Stomach Tube," G. Hodge, London. "A Case of Scurvy in a Child," H. T. Machell, Toronto. "A Case of Progressive Unilateral Facial Atrophy," T. F. McMahon, Toronto. "A Case of Morphœa," A. McPhedran, Toronto. "Notes on an Epidemic of Herpetic Tonsillitis," J. R. Hamilton, Port Dover. "The Antiseptic and Eliminative Treatment in Typhoid Fever," W. B. Thistle, Toronto. "Traumatic Hysteria," D. C. Meyers, Toronto. "Currents and Counter-Currents in Therapeutics—or a Plea for Rationalism in the Treatment of Disease," J. H. Sangster, Port Perry. "Intelligent Use of Rectal Injections, with Improvement of Ordinary Enema Syringe," P. P. Burrows, Lindsay. "Some Remarks on Pneumonia—with report of an interesting case," R. V. Bray, Chatham. "Metallic Sutures in Fracture of the Patella," J. J. Cassidy, Toronto. "Cases of Post-Pharyngeal Abscess, Double Cephalhæmatoma, Leucoma, Colitis, etc.," G. Acheson, Galt. "Traumatic Septicæmia," J. C. Mitchell, Enniskillen. "An Operative Procedure for Spina Bifida," H. Howitt, Guelph. "Intestinal Anastomosis—with Murphy's Button," J. L. Davison and L. Teskey, Toronto. "A Case of Anterior Abdominal Nephrectomy for Calculus—with patient," L. MacFarlane, Toronto. "An Operation for Hare-lip," A. Groves, Fergus. (a) "A Case of Ectopic Gestation—4½ mos. Operation and Recovery;" (b) "A Case of Mental Aberration Following Removal of an Ovarian Cyst," W. J. Gibson, Belleville; "Tumors of the Bladder—report of cases," F. LeM. Grasett, Toronto. "Seminal Vesiculitis," E. E. King, Toronto. "Foreign Bodies in the Knee-Joint," G. Bingham, Toronto. "Modern Experimental Surgery on Man and Woman—a criticism of operations done and the results obtained," J. F. W. Ross, Toronto. "The Use of Ichthyol in Gynæcology," L. Sweetnam, Toronto.

"Use of the Projection Microscope in the Teaching of Anatomy," A. Primrose, Toronto. "Display of Bacteria," J. Caven and F. N. Starr, Toronto. "Notes on Carcinoma," H. B. Anderson, Toronto. "Remarks on Appendicitis, with report of a case of recovery after rupture of abscess into the peritoneal cavity—exhibition of specimen," T. K. Holmes, Chatham. "Some Remarks on the Operation for Cleft Palate," G. McDonagh, Toronto.

A lime-light exhibition of photographic specimens will be given.

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TUBERCULOSIS.—In the report of the Royal Commission on tuberculosis a few of the conclusions arrived at were: That the flesh of animals suffering from the disease in a severe form was absolutely unfit for food; that where it occurs limitedly, there is danger when it is cut up; that the infective matter is not destroyed by roasting, baking or boiling; that milk only is infective when the udder itself is diseased; that the tuberculin may possibly give aid in diagnosis; that milk from sources of slightest suspicion should be boiled, which would, the *British Medical Journal* says, be tantamount to recommending all milk gotten through the ordinary trade channels to be boiled.

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SALOPHEN.—In the *Medical Bulletin* for May, there appears an article translated from Dr. A. Claus, in *Flandre Médicale*. The writer praises salophen highly in gout and rheumatism. It has marked analgesic properties. It has yielded excellent results in the treatment of migraine. In doses of 1 gramme the headache is usually relieved by the first dose, almost always by the second. In one case of migraine with diabetes mellitis, the salophen had an excellent effect. Diabetes mellitis the author regards as depending upon the arthritic diathesis and an especial nervous state. For this reason he would recommend the drug for the disease. In chorea the drug is useful on account of its anti-rheumatic and anti-nervous action.

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THE INFECTIVITY OF CANCER.—In an article on the infectivity of cancer D'Arcy Power, in the *British Medical Journal* for April 27th, says that experimentation by grafting cancer upon human beings is indefensible and unscientific. All experiments tended to show that it cannot be grafted from men to animals, for the animal cells seem to have the power of destroying human cancerous tissue. The writer alludes to the similarity existing between the appearances met with in

cancer cells and those in the blood of malaria patients, and says it might be that the "ague parasite" and the "cancer parasite" are members of the same family, the one acting on the blood corpuscles, the other upon the epithelial cells. He refers also to Haviland's observation of cancer occurring most frequently in those who live on water-logged soils, a conclusion in accord with that of medical men who practise near rivers liable to flood.

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TYPHOID FEVER IN COUNTRY DISTRICTS.—Dr. W. Osler, Baltimore, in *Maryland Medical Journal*, May 11th, makes out the following points for consideration: Every year many cases of typhoid fever are treated in the cities that come from the country. Many people in the cities take their holidays in some country place in the latter half of summer. It becomes a matter of great importance that there should be good control over the spread of typhoid fever. Many cities are supplied from rivers and streams, and it is of the utmost importance that these should be kept free from contamination. The cities should have some control over the streams. Then, again, the milk supply is of the greatest moment. Many cases of typhoid occur among the families that are daily supplying the cities with milk, and yet no proper precautions are taken to prevent the spread of the disease. There should be a rigid system of reporting and inspection, so that every care could be taken to avoid the risk of spreading the disease either by direct infection through the water or the milk supplies.

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SHOULD THE CARDIOPATH MARRY?—Dr. W. T. English, of Pittsburg, in *Medical and Surgical Reporter*, April 27th, deals fully with the above question. He points out the intimate relationship between the womanly functions and the circulatory organs. One of the earliest symptoms of conception is disturbance of the vascular mechanism and the action of the heart. As the uterine development goes on there is an ever-widening area over which the heart must propel the blood. There is also an increased volume of blood to be circulated. During the progress of pregnancy everything tends to add to the work of the heart. The condition of the digestive organs, the kidneys, the action of the skin, etc., endanger the heart when subject to organic disease. In cases with marked heart trouble, the patient very frequently miscarries. This, in cases of severe heart trouble, is a very serious matter. There is the risk at the time, and the depletion afterwards. When all the possible dangers are carefully considered, the woman with heart disease should be strongly dissuaded from marriage, alike on her own account and on that of her offspring.

CONSUMPTION AND MARRIAGE.—In the *Times and Register*, April 27th, there appeared an unusually outspoken editorial under the above caption. The article was written with reference to a breach of promise suit, where the gentleman broke off the engagement because of consumption in the lady's family history. The editorial takes the ground that the future prevention of consumption like that of insanity, must to a great extent depend upon the restriction of marriages among those predisposed to these diseases. It suggests that in a few generations it may be an accepted view that the concealment of consumption or insanity in the family history will be good ground for breaking off an engagement of marriage. Consumption is, no doubt, to a great extent a preventable disease. In any scheme for the stamping out of consumption the question of the marriage of persons springing from an infected stock must occupy a prominent position. How far the State is justified in allowing those with marked tendencies to consumption and insanity to multiply their numbers and thus burden the community is a question that must claim attention.

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INSANITY.—G. Fielding Blandford, in the *British Medical Journal*, April 20th, in an article on "Insanity," says: "If we wish to save our race from gradual mental decay, and not only to preserve life from such ills as zymotic diseases, but to raise up a strong and vigorous breed of healthy men and women, it is absolutely necessary that more attention shall be paid than hitherto to the selection of the individuals who are about to marry and reproduce. If men and women were racehorses, or shorthorns, or greyhounds, their breeding would be regulated, and all diseased or faulty stock would be carefully eliminated, and all inbreeding would be, as a matter of course, avoided. But being what we are, thinking only of ourselves and our own self-gratification, and nothing of the future race, we arrange our unions, and nobody has the right or the power or the courage to prevent us, when we have attained to years of discretion, namely, the statutory age of 21." Further on, the same writer says that, after hereditary transmission, there is probably no cause of insanity which exercises so potent an influence as alcoholic drinking.

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SOME EXPERIENCES WITH THYROID FEEDING.—Dr. Leo. Stieglitz, of New York (*N. Y. Medical Journal*, May 4th), reports four cases where he had employed thyroid extract. (1) This was a marked case of myxœdema. She was ordered gr. v. of Parke, Davis & Co.'s desiccated thyroid extract daily for first week, then twice a day for

second week, and three times a day afterwards. The patient made very rapid and marked improvement. (2) This case was ordered daily a five-grain tabloid of thyroid extract. Within a few days improvement began. (3) This case had *la grippe*, and following this considerable swelling in the feet. There followed distinct patches of scleroderma circumscriptum. She was put on the desiccated thyroid of Parke, Davis & Co. Improvement began under this treatment and progressed steadily. (4) This was a case of progressive hemiatrophy facialis. She was treated with thyroid extract. The treatment was given a fair trial, but with no improvement to the atrophy. The treatment appeared, however, to improve the spasms of the face that afflicted the patient a great deal. When the treatment was omitted the spasms returned, and again improved on the resumption of the treatment.

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THE QUICK CURATIVE TREATMENT OF GONORRHOEA.—Dr. F. A. Lyons, New York, in *Medical Record*, May 4, argues that gonorrhœa should be aborted. He contends that it is due to the gonococci, and that these should be destroyed as rapidly as possible. His plan is to make the patient urinate. He then injects into the urethra, while the patient is recumbent, with an ordinary conical-shaped soft rubber pointed clap syringe, one drachm of a 4 per cent. solution of nitrate of silver. When the syringe is removed the meatus is compressed for four or five minutes. This operation causes but little pain. When the patient presents himself in twenty-four hours, the discharge is examined carefully for gonococci. If any are found, a second injection is given. If none are found, the patient is left till next day. The solution for the second injection should be a 2 per cent. one. If the gonococci have not disappeared by the third injection, it is not well to proceed further, and the treatment should be a symptomatic one. But even where the gonococci did not all disappear, the ultimate course of the disease is greatly shortened.

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THE CAUSATION OF NERVOUS DISEASE.—Dr. M. Allan Starr, New York, in *Western Reserve Med. Jour.*, May, '95, reviews the above important subject. He treats of it under the following heads: 1. Exhaustion from overwork. This cause is so frequently met with that it is not necessary to emphasize it. Neurasthenia and nervous prostration is so common from this cause that every physician has met with cases. Many of these cases are on the very brink of ruin, and nothing will cure them but proper rest. 2. Defective nutrition from imperfect blood-supply. This cause of nervous disease is

common. It may arise from some condition injuring the general health, from improper food, from bad hygienic conditions. No matter from what cause, if the blood is insufficient in amount, or comes to any portion of the nervous system in insufficient supply, the nerve matter is not nourished, and it fails to do its work.

3. Active poisoning of the nervous matter. This may be from poisons formed within the body. These injurious waste products are circulating through the system in the blood, and affecting deleteriously the nerve elements. Or, in the second place, the nerve system may be poisoned from injurious articles taken into the system.

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A HOMILY ON DOCTOR'S FEES.—Dr. W. Symington Brown, in *American Practitioner and News*, May 4th, contends that the medical profession should hold no secrets, and in this respect claims the difference lies between it and a trade. The man who follows a trade may have trade secrets; but the doctor who makes a discovery publishes for the benefit of others. Traders do not follow this rule. With regard to fees the writer says the doctor must make enough to live. In the United States there is at least one physician to every six hundred persons. It may be safely stated that the average income does not exceed \$1,500 a year. Out of this must come expenses, the cost of living and keeping a family, and laying by a little for a rainy day. The prospect is far from a brilliant one. The medical army increases in a greater ratio than the population. Then comes the abuse of charity. The public is treated gratuitously, the patients are pauperized, and the doctor robbed of an honest living. But the professors in medical schools want cases to illustrate their lectures, and so the cases are sought after free. Another great abuse that has grown up and become a general custom is to attend clergymen and their families gratis. No good reason can be advanced for this usage. In many instances clergymen give certificates approving of quacks and quack medicines. In the usual progress towards poverty among a large number of the population the fees will come down. With the large number of doctors in the United States some remedy will have to be found to improve the condition of the profession. One way is fewer medical men. Another way is fewer medical schools.

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SUNSTROKE.—Dr. R. C. M. Page, of New York, in *New York Polyclinic*, May 15th, defines sunstroke as "a disease of the nervous system caused by exposure to excessive heat under certain predisposing conditions." After dealing with symptoms, etiology, pathology,

morbid anatomy, prognosis and sequelæ, the writer remarks on treatment as follows: (1) Prophylaxis consists in avoiding intemperance during the heated season, keeping the bowels open, attention to the general health, and care in exposing oneself to excessive heat. In mild cases open the clothing, place the patient in a cool place and sponge frequently with cool or cold water. Shower the head with cold water. (2) In severer cases, place the patient in a wet sheet 80° F to 85° F and apply ice in addition. Baths are given twice a day for half an hour at a time. These may have to be continued for days. The cold should not be too prolonged. The temperature and the pulse are the best guides. (3) Medicines have been used to reduce temperature. Antipyrin has been given hypodermically in 15-gr. doses, and with good results. The danger of depressant action must be borne in mind. Quinine has also been employed in the same way; but the doses necessary to reduce temperature are injurious to the brain. Phenacetin, gr. x, or antifebrin, gr. iii, by the mouth would be safer. (4) In the case of convulsions chloroform may be administered. A better plan, however, is the hypodermic use of morphia. (5) The bowels should be kept open. The use of drastics is to be condemned. (6) Venesection is only permissible in sthenic cases, or where the apoplectic symptoms continue after the reduction of the body temperature. (7) For the after-headache, sod. brom. and tr. verat. vir. may be employed. Sometimes ergot relieves it. Counter-irritation should be applied to the back of the neck when there are indications of meningitis.

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THE TREATMENT OF TYPHOID FEVER WITH TYPHOID THYMUS EXTRACT.—Dr. Alex. Lambert, of New York (*N. Y. Medical Journal*, April 27), gives an account of his experience with this method of treating typhoid fever. In 1893, Eugene Fraenkel reported 57 cases, and Th. Rumpf 30 cases treated with cultures of the typhoid bacillus in thymus bouillon. These cultures are injected deep into the gluteal region. An injection is made about twenty-four hours later. There is often a rise of temperature, and there may be chills. On the third day there is a decided fall of temperature, and on the day following a still further reduction. When the fall of temperature was not complete, it changed from the continuous to the intermittent type. Much of the somnolence, stupor and delirium disappeared, the tongue cleansed, and the diarrhœa abated. This treatment did not prevent complications or relapses. The latter, however, yielded readily to further injections. The earlier the stage at which treatment began the better the results. The treatment was effective in severe and mild

cases. Dr. Lambert reports 28 cases. Of these, 15 showed improvement, no doubt due to the treatment; 12 cases did not improve under the injections, and 1 died. The best method of giving the injections seemed to be to give an injection every twenty-four hours of increasing amounts of 1, 2, 3, 4 and 5 cubic centimetres. This plan gave the best results, both as to temperature and the general improvement of the patient. The tongue cleansed, the temperature fell, the stupor disappeared, diarrhoea improved and the strength increased. There were five cases of relapse, but these were favorably affected by the treatment. In the 12 cases that did not improve, treatment commenced on an average on the fifteenth day; whereas in those that did improve it was begun on the tenth day as an average. In some of these cases there was a marked fall of temperature; but owing to the late stage of the disease it was impossible to say whether the disease had been modified by it, or the convalescence hastened. The writer then refers to the cases reported by Von Jaksch, 17 altogether, and to those of Kraus and Buswell, 12 cases. Dr. Lambert has not obtained the brilliant results alleged by Fraenkel and Rumpf. It seemed to have been of benefit in a little over half the number of cases. In the cases where benefit ensued the severity of the symptoms was very much modified.

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ASTHMA.—Dr. F. F. Bell, of Windsor, Ont. (*Medical Age*, January 25th, 1895), contends that asthma is a diathetical disease, and that this diathesis must become established before there can be asthma, either hereditary or acquired. In many cases, prior to the first attack, the person experiences some unusual symptoms. He may be excessively drowsy, or very buoyant; there may be neuralgic pains or digestive disturbances. The attacks usually come on between two to six in the morning, or just after going to bed. A full stomach, some uterine or ovarian trouble, an odor such as that from a flower, the emanations from certain animals, may cause an attack. The pneumo-gastric nerve, which sends the nerve stimulus to the muscular fibres in the bronchi, and produces the regular easy rhythm of health, becomes over-active and throws these muscular fibres into a tetanic condition. The diaphragm also becomes involved. The causes of these spasms are numerous. An attack of bronchitis irritates the nerve-endings, and gives rise to an attack of asthma. Then again rhinitis and other diseases of the nasal cavities may start the spasm by acting upon the nerve-endings. Syphilitic gummata acting centrally may cause asthma. The poison of ague also causes at times attacks; so with troubles in the stomach, bowels or heart.

The treatment is usually first to relieve the paroxysm. For this purpose the fumes of bibulous paper soaked in extract of Stramonium seeds, belladonna leaves, nitre, and then dried. Chloral bromides, lobelia, cocaine, atropine, morphine, caffeine, Hoffman's anodyne, apomorphine, may alone or in combinations break up an attack. In the intervals counter-irritation over the cervical region is of much value. The drugs that do most good are the arseniates, strychnine, quinine, brucine, grindelia robusta, the iodides and electricity. Regular exercise and baths are of much service. Flannels should be worn. The writer has found benefit from the hypodermic injection of 1-100 atropine during a spasm. This paralyses the nerve-endings of the vagus, and gives relief. The following formulæ are recommended: A capsule containing two grains lactopneum, one grain quinine, three grains muriate of ammonia, one-eighth grain capsicum, one twenty-fourth grain strychnine four times a day, and pot. iodid. grains XC, Fowler's solution ℥i., Hoffman's anodyne ℥iiss., tr. belladonna ℥ii., sq. arrant amar. ad. ℥vi., two teaspoonfuls in water an hour after meals.

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ON THE METHODS OF EMPTYING AN OBSTRUCTED BOWEL.—Dr. W. Thornley Stoker (*British Medical Journal*, January 26th) thinks that there is too free a resort to operation in general, and that some cases of acute obstruction could be relieved that are now operated upon by other means. There are cases of extreme distention of the bowel, and very large accumulation of faecal matter. The peristalsis of the bowel has been poor, and finally the condition of "ileus paralyticus" is produced. In these cases of faecal distention the writer, by the way, President of the Royal College of Surgeons, Ireland, holds that laparotomy is an extremely fatal operation, and should only be undertaken when other legitimate means have failed. The application of heat and rubefacients, the author contends, does no good. They sometimes cause such redness as may obscure the diagnosis. If poultices or massage be employed, they should be used so as to soothe and stimulate, and not to irritate. Belladonna is a valuable drug when given sufficiently early. It should be given without opium. It relieves pain and increases peristalsis. When there is much distention by faeces and flatus, it does its work. It must be pushed by full doses frequently given until the physiological effects of the drug are induced. It is worthy of remark that this drug is well borne in acute cases of obstruction. It strengthens the weak heart in these cases. Of opium the writer entertains "a respectful terror." When the pain

demands its employment, it should be given in the form of hypodermics of morphia. With regard to the early employment of purgatives, the author does not hold as strong objections as formerly. He employs calomel along with belladonna sometimes; but his favorites are the salines, and generally sulphate of soda. He gives it in hourly doses of one or two drachms. The worst that may result is some disturbance of the stomach. The great desideratum is a reliable hypodermic purgative. The process of washing out the bowel is then described. The writer condemns the attempt to pass the long tube, such as O'Brien's, into the bowel. He holds that great injury may be done by them, and even perforation. For the purpose of enemata the writer uses only two instruments, one an ordinary Higginson's syringe, the other a rubber tube and funnel. The tube is about half an inch in diameter. This tube can be introduced into the rectum from 3 to 9 inches. To the other end is attached the funnel. The patient lies on the back or left side, with the pelvis well raised. The only fluid that should be used is warm water, and 8 to 10 gallons may be employed at one sitting. The fluid is allowed to flow into the bowel until there is a feeling of discomfort, the funnel is then lowered and the water runs out into some vessel. This process of filling and emptying the bowel is repeated until the fecal matter is softened down and washed away. The gentle pushing in and pulling out of the tube assists the passage of feces and flatus through the tube. The advantages are—safety, the currents favor peristalsis, the pressure can be regulated easily, the enormous quantity of water that can be used, and the operation is not fatiguing or painful to the patient. The writer states that this is the method yielding the best results in fecal obstruction.

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DR. BERTRAM SPENCER has been appointed an associate coroner for the city of Toronto.

WE regret to announce the death of Dr. J. Barker Peters at Medicine Hat, May 11th.

DRS. ALBERT A. MACDONALD and Allen Baines, of this city, are attending the meeting of the American Pediatric Society at Hot Springs, Va. Drs. Welford, of Woodstock, and Blackader, of Montreal, are the other Canadians present. These gentlemen are the guests of the Chesapeake and Ohio Railroad while attending the meeting of this Association.

## Correspondence

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

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*To the Members of the College of Physicians and Surgeons of Ontario.*

GENTLEMEN,—Besides the careful supervision and intelligent criticism of the votes and contentions of your own elected representatives, recommended in my last letter, you will find it both profitable and interesting to closely watch the attitude of the homœopathic members of the Council, in its coming session, especially with respect to the stand taken by them on matters of economy, and finance, and projected efforts at reform. There is no disposition to deal illiberally with our homœopathic fellow-practitioners. Rather would we strain justice to the point of indulgence in their behalf, as becomes a large and powerful organization in its bearing towards a mere handful of men who do not form an integral part of the profession. We are not prepared, however, to find a generous forbearance on our side repaid by anything savoring of a hard-and-fast alliance of their representatives with our opponents in the Council. Of the two main elements in that body, homœopaths would naturally be supposed to identify themselves with the profession rather than with the schools, and might be expected to have prescience enough to see that their interests are concerned in so doing. They no longer hold the balance of power in the Council, and consequently have, in future, more to expect from the goodwill and forbearance of the profession than from the gratitude of the schools. The fact that they have so well known how to make the most of their past opportunities, warrants the presumption that they will not now be found standing in their own light. Although forming but one-fiftieth of our number, they have hitherto sent to the Council very nearly half as many elected members as we have supplied; while at the present moment, and for some time past, they have, on the Board of Examiners, secured three seats out of the six conceded by the amended Act to the profession at large. They have also, through the gratitude or the easy complaisance of their official associates, succeeded in modifying the Ontario Medical Act in many important particulars, and always to their own peculiar advantage. In a financial point of view they have done equally well. As nearly as can be ascertained from the data procurable, their whole contribution to the professional treasury since their amalgamation with the profession, in the shape of Council fees and assessment dues, aggregates less than \$2,000, while during the same period they have taken

from it some \$5,000 as examiners' fees, and nearly \$15,000 as payment for attendance at Council and committee meetings, thus securing out of the connection a clear profit of from \$18,000 to \$20,000. In view of these facts, it is surmised by many that the homœopathic members of the Council will look askance at all attempts to cut down the expenditure, especially on items which touch their own emoluments and those of the examiners. We imagine, on the contrary, that they will prove amenable to reason, and that wiser counsels will prevail. We have the somewhat ostentatiously paraded assurance of their chief spokesman in his address last June, that they are not disposed to run counter to the wishes of the profession, and that even in the matter of the assessment or non-assessment of the annual tax they are prepared to respect the decision of "a majority of the territorial representatives." Whether these emphatic assurances were mere froth, or had any solid basis in fact, will be fully tested at this meeting. Should the events of the session prove the truthfulness of the accomplished ex-president's statements on this point, much of the irritation caused by his ill-judged attempt to interfere in the territorial elections last year will be forgotten. If otherwise, the fact will doubtless largely color the future relations of the general profession to the homœopaths as a body, and may be held to excuse, if it does not invite, the reduction of the very anomalous privileges, they at present enjoy, within the bounds of equity, or, at all events, within the somewhat narrow limitations of the strict letter of the law as originally set forth in the Medical Act of 1868.

Yours truly,

Port Perry, May 18th.

JOHN H. SANGSTER.

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### Registration in Illinois.

*To the Editor of the CANADIAN MEDICAL REVIEW.*

DEAR SIR,—Kindly allow me to correct a statement appearing in May's REVIEW re registration in Illinois. The presentation of a diploma will not suffice. Applicants from Ontario must present the diploma of the Ontario College of Physicians and Surgeons, or pass the examination prescribed by the State Board of Health. No college or university diploma is recognized. The examination costs \$20.

If applicant possesses the Ontario diploma, he must pay \$5 for certificate from the State Board of Health, and \$1 for registration to county clerk, wherever he may elect to settle.

The above may save annoyance to physicians intending to settle in this State.

Chicago, Ill.

J. F. BURKHOLDER.

## Miscellaneous.

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SCIENTIFIC RESEARCH IN MEDICINE.—It is altogether to be regretted that even the rising generations of physicians are not imbued with this idea. In spite of the hopeful scientific tendencies of the last half century, there still exists a depressing atmosphere of practicality. Young men of marked ability are forever weighing their scientific tastes in the balance with the practical demands of their profession, and entirely apart from the pressure of circumstances, are finding the greater weight of inducement in the practical fields.—*Boston Medical and Surgical Journal.*

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FEMALE OR WOMAN.—Dr. Howard A. Kelly writes as follows to the editor of the *American Journal of Obstetrics*: “A good friend with a fine English sense who occasionally looks over my shoulder as I write, left this note (‘Female’ or ‘Woman’?) pinned to one of my papers a few days ago. I think the fault common enough to be worth while correcting publicly. And as it is manifestly an error to which a gynæcologist is more prone than other men, the correction ought to appear in the *American Journal of Obstetrics*: ‘Take care not to use the word “female” as meaning a woman. It is correct to speak of the female pelvic organs, but a “female” is not a woman; it is a cow, a mare, any animal of the female sex. It is old-fashioned English to call women females, and the expression is coarse in this sense.’”

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A SLIGHT MISTAKE.—The following instance where a bad cold caused a startling conversation is reported in the *Sanitarian*: “A modest young newspaper man was invited to a party at a residence where the home had recently been blessed with an addition to the family. Accompanied by his best girl he met his hostess at the door, and, after the customary salutations, asked after the baby. The lady was suffering from a severe cold, which made her slightly deaf, and she mistakenly supposed that the young man was inquiring about her cold. She replied that though she usually had one every winter, this was the worst she ever had; it kept her awake at night a good deal at first and confined her to her bed. Then, noticing that the scribe was becoming pale and nervous, she said that she could see by his looks that he was going to have one just like her’s, and asked him if he wished to lie down. The paper came out as usual the next week, but the editor has given up inquiring about babies.”

PRACTICIAN OR PRACTITIONER.—The *Medical News*, in an interesting editorial on "Questions of Nomenclature," characterizes the term practitioner in the following language: "Medical language has a somewhat fatalistic tendency to philologic barbarism that healthy modern minds should withstand. No science is so given to absurdities of nomenclature. Even a much-used synonym of physicians is philologically more than outlandish. The French have a word *praticien* for one who practises, for example, the law, and we have the same word in medical English, unused, but properly formed—*practician*. With megalosaurean wit we devise and use the linguistic outrage, *practitioner*. With just as much reason should we say *academicianer* or *dentistianer*. A practiser is, of course, one who practises; a practitioner, therefore, must be one who practitions!"

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LADY DOCTOR OR PHYSICIENNE.—A weekly penny paper called *Answers*, which is said to circulate by the million, suggests "Physicienne" as a title for female members of the medical profession, by way of an alternative for *doctora* or *doctorina*, and other equally euphonious designations. Perhaps the suggestion is intended as a witticism, for the journal aims, not very successfully, at facetiousness, but if so we question whether the real point of the joke will be apparent to the majority of readers. The meaning ordinarily attached to the word "physicien" in French is conjurer or mountebank; a man who extracts teeth *coram populo*, makes omelets in a hat, or produces endless lengths of ribbon out of his mouth; and although the feminine inflection is absent from the dictionary, "physicienne" can only be regarded as standing for the female of that ilk.—*Provincial Medical Journal*.

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STEARNS' CASCARA AROMATIC is an aromatic, sweetened fluid extract of Cascara Sagrada, and is applicable in all cases where regular Cascara is indicated. As a palatable preparation it is far superior to Cascara Cordial and similar preparations, and has the additional advantage of being concentrated, and may therefore be administered in correspondingly smaller doses. Recent investigations of Cascara have shown the bitter principle to be devoid of laxative or desirable therapeutic properties, and, taking advantage of these facts, Cascara Aromatic was prepared by a suitable process which eliminates the bitter principle entirely. The bitter is not merely masked, but is removed entirely. The resulting product is a valuable remedy in chronic constipation and dyspepsia, and indigestion accompanied by constipation. It increases intestinal peristaltic action and stimulates

the hepatic and other secretions of the alimentary canal. In constipation it should be used in carefully graduated doses, sufficient to move the bowels in a natural manner, but not sufficient to purge, as catharis is not desirable. Its use should be persisted in, so as to give the organs time to resume their natural functions with vigor and regularity.

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WHO OWNS THE AMPUTATED LEG?—The Supreme Court of Justice of Belgium has just been called upon to decide a novel and extraordinary question. One of the leading surgeons of Brussels had occasion, about a year ago, to amputate the leg of a young married lady belonging to the highest circles of the aristocracy. The operator was so pleased with his job that he preserved the leg in a jar of spirits of wine and placed it on exhibition in his consulting room, a card being affixed to the jar giving the patient's name and the details concerning the circumstances which had rendered the operation necessary. On hearing this, the husband of the lady demanded the immediate discontinuance of the exhibition, and the return of the severed member as being his property. To this the surgeon demurred. He admitted the plaintiff had property rights in the leg while it formed part of his wife, but argued that the leg in its present condition was the result of his (defendant's) skill and the work of his own hands, and that he was clearly entitled to keep it. The court seemed rather staggered by this line of argument, and, after taking a fortnight to consider the question, finally decided against the doctor and in favor of the husband's claim to the possession of the amputated leg of his better-half.—*40 Cent. L. J.*, 101.

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WEIGHING THE BABY.—Weighing the baby should never be neglected, for however well and happy it may seem, if it is not putting on its normal addition of weight there is something wrong. In adults, loss of weight is one of the most important signs of diseases which interfere with nutrition, but in infants it is not a question merely of loss of weight; any lessening of the normal gain should attract attention, for long before the various troubles of digestion, to which hand-fed infants are so liable, show themselves by general symptoms or by wasting they will interfere with that steady increase of weight which week by week a healthy infant shows. Dr. Griffith, lecturing on infantile disorders, points out that for from three to five days after birth it is common for children to lose weight. During that time they lose meconium and urine, and water is evaporated in respiration, while they have not yet begun to absorb their full supply of nutriment.

At the end of the first week, however, the baby should have made up its weight to what it was at birth. Then, from the end of the first week, it should gain an ounce a day. "A baby," he says, "which gains half an ounce a day is doing fairly well, but a child doing thoroughly well gains double that amount or more. This should continue until the fourth month, after which a daily gain of half an ounce a day is satisfactory." Accurate observation and careful recording of the weight of an infant gives the earliest warning of digestive troubles, and should be looked on in the light of a duty by those who undertake the responsible task of bringing up a child by hand, for on the success with which the child digests the food presented to it depends, in large degree, the perfection of the framework on which the future man is built.—*The Hospital*.

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SHOULD WOMAN RIDE HORSEBACK ASTRIDE?—One of the riding-masters of a popular riding-school in this city has proposed to give a course of lectures on equestrianism in all its phases. He further proposes to devote a whole evening to the discussion of the question, Should woman ride horseback astride? The questions which he will deal with, put more categorically, are these: "Is there any reason why the sense of propriety should hinder a woman from riding on horseback astride? Is there any reason why a costume, both elegant and modest in design, and which reveals less of a woman's form than the habit worn for the last years, should not be used by woman when riding? Will it add to the comfort, ease, repose, relaxation and firmness in woman's seat on horseback, and thereby increase endurance and facilitate the learning of horsemanship for woman? What is the opinion of competent and learned physicians as to the advisability of riding astride, from a physiological standpoint?" We are sure that many, if not all, of our readers will say that there is absolutely no physiological reason why woman should not ride astride; but probably none of those who say this will consent to let their wives or daughters ride in this way. The mighty power of fashion, custom and habit is infinitely stronger than that of reason, logic or physiology. There are probably more reasons why man should ride side-saddle than that woman should not sit in the natural bifurcated position, for the disease of the Scythians was produced by this latter posture as assumed by the male. Perhaps, however, some of our readers can conjure up some real physiological argument in favor of the side-saddle style; and if so, we shall be glad to hear from him. So far as physiology goes, it teaches that man should ride side-saddle and woman astride. This may be the final evolution of the matter.—*Medical Record*.

COLLEGE OF PHYSICIANS AND SURGEONS.—The following candidates have passed the final examination of the College of Physicians and Surgeons of Ontario, 1895: W. L. T. Addison, Toronto; A. W. Aiken, Orangeville; Mary E. Allen, Fordwich; N. J. Amyot, St. Thomas; George W. Brown, Aylmer West; Sidney B. Bean, Bright; James Becket, Thamesville; J. W. Brien, Essex Centre; G. W. Badgerow, Eglington; J. H. Cormack, Kingston; James G. Caven, Toronto; M. Currie, Picton; J. A. Cowper, Welland; R. A. Craft, Chisholm; C. D. Chapin, Brantford; W. J. Chapman, Toronto; W. Douglas, Chatham; C. A. Drummond, Meaford; R. A. Downey, Toronto; Jeanie I. Dow, Fergus; F. C. Delahey, Pembroke; George Ellicott, Toronto; A. S. Elliott, Scotch Block; W. A. Feader, Iroquois; J. H. Ferguson, Toronto; T. H. Farrell, Kingston; H. M. Featherstone, Nelson; S. E. Fleming, Millbank; T. F. Flaherty, Thorndale; J. F. Gibson, Kingston; A. Gibson, Orton; C. W. F. Gorrell, Brockville; F. C. Hagar, Kingston; F. C. Harris, Tuscarora; J. C. Hutchison, Fordwich; T. B. Hewson, Port Hope; Jennie Hill, Bond Head; G. W. Hall, Little Britain; J. N. Hutchison, London; W. Hird, Uxbridge; A. J. Hunter, Toronto; J. F. James, Strathroy; C. G. Johnston, Athens; C. J. Kelly, West Flamboro'; E. T. Kellam, Seaforth; W. D. Keith, Toronto; M. O. Klotz, Ottawa; J. B. Lancaster, Culloden; A. C. Lambert, Toronto; A. S. Langrill, Ohsweken; J. G. Lamont, Ripley; W. C. Laidlaw, Toronto; E. H. Marselis, Bouck's Hill; A. K. Merritt, Scotland; A. A. Milligan, Toronto; J. D. Monteith, Stratford; Daisy M. Macklin, Stratford; W. McDonald, Galt; T. McCrae, Guelph; F. McLennan, Lockalsh; W. B. McKecknie, Aberdour; Annie B. McCallum, Gananoque; H. S. McDonald, Kingston; J. A. McBroom, Washburn; J. A. McNiven, Dorchester; M. McPhail, Sonya; T. W. G. McKay, Toronto; W. T. McArthur, Moorefield; A. E. Northwood, Chatham; J. I. Pratt, Heathcote; Rose Pringle, Fergus; F. Parker, Stratford; H. G. Pickard, Glamis; H. M. Paterson, Rodney; J. H. Ratz, Elmira; E. K. Richardson, Flesherton; F. S. Rounthwaite, Collingwood; H. A. Stevenson, London; J. Sheahan, Newark; A. A. Small, Toronto; D. W. Shier, Cannington; Maggie Symington, Brighton; D. R. Simpson, Hamilton; T. H. Sneath, Midhurst; E. Seaborn, London; J. G. M. Sloan, Annan; H. E. Tremayne, Mimico; F. L. Vaux, Brockville; R. J. Walker, Strathroy; W. C. Whitteker, North Williamsburg; F. G. Wallbridge, Belleville; G. S. Young, Stouffville; J. M. Zumstein, Elcho.