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A MONTHLY JOURNAL OF MEDICINE SURGERY AND ALLIED SCIENCES

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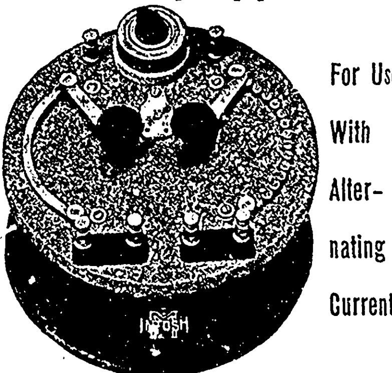

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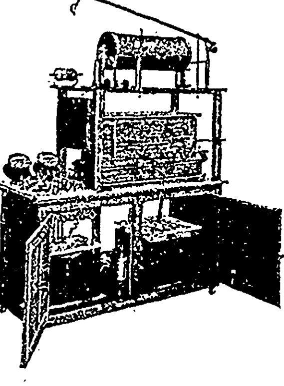

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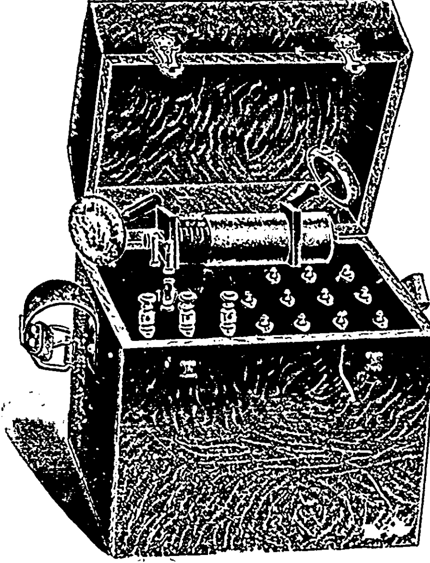

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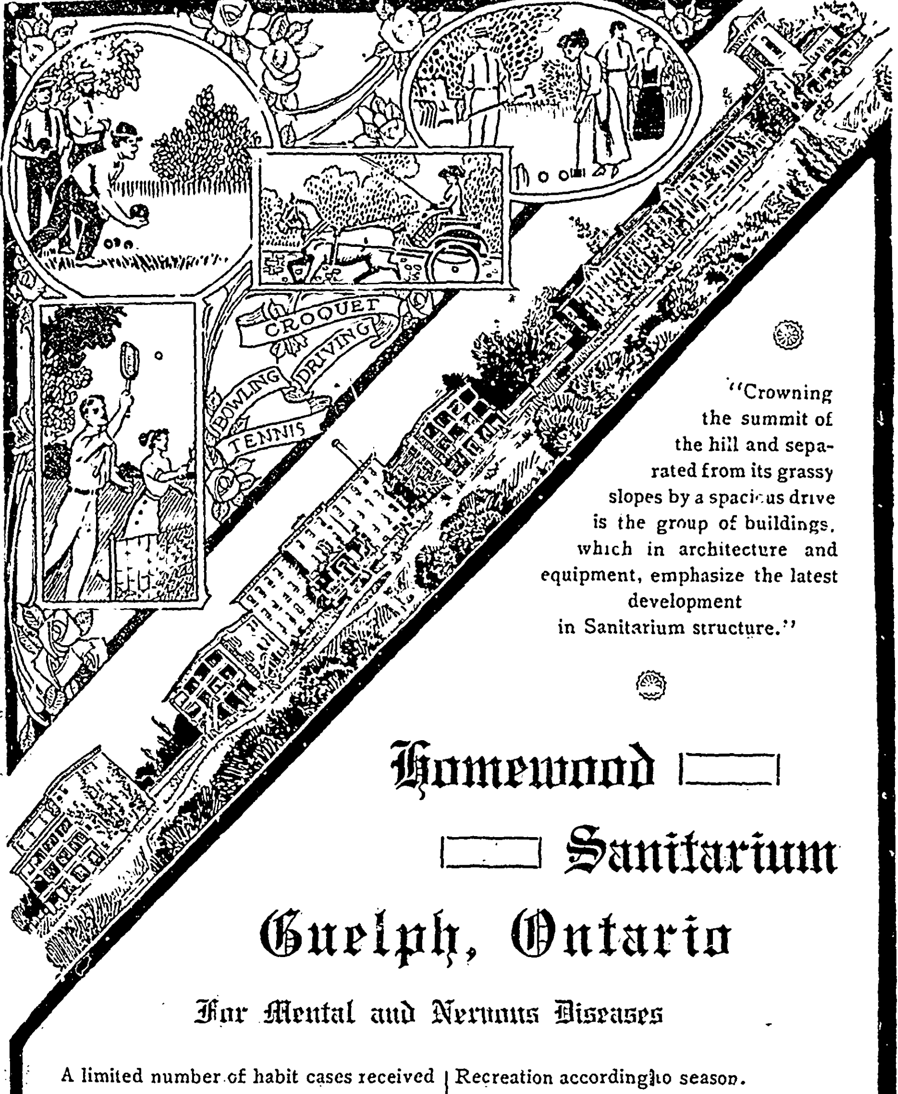

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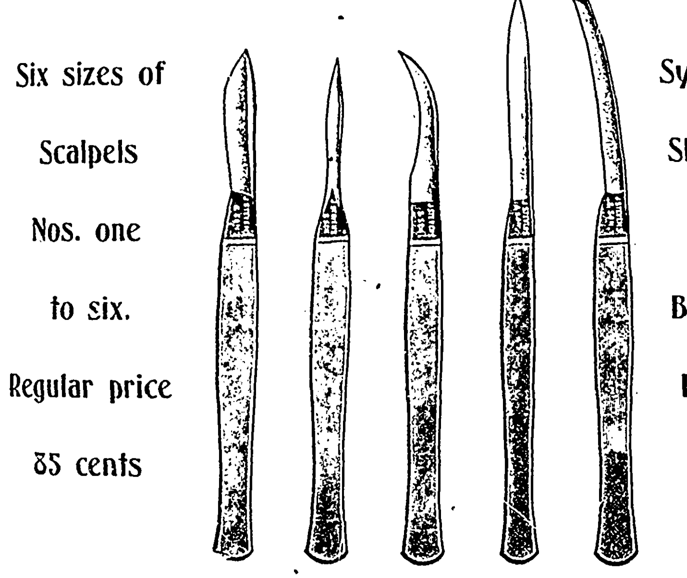

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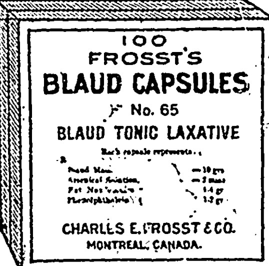

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MEDICAL JOURNAL

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ORIGINAL COMMUNICATIONS

THE TREATMENT OF SOME COMMON DISEASES OF THE SKIN.

By Phineas S. Abraham, M.D., F.R.C.S.
(Surgeon to the Hospital for Diseases of the Skin, Blackfriars, London, Eng.)

Gentlemen,—When your chairman, Dr. Redfern, did me the honor to invite me to address you on this occasion, it occurred to me that it might perhaps be more acceptable if I put together some rough notes of certain methods of treatment which I have found useful in some of the commoner diseases of the skin, rather than that I should inflict upon you an elaborate essay upon some special subject. I must first of all apologize for the very fragmentary nature of my communication, and secondly I must disclaim any idea of particular originality in the measure that I am going to recommend. Many of the remedies that I shall mention are as old as the hills and I dare say are well known to you, and others are merely modifications of methods of treatment recommended by others. I was once present when an eminent specialist deprecated the admission of general practitioners into a certain special society on the ground that he did not see why specialists should give themselves away or give away their "tips," unless for a special fee. Fortunate, some of us still believe that we belong to a scientific profession and are sufficiently imbued with the Hippocratic spirit to be above such contemptible small-mindedness. At any rate, most of

us specialists are always ready to impart all we know—little though it may be—to any brother practitioner who may consider it worth his while to listen to us either at the hospital or elsewhere.

I propose on this occasion to speak particularly upon the treatment of the following common diseases—eczema, psoriasis, impetigo, acne, and ringworm.

Eczema.

That the numerous cases of cutaneous eruptions which are included under this name have more than one pathological cause most dermatologists agree. There can be no doubt, however, that the ubiquitous microbe it at the bottom of any of them, and it is to my mind more than probable that there is more than one microbe the growth and development of which in the skin will produce the inflammation, irritation, exudation, and exfoliation which are more or less characteristic of "eczema."

As with other microbic infections, moreover, another factor is necessary for the production of the disease: the micro-organisms will not flourish if the soil or cultivating medium—i.e., the tissues and juices thereof—be not suitable. Some of the modern dermatologists, especially on the continent, are, I fancy, rather inclined to ignore this latter factor and to depend too much upon purely external applications in the treatment of eczema. On the other hand, there can be no doubt that the older practitioners relied toomuch on internal medication in this and in many other diseases of the skin. I feel sure that in most cases the best results are obtained by simultaneous external and internal remedies. Our aim should be to get the whole system—all the organs of the body—in a thoroughly healthy condition as well as to destroy the microbes or prevent their growth, and we must see to the digestion, to constipation, to the kidneys, to the circulation, and even to the nervous system—to everything, in fact, which may directly or indirectly influence the condition of the tissues and fluids of the skin.

I frequently give with benefit an iron and magnesia mixture, e.g., the mistura ferri aperiens of most hospital pharmacopoeias, with a little nux vomica as a digestive tonic, or sometimes an alkaline bitter mixture with an aperient if necessary, and if able I regulate the diet as much as possible. As a rule I recommend simple, plainly-cooked food, the avoidance of much sugar, tea, strong coffee, pastry, cheese, beer, acid and sweet wines, or much alcohol in any form. Externally, the applications will vary with the form of the eczema, its acuteness, extent, position, &c. In acute inflamed cases, antisepsis, protection, and reducation of inflammation and exudation are to be aimed at, and either powders, pastes, liniments, ointments, or zinc gelatins may be employed. Many cases do well with what we at Blackfriars call the "unguentum hydrargyri cum plumbo," which contains 10 grains of acetate of lead, 10 grains of calomel, 20 grains of oxide of zinc, 20 grains of ointment of nitrate of mercury, and one ounce of vaseline. But occasionally an eczematous skin will not stand an ordinary ointment, and a modification of Lassar's paste may then be tried—e.g., three drachms each of zinc oxide and starch, 10 grains of salicylic acid, and one ounce of vaseline, or a calamine liniment containing one drachm of zinc and half an ounce each of olive oil and lime water. When the weeping and inflammation are excessive a powder thickly dusted on is sometimes effective—e.g., half an ounce of starch, two drachms of oxide of zinc, and one drachm of powdered borax or boric acid. Many cases of acute eczema which have resisted other applications have yielded in my hands to the zinc-gelatin treatment (of Pick and Unna)—viz., half an ounce of gelatin, three drachms of oxide of zinc, one ounce of water, and half an ounce of glycerine, and I generally add 10 *minims of ichthyol. The mass melted in a glue-pot and* painted over forms an elastic, protective, and soothing covering. In all cases, immediately before applying any of the above, I order the parts affected to be well bathed with a very dilute antiseptic lotion. In preference I use a lotion containing half a drachm of creolin to a pint of soft boiled water, because it is effective as an antipruritic as well as being an

antiseptic and—an element of importance in hospital practice —because it is inexpensive. Other weak antiseptic lotions are no doubt equally as good.

In dry eczema and where there is but little inflammation, tarry ointments are usually very efficacious. Our favorite one at Blackfriars is the so-called "unguentum petrolei compositum." This contains half a drachm of alcoholic solution of coal tar, 10 grains of ammoniated mercury, and an ounce of vaseline. Creolin is sometimes with benefit substituted for the alcoholic solution of coal tar and I dare say that the liquor picis carbonis would also do.

As with the acute eczemas I always advise bathing the parts affected with a weak tarry lotion before applying the ointment night and morning, or even, if the eruption be extensive, a tepid bath containing from half a drachm to one drachm of creolin or other tar product to about six gallons of water. Soap is generally detrimental in eczemas, especially in the acute form, and I frequently recommend a muslin bag filled with bran to be used as a substitute. A warm sitz bath night and morning with rather more creolin in it—say one drachm to two gallons—I have found very useful in obstinate cases of eczema of the perineum and anus. In these cases, too, I have sometimes found the addition to the tar ointment of 10 grains of sulphur or 25 grains of ichthyol to be of good effect. This is applied immediately after the bath.

In eczemas of the limbs I keep the ointment bandaged on, and I am sure that careful bandaging of the legs from the foot to the knee is an important adjunct to the treatment, especially when varicose veins are also present, as they often are. There is one matter I would like to point out in the treatment of eczema. It is a mistake to use strong ointments —a fact that, I believe, was first recognized by the elder Startin, the founder of Blackfriars Hospital for Diseases of the Skin, and which has not yet been grasped by the editors of the British Pharmacopoeia, for the officinal ointments therein set down are mostly too strong in skin cases.

Psoriasis.

Although I regard the constitutional element in psoriasis of even more etiological importance than in eczema, seeing as we do among its other features its tendency to occur in several members of the same family, and in gouty and rheumatic subjects, I have come to the conclusion that external treatment is, comparatively even, of much greater use in this disease. As with eczema we ought to consider the state of the internal organs as well as any "diathesis" which may be indicated. I believe that the older practitioners were often right in giving alkalies and diuretics in these cases, but I have long become convinced that there is no particular drug administered internally which can fairly be regarded as a specific for psoriasis. As for arsenic, I consider that its vaunted specific efficacy in the treatment of this disease is little short of a medical myth. I could produce notes of numerous cases in which its persistent exhibition for years has produced no effect either in removing the efflorescence, or in preventing its recurrence after its removal by external treatment. If, as perhaps happens occasionally, the patches disappear during a prolonged course of the drug, it has only been, according to my view, either after the patient has been made very ill, the nutrition of all the tissues having suffered—the skin with its patches of psoriasis along with the rest—or from the effect of concomitant measures. We frequently, indeed, see the efflorescence of psoriasis temporarily vanish during some other intermediate severe affection—gastritis, fevers, influenza—and I have even seen the spots go when a patient has meanwhile contracted syphilis.

Thyroid gland is another much vaunted drug which I have also discarded in the treatment of psoriasis. Some years ago I tried it extensively in the disease, and came to the conclusion that although in a few cases it undoubtedly caused the exfoliation and disappearance of the spots, in the majority it had no effect, and, indeed, frequently made the patients very ill without doing much good to the psoriasis. Even in those cases in which the results were good the rapidity of

cure was by no means greater than with the ordinary external methods of treatment, nor was there any less tendency to recurrence. The external application of chrysarobin undoubtedly removes the efflorescence quicker than anything else. As an ointment, however, it has its drawbacks—ruining the patient's clothes, and producing severe and disagreeable erythema in tender parts and inflammation of the eyes if accidentally carried thereto. I use it now always in the form of a solution, to be rubbed in only on the patches which are situated on the extensor surfaces where the skin is less tender —e.g., 40 grains of chrysarobin, 10 grains of salicylic acid and one ounce of solution of gutta-percha (in chloroform), this forms a film which, when dry, does not stain the linen. As it peels off it is to be replaced every day or two—generally until an erythematous blush appears around. A more or less saturated solution of chrysarobin in benzine, rubbed into the patch, and then when dry painted over with collodion or the liquor gutta-percha is also very effective. For other parts of the body I usually order a strong tar or creolin ointment—e.g., one drachm of creolin, 10 grains of ammoniated mercury, and an ounce of vaseline, often also with the addition of from 10 to 20 grains of salicylic acid. If possible I make the patients soak themselves for a quarter of an hour or twenty minutes every night in a warm bath containing creolin and then thoroughly inunct the patches with the ointment.

For psoriasis of the scalp, the most efficacious treatment in my experience is an ointment containing a drachm of ammoniated mercury and three and a half drachms each of soft soap and vaseline to be well rubbed in every night. By these measures thoroughly carried out the most inveterate cases can, I believe, be "cured" in a few weeks; and I am not aware then that the affection then shows more tendency to recur than after any other method of treatment. Indeed, I know several old patients who were so treated who have had no return of their psoriasis for many years.

Impetigo.

Everyone who visits the out-patient department of the West London Hospital is surprised at the enormous number

of cases of impetigo that we see there and I have no good explanation of the fact that the disease is so prevalent in Hammersmith and the neighborhood. In most skin clinics the cases of eczema are by far the most numerous; at Hammersmith the impetigo cases certainly predominate. Fortunately it is a disease easily cured and by the good old-fashioned remedy—ammoniated mercury ointment.

I do not approve of the crusts being removed by poulticing. Warm oil or a weak, warm antiseptic lotion ought to be sufficient. I generally order a weak creolin lotion for this purpose, the ointment to be applied immediately afterwards and re-applied night and morning. If pediculi are present, as is usually the case in the heads of our London School Board children, I recommend a thorough nightly washing with soft soap and hot water immediately before applying the ointment. If this treatment be kept up for some weeks the young pediculi are dealt with as they come forth from the nits and the pediculosis is soon eradicated.

Acne.

This is another common affection which in my experience can be cured with certainty and in a comparatively short time by a judicious combination of internal and external remedies. I believe that unless the skin is in a more or less unhealthy state the pus and comedo-producing organisms do not perform their nefarious function. The majority of acne patients will give some indication of dyspeptic trouble, constipation &c., and the rosaceous cases particularly of flushings of the face, &c., and not infrequently they give a history of their faces being worse at the menstrual period. Most of them I find to be benefitted by the tonic and aperient iron and magnesia mixture between meals, others by an alkaline bismuth mixture before food. In all cases I recommend the application to the spots every night of the compound sulphur ointment of Blackfriars which contains 30 grains of sulphur, 10 grains of ammoniated mercury, and an ounce of vaseline, slightly varying the quantities in particular cases and adding oxide of zinc if there be much inflammation. Occasionally

the old sulphur and lime-water lotion does well, but I find as a rule that the above ointment does better. Before its application I make the patients bathe the face with hot water and a 10 per cent. ichthyol soap well lathered on. This is to be done again in the morning and very often I tell them to keep the lather on for as long as possible. But a still more important part of the treatment, in my opinion, is the cautious application to each pimple of the tiniest driplet of pure carbolic acid, just liquefied with a little water, as recommended many years ago by Dr. Walter Smith of Dublin. As a rule, one application aborts and cures the pustule. The rapid efficacy of this application is particularly apparent in those very bad cases of recent alcoholic acne. In indurated cases where subcutaneous abscesses have formed and where the pustules are large and deep I puncture them, and with a small blunt-pointed hypodermic syringe needle, with the orifice apical. I thoroughly wash out the cavity with some lotion—1 in 1000 sublimate, 1 in 20 carbolic, izal, or chinosol. I do not think it matters much which—in fact, I treat it as one would treat antiseptically an ordinary surgical abscess. I think it always well to remove as many comedones as possible in acne cases, and for this I use the comedo extractor which has been made for me by several London instrument makers.

Ringworm.

As we all know, many cases of ringworm of the scalp can be easily cured by the application of iodine tincture and liniment, Costa's paste turpentine, or even common ink. When, however, the fungus gets deep down into the hair follicles it is not so easy to get at, and the case even in the most experienced hands may last for years. Durin the past 15 years I think I have experimented with most of the methods, and the number is legion, that have been proposed for the treatment of ringworm. I am now advising the following measures in the majority of cases. The scalp to be shaved every fortnight and calico skull caps to be worn day and night, an ointment consisting of one drachm each of pure carbolic acid and salicylic acid to the ounce of vaseline to be

well rubbed in with a stiff brush night and morning over the patches, and the rest of the scalp slightly smeared over with the same ointment. Twice a week I have the scalp lathered with hot water and a soapy mixture containing two ounces of soft soap, two drachms of glycerine of carbolic acid, and two drachms of glycerine or boric acid, to be followed immediately by an application of the ointment. Once or twice a week, if possible, I use immediately after the washing my special pump which forces in by the atmospheric pressure any parasiticide liquid which you may wish to use. The area of scalp beneath the bell becomes impregnated with the fluid, making the soil very unpleasant at least for the undesirable trichophyton. I generally employ pure creasote and sometimes equal parts of ozonic ether and quaiacol which penetrates readily. Before using this machine it is as well to remove as much fat as possible from the follicles by swabbing the patch with ether. Many cases that have resisted other methods of treatment for years have in my hands yielded to this.

Conclusion.

I think, gentlemen, that I have now wearied you enough, but before concluding I should like to express my opinion that we are in this country in a great degree handicapped in the treatment of diseases of the skin from the fact that we cannot always have the various necessary measures thoroughly carried out. It may be all very well for the hospital patients and for very wealthy people who have the time to devote and who can afford to go to the West End nursing homes. In a large number of cases, however, the initial prescription and the occasional visit to the skilled practitioner are deemed sufficient; the circumstances of the patient's home rarely lend themselves to thorough inunction, suitable baths, &c., and, indeed, are seldom adequate, and the result often is that the case "hangs fire." The continental patient suffering from a disease of the skin is, on the other hand, better off. He goes to an experienced special practitioner who admits him into his private hospital at a cost varying according to his means, is seen and dressed every day by the practitioner himself or

by his assistants, with frequent modifications of treatment as indicated, and I am obliged to admit is often cured quicker and more satisfactorily than he would be in this country. I have myself more than once—an admission which I regret to have to make—felt constrained to send patients who were above the hospital class to Aix la Chapelle, to Hamburg, and to other places abroad, because I conscientiously knew that their cases would be more thoroughly dealt with and at less expense than in a London nursing home. I have only now to thank you for listening to these very desultory remarks. I hope, however, that some of the measures which I have mentioned may prove of use to some of you.

A CASE OF TRAUMATIC NEUROSIS, ILLUSTRATING SUCCESSFUL PSYCHOTHERAPY.

By Tom A. Williams, M.B., C.M., Edin.
Washington, D. C.

The pessimism, due to the want of success which has hitherto characterized medical efforts against the hystero-neurasthenic syndrome induced by industrial accidents, and especially those on railways, bids fair to be replaced by a very different attitude, thanks to the illumination of the whole subject of hysteria which we owe to the insight and energy of Babinski,[1] who has effectually shown the purely fantastical nature of hysteria described in the text-books after the traditions of Charcot.

It is unfortunate that some clinicians, and more especially some neurologists, have not taken the trouble to study the mass of evidence about hysteria which has been accumulated since Charcot's day, and continue to write in some such strain as the following:—Thus Church and Petersen (1908 edition) quote only the older article of Dutil, saying "a certain number of elementary phenomena, sensations, and images are not preserved and appear to be repressed in the realm of consciousness." "In addition, there are a number of organic phenomena—disturbances of nutrition, trophic and vasomotor disorders of a neurotic charter." "The stigmata tend to persist as long as the affection lasts." "In the great majority of hysterias the visual field is found concentrically contracted." "The red visual field exceeds the blue." "Both anesthesia and hyperesthesia are usually present in a given case." "Pulmonary congestion, hemoptysis, etc., are not very rare." "The trophic accidents of hysteria are of recent recognition" (an extraordinary statement). "Even cutaneous gangrene has been recorded." "Neurotic edema usually appears in parts hysterically affected." "Muscular atrophies have been observed by a number of reliable observers."

Worse still writes Saville in a recent lecture published in the "Lancet." "I cannot agree that hysterics are invariably or especially susceptible to auto and hereto suggestions or are more hypnotisable than non-hysterical subjects." But he gives no facts or reasons for this belief, merely stating further that "alteration and tendency to change and evanescence of mental state, called caprice by Sydenham, is the peculiarity par excellence by which we recognize a hysterical mind." "When this means of identification fails," he seeks it in "emotional instability, a tendency to abstraction or automatism, especially coupled with certain physical symptoms, as flushing and fainting." He naively rejects the observations of both Freud and Janet on the ground that "their studies are carried on in psychological clinics, where patients apply principally or solely on account of mental defects;" and believes they take "too narrow a view, because they do not mention or explain circulatory and somatic symptoms, and also state that they occur much less frequently than do observers engaged in general medicine." Saville can know very little of the Salpetrière clinic in making such a remark, for there the number of persons suffering from physical defects of the nervous system is enormous,[2] and it is there that Freud first formulated his theory, and Janet still works. They do not mention the physical symptoms in the same naif way as formerly, because they have long ceased to regard certain of them as belonging to hysteria, other neuroses (in the true sense) having now been delimited, and other conditions such as palpitations, flushings, syncope and convulsions being capable of easy production either directly by suggestion or indirectly via an emotion. Everyone surely must be familiar with the pallor, cold flashes and syncope of fear and the blush of shame, as well as the convulsive attack of the tantrums of childhood. To invoke a hypothetical splancho-neurosis to explain such every day phenomena shows great ignorance of well-known data concerning the emotions.

The illustration which he uses to enforce a long settled thesis that some hysterical phenomena at least are psycho-

genetic is unfortunate at least; for the example he gives is that of the tics, the full description of which Meige and Reindell[3] long ago showed to be quite different to hysteria; and as a member of the national hospital staff[3] has translated their book, the knowledge it conveys should be common property.

As gratuitious and discredited for lack of evidence is his hypothesis that hysterical symptoms must be explained by local modifications, by cerebral anemia due to vaso-motor instability. Science is very far indeed from such hypothesis; and any premature adherence thereto on the part of clinicians only hinders the advance of the real knowledge gained by a study of phenomena, by making them unconsciously distort the facts to conform to an explanation which appears scientific because physiological. The knowledge of neurological diagnosis needed to exclude definite organic perturbations of the nervous system,[4] and an acquaintance with the modern work of Charcot's followers, indicate that there is only one fact certain and indisputable about the reactions of hystericals, and that is that they are "susceptible to production by suggestion and of removal by suggestion-persuasion."

This is not the occasion to refute such notions, nor even to indicate in extenso the reasons for dissent; for the writer's recent articles[5] have fully set forth the evidence, and in a communication to the Congress on Industrial Accidents at Rome,[6] the application of the doctrine that the primitive symptoms of traumatic neurosis are hysterical, neither more or less, in that they are each and all "susceptible of production by suggestion and of removal by suggestion-persuasion." I say primitive advisedly; because, although a hysterical contracture for example is produced by suggestion, yet the shortening of the tendons which may follow its prolongation is the result of organic changes due to persistence of a faulty attitude, and cannot be removed by suggestion-persuasion. Again, although the anorexia of certain gastric neuroses is caused through suggestion[7] and removable thereby, yet the emaciation, asthenia and gastric insufficiency which result cannot be thus removed; for they are organic consequences

secondary to starvation induced by the fixed idea, the eroneous belief that food will not agree.[8]

Similarly, in the case which follows, the loss of appetite, insomnia, emaciation and unhealthy tint of the skin were *secondary to the mental worry concerning the circumstances* in which he was placed through his fixed idea, the false belief that he was irretrievably damaged in his spinal cord, and would be unable to earn a living for himself and family; and his whole affective tone thus became morbid secondarily to an idea derived by suggestion, as will appear.

It is that of a railroad brakeman who was thrown by the giving way of a stirrup while his train was traveling about ten miles an hour. He fell on the small of his back against a bank of earth, rolled over two or three times, and lost consciousness for over half an hour. After crawling about half a mile he was found. He felt sick all over, and brought up blood, which also came from the urine and bowels, only that day, however. After reaching his home town, he was assisted to his house, one and a quarter miles away. He did not sleep that night, but rested the next morning. In the afternoon he became restless, and sticking pains occurred in the back and lasted several days. He was up and about with a crutch in fourteen days; but shortly afterwards he lost the use of his legs, **having to move them with his hands**; he then walked about on crutches, though he felt faint after progressing two or three squares. On account of anxiety and want of means, he soon after went to live with his mother, his wife going to her father. When questioned, he replied, "Well, yes, I missed her;" but he stated that he was **too much preoccupied with his health** to care much. About three months later he was able to hobble with a stick only, but varied from day to day in his power to do so.

He says he feels a buzzing and severe pain in the head as well as in the back; these did not begin until one month after the injury. He worried much over his position and circumstances and the dependence of his wife, in being unable to help her and his mother, who was an invalid with a younger

boy to take care of. (He wept while relating this.) He had never worried before his accident, but now he cannot help it, for though he is $225.00 by an accident insurance company, they will not pay him anything. He does not know what to think about his health; for though the railroad doctor upon seeing him after the accident declared that he would soon recover and be able to work, he has lost over twenty pounds in weight, has become very weak, has sore throat, and capricious appetite and sallow skin, anw weeps nearly every day. Moreover, about ten days after the injury, two other doctors, called in by his family, each said independently of the other that he had a congestion of the spine, which, though probably temporary, might last a life-time. He had a very severe "fainting-spell" one day after a cold; but when interrogated, he confessed to having eaten a large meal of sweet milk and cold slaw, and this was the only occasion since the accident upon which he had actually vomited, though he had often had a dull sick feeling when over-heated. He wishes he had never seen a railroad, "meaning nothing detrimental to anyone but myself."

He has employed attorneys, who are bringing a claim against the company: he has asked for two thousand five hundred dollars and employment, and has received much sympathy from his friends. "I answer a thousand questions a day." When asked his object in this, he replied, "I will be frank with you and all; I was looking forward to promotion. It was no fault of mine that I was injured; if it had been, I would have said nothing. I merely ask for a sum of money and a job I could do. I could get around and do a job I could do, but I would never run railroad again; for in catching a box local, it means heavy weights all day, and I cannot gain promotion except through this." He thought he might do office work, though he dreaded it, for out-door work suited him better than the confinement of bookkeeping; besides a good brakeman can make a hundred dollars a month.

Upon examination I found the tendon reflexes equal on the two sides and neither and neither exaggerated nor unduly feeble. The cutaneous reflexes were all unusually active with

the exception of the plantar, in which, however, the toes distinctly flexed upon several occasions, until inhibited volitionally. When I distracted his attention, however, flexion again occurred. Sensibility: A pin prick on the lower limbs is called a punch, cold steel is called warm, and the diapason is only felt when in full vibration. Cottonwool is unfelt in front as high as the groin, and behind as high as the iliac crest on the right side, at first; but after the left side had been examined and found insensitive only as far as the gluteal fold, he confessed to feeling the wool on the right buttock also. When asked to say when he did not feel the wool, he said "No" the first seven times he was touched on various parts of the lower limb, later ceasing to reply. The gluteal anesthetic boundary varied by about two inches at different examinations. In the lumbar region, he was bi-laterally hyperesthetic in a two-inch zone shading off below and sometimes extending on to the buttocks. Posteriorly, the upper border of the zone corresponds to D.12 and L.1, laterally to D.10-11 and anteriorly, to D.8-9. The motor power was good. When he attempts to use the legs alone, he strongly tightens up the antagonist muscles; but when his attention is diverted, he can maintain powerful extension at the knee, even on the left side, though he declared himself weak there from an old dog-bite. Babinski's combined flexion,[9] and Hoover's[10] and Zenner's[11] tests were all negative.

The pupils are equally dilated and respond promptly and vigorously to light and accommodation, but no pain reflex could be elicited.

There was no less of memory or other intellectual defect, although the affectivity was perturbed as described.

It should be evident that the incapacity of this man arose from the fixed idea, very probably inculcated after the accident by his friends, although to largely by the common belief of railroad employees, that an accident can induce serious nervous disease. The doubtful prognosis of the doctors, evidently unskilled in neurological diagnosis, strongly fortified the man's belief and consequent anxiety. The anesthesia, induced by

previous medical examination,[12] might have deceived an inexperienced observer; but the wool test, which had not previously been employed as I performed it,[13] quickly revealed not only an "uneducated" line of demarcation, but demonstrated that the man did feel by the very fact that he said he did not. Of course, even had I not succeeded in thus demonstrating the incongruity of syndrome with the neuro-pathology of the spinal cord, the complete conservation of all the reflexes was sufficient to show that the anesthesia did not arise from disease of the spinal cord.

The diagnosis then was hysteria, the psychic elements of which were clearly revealed in the foregoing history. The prognosis given was favorable; but I first explained to the patient and doctor separately the real genesis of the disorder, showing the former the effects of worry and anxiety upon bodily nutrition, and the role of ideas over bodily activity.

The treatment I recommended was the re-establishment of good nutrition, regular exercise, a removal of grief and worry by the assurance of a reasonable compensation for the anxiety and loss he had suffered (for though his ideas were erroneous, and he was in one sense of the word a simulator, he was so unconsciously and because of the environmental beliefs he had acquired), and the declaration that by following my treatment he would be capable of moderate work in a few weeks, and in a short time would be entirely restored to health. Being asked for a certificate, I gave the following to both patient and doctor:

"This is to certify that I find Mr. V. to be suffering from a condition of incapacity for free walking or mental or physical work from the effects of a fall from a brake car (as I am informed). This state is induced, as a result of the aforesaid accident, by the worry, anxiety and loss of means directly caused thereby. I believe that by appropriate treatment he oculd be restored to a certain extent within one month, and that within three months he could be fully capable of pursuing any laborious vocation he chose. He is, however, at present in too low a state to be capable of long, continuous

labor, even though the incapacity of the limbs were immediately removed. There is, and has been, no disease of the spinal cord or peripheral nerves at play in the induction of any of the symptoms which I find. The erroneous belief that there has been such an injury powerfully contributes to the anxiety which maintains his present state."

As to the outcome, a letter from the doctor a few days ago stated in reply to my query: "We compensated V. by a sum of six hundred dollars; and he went back to work on time, just as you predicted." **Naturum morborum curationes ostendunt.**

The replacement of this morbid feeling tone by another cannot be direct; but must be accomplished by replacement of the causative idea by another, and this is what indeed the psychotherapist does in the gastric neurosis.[14] But in traumatic cases, the litigious element prevents this, for the patient is suspicious of everyone who does not accede at once to his fixed idea that he is incapacitated, and medical men as a whole are not noted for the psychological finesse required in approaching such cases. Hence, access, even if gained, is quickly lost, except by the medical men whose belief concords with that of the patient; and these, believing as falsely as he, are as helpless to cure him.

It must be remembered, too, that mere affirmation may prove a very poor appeal, for a cold, intellectual acceptance is not enough to change an attitude or mood which has been assumed for any considerable time. Intellectual acceptance must entrain immediate action, whether emotional or not, for the whole bearing of the patient's mood must be orientated towards a desired idea, that of disappearance of the hurtful idea-emotion complex. Thus, I obtained the active consent of my patient, and he was invited to dine with his doctor that night, made to feel optimistic, and then taken home, and the settlement clinched at once.

It is clear that the return of this man's functional capacity was the result of the enlightenment and skillful persuasion

he received during our interview, seconded by his physician, who saw that immediate action followed an intellectual conviction which might not have been maintained against the counter-suggestions he would have again received in the environment of invalidism which had grown up around him. It must be remembered that patients with a fixed idea become aboulic where other matters are concerned. Thus Brissaud[15] remarked of a patient who went into a fit when they gently attempted to extend the contracture of a limb which had lasted five years since the railway accident, "this contracture is his life." Misoneism,[16] the impossibility of adaptation to unusual conditions, is common enough, and its intensity is proportional to the length of time during which the mental habit has persisted, as well as to the affection, so to speak, with which one's habit or defect has been cherished and the age at which they have been acquired; and in such persons conviction soon becomes inert if allowed to sleep.

The effects of an emotion such as fear quickly pass away unless they are maintained artificially ideationally, as by suggestion, which need not necessarily be made after the event, but may be latent, as in the following case:

A girl was brought to Babinski,[17] having become monoplegic upon receiving an electric shock while crossing a tramway line. This seemed like paralysis not caused by suggestion, but after the symptom had been removed by persuasion, further inquiry elicited the fact that the patient had overheard some months previously a conversation between some electricians who were speaking of the dangers arising from electric shocks of the above description. It is evident that upon experiencing the shock, there had flashed into the patient's mind a datum learnt from the conversation she had overheard and apparently forgotten, and that this memory furnished the suggestion at the base of the palsy she developed.

A suggestion need not even be explicit, but is often implicit in the whole conduct of those who surround us. It may occur in consequence of manifestly insincere attempts to minimize what the patient sees that from their very manner those

who surround him believe to be gravely dangerous. Alarm is difficult to conceal, and is very contagious, but it is soon dissipated when a reassuring idea is successfully implanted. Some theorists believe that the trauma of fright increases susceptibility to "neurosis" by creating new physiologic dispositions in the spinal and lower neurons; but we have no evidence to show that such dispositions are modifiable volitionally. The true neuroses, that is functional affections of lower nerve paths the physical basis of which it at present unknown to us, can be neither acquired nor removed by psychic means. To telencephalic anomalies the word "psychosis[18] should be applied, and the traumatic neurosis is of this type; for, to explain the reactions of these patients, we must invoke the labile differentiability of neopallial, psychic adaptation rather than the inherent neuric arrangements which are disposed toward the precurrent and consummatory reflexes phylogenetically organized, which we call instincts.

Hence, traumatic neurosis is only one form of suggestion psychosis; for suggestion is sufficient and efficient, and no other alleged cause is even essential; that is to say, the condition is pure hysteria, for its primary symptoms are each "susceptible of production by suggestion and of removal by suggestion-persuasion."

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THE PRESENT STATUS OF OBSTETRICAL EDUCATION IN EUROPE AND AMERICA.

Being the Report of the American Gynaecological Society's Committee, With Recommendations, for the Improvement of Obstetrical Teaching in America.

The committee, consisting of Dr. B. C. Hirst (chairman), Dr. E. B. Cragin, Dr. J. C. Edgar, Dr. C. M. Green, Dr. E. P. Davis, Dr. J. W. Williams, and Dr. J. C. Webster, reported as follows:

Your committee has received reports from Great Britain, Germany, Austria, Switzerland, France and Italy. In contrast with the present system in those countries, a report is submitted from seven representative medical schools in the United States, which may be fairly classed among the best medical schools in this country.

Great Britain.

A course of lectures, thirty to forty or more each year, is given in obstetrics in all London schools. It usually extends over two years and lectures on gynaecology are given at many schools in addition to those in obstetrics. You will find details as to hours in the "British Medical Journal" for September 4, 1909.

The work in obstetrics consists of these lectures, clinical teaching in the obstetrical wards (most of the general hospitals now have beds for this numbering from eight to twelve). A class of practical obstetrics, demonstrations in the museum, personal attendance on about fifty cases each student, the number varying with the different hospitals. Each student must attend twenty cases and in addition each university student (Oxford and Cambridge) must have previously attended cases in the lying-in wards for at least one month.

The teachers of obstetrics also teach diseases of women and their surgical treatment; they are the only teachers who do teach this subject in the medical schools for men students.

(Signed) Herbert Spencer.

Germany.

I have arranged the instruction in obstetrics and gynaecology in the University of Königsberg as follows:

Sixth Semester: Theoretical obstetrics.

Seventh Semester: Obstetrical gynaecological clinic (as spectator); a course in gynaecological diagnosis. A course in examinations of pregnant women.

Eighth Semester: Obstetrical gynaecological clinic (as practitioner). A course on obstetrical operations on the mannikin.

Ninth Semester: Obstetrical gynaecological clinic (as practitioner). A course in microscopical diagnosis. A course in minor gynaecological therapeutics. The physiology and pathology of the new born infant.

Tenth Semester: Obstetrical gynaecological clinic. Course in obstetrical operations. Course in cystoscopy. Physiology and pathology of the puerperium. A demonstration, weekly, for nine weeks of pathological anatomy (with the epidiascope, microscope, etc.)

Each student of the tenth semester must live a month in the clinic where he observes and conducts about forty labors and performs the minor operations.

(Signed) **Professor Winter.**

Austria.

Of the five years' course, the student must occupy himself during one year with obstetrics and gynaecology. During this time he is obliged to attend the lectures ten hours a week. During this time also he must have his practical training in which he has the opportunity to see a large number of labors and to perform minor operations such as perineal lacerations, episeotomy, manual extractions, etc.

There is mannikin practice in the obsetrical operations.

In addition, he receives practical training in the examination of pregnant women and in gynaecological patients and operations performed upon the mannikin.

(Signed) **Heinrich Peham,**
University Professor of Obstetrics and Gynaecology, Vienna.

Switzerland.

1. During the customary term semester medical course, three or four semesters are devoted to obstetrics and gynaecology. Three semesters are obligatory.

2. During this time, the students visit the obstetrical gynaecological clinic and polyclinic where opportunity is afforded them to observe gynaecological cases, to examine pregnant women, and thus to acquire the necessary technical skill. In addition, a certain proportion of the students attend the theoretical lectures on obstetrics and gynaecology, which are not obligatory.

The obstetrical operations are practiced upon the mannikin, and in addition the students occasionally have the opportunity to perform these operations upon the living patient under the supervision of an instructor.

In the final examination, there is required:

1. Practical demonstration of sufficient knowledge in the examination of pregnant and parturient women and of gynaecological patients.

2. The performance of several obstetrical operations on the mannikin.

3. A theoretical oral examination on obstetrics and gynaecology.

(Signed) Th. Wyder,
Director of the Frauenklinik of the University of Zürich.

France.

In answer to your letter of November 26th, I went to see Professor Lannelonge, one of the leading surgeons here, also a member of the Institut de France and senator. The following is a translation of the answers he dictated to me after reading the questions of your letter:

Two terms of six months each are devoted to the study of midwifery and obstetrics. The students of the two clinical departments are inscribed turn about night and day to attend the hospital wards and follow the the labor hour by hour till period of delivery. During a term they can follow about fifteen cases or more if they wish to do so.

The scope of the course in obstetrics includes not only delivery proper but also all the medical or surgical treatment of women's diseases such as, for example, fibromata, disease of theovaries, of the large ligaments, etc.

In France the courses are no more given in a theoretical way but are principally practical demonstrations either in the lecture rooms or in the hospitals (woman's wards). All apparatus or instruments for demonstration are used, mannikin work, ward work, polyclinic service, touch course, etc.

In one word the teaching is very complete and great stress is laid on the assiduity of candidates. One can say that after their two terms of practically two years' duration, the students are quite qualified to undertake any kind of delivery and have a sufficient knowledge of women's disease from a practical view as well as from a scientific one, this study being far from neglected.

Italy.

In Italy there are schools for obstetrics and gynaecology for physicians annexed to all the universities. Equally in all the universities are annexed schools for midwives. In Florence there is the superior institute for obstetricians and physicians.

The course of obstetrics is of one year for the physicans (the full university course for physicians is six years) and the course of obstetrics is by rule assigned at the sixth year. For midwives the course is of two years.

The character of teaching is theoretical and experimental (clinic), and comprises also the assistance of women in labor made by the teachers or by their assistants.

The course includes also diseases of women and their operative treatment, as well as the physiology and pathology of the child bearing process.

The theoretical instruction is given three times a week for the students in medicine, while it is daily for the midwives. The clinic practice is daily for everybody.

The students in medicine and the midwives cannot perform any operation before the end of their course of studies.

The examination is only theoretical.

Columbia University College of Physicians and Surgeons, Medical Department.

Course in Obstetrics.

	Hours.
Second Year. Recitations and demonstrations (once a week for thirty weeks)	30
Third Year. (First Half) Didactic lectures (twice a week for one half year)	30
Clinical lectures (once a week for one half year)..	15
Fourth Year. Practical instruction in hospital and tenements:	

(a) Three weeks' service in hospital; two weeks being spent on day duty and one week on night duty. During this term of service each student receives daily bedside instruction and makes ante partum examinations both abdominal and vaginal on from fifty to sixty pregnant women. Moreover, the students on duty receive a daily clinical lecture and mannikin instruction from an instructor in obstetrics who is the resident obstetrician.

(b) Two weeks' service in the tenements; one week being spent on day duty and one week on night duty.

Each student during his five weeks of practical service delivers personally on an average seven or eight cases and sees from forty to fifty deliveries.

Course in Gynaecology.

	Hours.
Third Year. (First Half) Recitations (once a week for fifteen weeks)	15
(Second Half) Didactic lectures (twice a week for fifteen weeks)	30
Clinical lectures (once a week for fifteen weeks)..	15

Fourth Year. Practical instruction in small sections in dispensary and hospital, twenty-six hours for each student 26

(Signed) E. B. Cragin.

Cornell University Medical College, New York City.

Plan of Instruction in Obstetrics, January, 1910.

	Hours.
Second Year. Recitations, thirty-two hours	32
Third Year.	
Section and mannikin wark sixteen hours........	16
Clinics, sixteen hours	16
Illustrative lectures, thirty-two hours	32
Recitations, thirty-two hours	32
Fourth Year. Clinics	16
Total	144

In addition, students are required to reside for at least two weeks in the Manhattan Maternity or other hospital and personally confine at least six women.

(Signed) J. Clifton Edgar.

Harvard Medical School. Medical Department of Harvard University.

Department of Obstetrics and Gynaecology.

A. Course in Obstetrics.

	Hours.
Third Year. Lectures on the theory and practice of obstetrics, twice a week	64
Recitations, once a week	32
Conferences, once a week	32

Clinical instruction:—Each student spends two weeks in hospital residence, devoting his whole time, day and night, to his obstetrical opportunities. He sees operations and normal deliveries and under supervision and instruction he personally attends from six to ten out-patient cases. After his two weeks of residence he is required to devote a part of his time for a

week or more to completing the visits on his patients and writing reports of his cases.

Fourth Year. (In the Harvard Medical School the work of the fourth year is elective; but all students intending to practice medicine elect obstetrics.)

The class work in sections of from six to ten, and each student in obstetrics devotes his entire time for o month. For two weeks he is in hospital residence, and attends from six to ten out-patients, under supervision and instruction. After his period of residence, he completes the visits of convalescence and reports on his cases. There is a clinical lecture and ward visit every forenoon (except Sunday), at which the student has opportunity for ante partum examinations (inspection, palpation, auscultation, pelvimetry, and estimates of size of foetus, for witnessing normal and operative deliveries, for studying puerperal convalescence, and the care of young infants). Each student has also a course of instruction, with mannikin and foetal cadavar, in which the various obstetric operations are demonstrated and repeated by the student. Each student also writes a thesis on an approved subject of his choice.

(Many of the Harvard students make use of the opportunities afforded by the summer course of the Harvard Medictl School, and thus increase their clinical trainaing. In addition to the many cases witnessed, the graduates of 1909 attended personally an average of twenty-three cases.

B. Course in Gynaecology.

	Hours.
Third Year. (Second Half) Lectures or recitations twice a week	32

Clinical exercises in small sections:—Each student attends six clinics, lasting from one and a half to two hours. In these clinics the student is instructed in physical examination, diagnosis, and the treatment of ambulatory cases.

Fourth Year (elective, taken by a large part of the class).

Instruction is given in sections of from six to ten students, and each student devotes his entire time during the forenoons of two months. The work is clinical and is given in the wards and out-patient department of the Boston City Hospital. Opportunity is afforded for practice in history taking, examination, diagnosis, and minor treatment in the out-patient department. In the house service the student hears clinical lectures daily, has opportunity for physical examinations, and witnesses operations with demonstration; he follows the convalescence of cases, and each in turn assists in the work of the resident staff. Each student also has abundant opportunity for the study, under supervision, of pathological specimens removed in his presence by operation, and each student writes a thesis on an approved subject of his choice.

(Signed) C. M. Green.

Jefferson Medical College, Philadelphia.

Course in Obstetrics.

The anatomy and physiology of reproduction fully taught by the departments of anatomy and physiology in the first two years. Embryology and histology are included in this teachin.

	Hours.
Third Year. Three didactic lectures and recitations weekly	90
Demonstration with the mannikin and diagnosis obstetric manipulations and vaginal deliveries..	18
At least one case of spontaneous parturition in hospital, fully demonstrated by an instructor..	
Fourth Year. Lectures to the entire class, one weekly	30
Hospital ward classes with the examination of pregnant patients, the study of complications of pregnancy, the puerperal period, normal infancy, and complications	16
Clinical conferences in hospital with study of ceses	24
Demonstrations of hospital cases by instructors to small groups of students	16

From two to six cases delivered in tenements and under supervision and instruction.

Written reports of these cases with quizzes upon the reports by a demonstrator.

Record of all work done during the senior year, which record with final examination constitutes final grade for securing a degree.

(Signed) E. P. Davis.

Johns Hopkins University, Baltimore.

Courses in Obstetrics.

Third Year; obligatory course.	Hours.
Recitations and demonstrations twice weekly for thirty-three weeks	66
Mannikin work, once a week for thirty-three weeks	33
Ward rounds and clinics in groups, once a week for sixteen weeks	16
Examination of pregnant patients in groups, once a week for sixteen weeks	16
Total	131
Obligatory attendance of at least five cases of labor under supervision in the ward.	
Optional work and course in obstetrical histology and pathology, two hours a week for eleven weeks	24

Fourth Year; elective work.

Repeated every eleven weeks to not more than ten students each time. Each course occupies ninety-nine hours, not including obligatory attendance on at least ten cases of labor in the out-patient department and attendance at as many operations in the ward as feasible. The course consists of:

Ward rounds	11
Conferences	11
Discharge examination of puerperal women	11

A practical course in pelvimetry	11
A laboratory course in infant feeding..........	11
Nursery rounds	11
A practical and laboratory course on the toxaemias of pregnancy	22
A course in comparative placentation	11

I might add that many of the students in these groups see from twenty-five to forty outdoor deliveries. In each case they are accompanied by an assistant and a trained nurse, and I find that such training is even more valuable than the ward deliveries. They also make visits for the first five, the seventh and tenth days of the puerperium in normal cases, and as many visits as may be necessary in abnormal cases. These visits are checked in two ways, first, by having the student leave a daily written report in the letter box of the resident obstetrician, and secondly, by having the nurse, who makes daily visits for ten days, render a similar report.

(Signed) J. W. Williams.

University of Chicago.

The subjects of obstetrics and gynaecology are taught in the junior and senior years of laboratory, recitation, and conference courses, in dispensary and hospital clinics, and in the conduct of labor in the homes of patients. Students are obliged to commence their studies by taking the laboratory and recitation courses. Final examinations in both courses are compulsory.

Obstetrics.

1. Conference course on normal pregnancy, child labor, and the puerperium. A lecture and recitation course. Each section limited to forty students.

2. Clinical conference on normal pregnancy, child labor, and the puerperium. Prerequisite, course 1. Limited to forty students.

3. Clinical conference on the pathology of pregnancy, child labor, and the puerperium. Prerequisite, courses 1 and

2. Limited to twenty-five students.

Senior Year.

4. Practical obstetrics. Perequisite, courses 1, 2 and 3. Limited to fifteen students.

Clinical obstetrics. In the maternity department of the Presbyterian Hospital, Charity Hospital, Chicago Lying-in Dispensary, Chicago Maternity, and Central Free Dispensary. Prerequisite, courses 1 and 2. Throughout the year. Attendance upon cases of confinement in various hospitals, and at the homes of patients is required of each student before graduation. Each student will be summoned to cases at the time of delivery, and will attend the patients during and after delivery, under supervision. Clinical records must be kept by students and certificates obtained for attendance on five cases.

Gynaecology.

Junior Year.

6. Laboratory and recitation courses: Limited to twenty-five students.
7. Clinical conference: Prerequisite, course 6. Limited to forty students.
8. Dispensary clinics: Conferences in practical gynaecology. Limited to four in each section. Prequisite, course 6. Twenty-four hours. Four minor operations each term throughout the year.

Senior Year.

9. College clinics: In gynaecology and obstetrics. Prerequisite, course 6. Forty-eight hours. Four major operations each quarter throughout the year.
10. Special laboratory work: For a limited number of students selected by the department staff.

Our teaching methods have been gradually changing in the last ten years. Systematic lectures have been entirely or almost entirely abolished and we have endeavored to instruct our students in small classes. Twenty-two majors of work are required in the junior and senior years, three being neces-

sary in obstetrics and gynaecology (at least two majors in obstetrics are required). Most students voluntarily take more than the requisite three majors.

The faculty feels strongly that there should be an extra fifth year in which more clinical instruction could be given. However, as all our graduates are able to obtain interneships, we feel that we are better off than most medical schools.

The enclosed statement of departmental work gives a detailed account of our method of instruction.

We feel that the number of obstetric cases which should be attended by students is too small. It should be at least twelve. We intend to increase this requirement as our clinical facilities improve.

(Signed) J. C. Webster.

University of Pennsylvania, Medical Department.

Course in Obstetrics.

	Hours.
Third Year. Clinical lectures, twice a week........	60
Demonstrations of abdominal palpation, pelmimetry, etc., to individual students, each	1
Attendance on a patient in the hospital under supervision and visits daily for two weeks afterward, average	24
Recitations, voluntary (quiz).	
Fourth Year. One clinical lecture a week for half the year	18
Two weeks of ward class instruction for two hours a day	24
Six demonstrations on the mannikin to sections..	6
One week's residence in the Southeastern Dispensary for outpatient work.	
Number of labors attended by each student, average seven.	
Recitations, voluntary (quiz).	

Scope of instruction. The physiology and pathology of the child-bearing process including all the complications and pathological consequences at all periods and their treatment, medical and surgical.

(Signed) B. C. Hirst.

Recommendations.

We recommend that the teaching of obstetrics should occupy at least two years of the medical course and that those expecting to practice obstetrics, should be urged to avail themselves of elective opportunities.

That the number of labor cases personally attended by each undergraduate student should be at least six, under supervision and instruction.

Character of instruction. We recommend all the known methods of teaching this branch of medicine, namely: Didactic lectures, clinical lectures, clinical conferences, ward classes and touch courses, hospital and outpatient instruction, mannikin practice in operative obstetrics, and recitations.

Of the first three methods, we recommend specially, clinical lectures and conferences.

We recommend that ample facilities should be afforded students to make ante partum examinations, including inspection, abdominal palpation, pelvimetry, foetometry, vaginal examinations, etc.

We recommend that two weeks' hospital residence should be required before the outpatient practice.

Scope of Instruction. It is recommended, that as obstetrics at present includes pregnancy and parturition, their complications and consequences, and the complete recovery of the woman after labor; that obstetrics instruction should include the medical and surgical treatment of these conditions.

The tendency of obstetrics to become more surgical in practice and to require a surgical training, is evidenced by the fact that in medical schools of Europe and in more than

one-third of the first fifteen medical colleges of this country, namely, Columbia, Cornell, Jefferson, Medico-Chirurgical, Tulane, Yale, Long Island, Harvard, Johns Hopkins, Rush, Bellevue, Western Reserve, Michigan, University of Pennsylvania, California, the chairs of obstetrics and gynaecology are combined under one head. Of these fifteen medical schools, six have combined chairs.

(Signed) E. B. CRAGIN,
J. C. EDGAR,
C. M. GREEN,
E. P. DAVIS,
J. W. WILLIAMS,
J. C. WEBSTER,
B. C. HIRST,
Chairman.

INTERNATIONAL COMMISSION ON CONTROL OF TUBERCULOSIS AMONG DOMESTIC ANIMALS.

By M. H. Reynolds, Secretary.

It seems desirable that the public should be given opportunity to know what this commission is doing in as much as the commission represents indirectly the Canadian and United States governments, and involves live stock sanitary control work of all of the individual States.

The last session held at Detroit was devoted largely to reports. There were present representatives of Canadian and American breeders, Canadian and United States Departments of Agriculture, Canadian and American veterinarians. The following reported: Committee on Education and Legislation; Committee on Location of Tuberculosis in cattle; Committee on Dissemination of Tuberculosis; and the Committee on Disposition of Tuberculous cattle. The Committee on Education and Legislation made a partial report presenting a critical study of experience of certain States in their efforts to deal with this problem. The purpose of this was to present full information for the Commission concerning mistakes and failures, and comparative successes of communities that have undertaken serious work with tuberculosis.

The Committee on Location of Tuberculosis in Cattle presented their report under such headings as "Provision for Notification," "Location by Tuberculin Test," "Location of Infected Herds Through Meat Inspection Service," "Most Important Sources of Animal Tuberculosis."

The Committee on Dissemination of Bovine Tuberculosis presented its study under such headings as "Introduction of Disease into the Herd," "Dissemination by Feeding to Calves," "Dissemination by Contact at Shows," "Dissemination by Placing Healthy Animals in Infected Cars," "Dissemination by Pasture Exposure." The discussion on this report gave considerable attention to the problem of tracing back from

the killing floor to the infected farm with a view to detecting the diseased herds and concentrating control work as much as possible on diseased herds.

The Committee on Disposition of Tubercular Cattle reported *concerning the necessity of accepting tuberculin for* diagnosis as a fundamental; the necessity of voluntary co-operation and the superiority of voluntary co-operation to measures of compulsion. This committee considered the feasibility of the Bang and Ostertag methods of dealing with tubercular herds under American conditions. It also made recommendations concerning the relation of indemnity to final disposition of carcass; the principle of carcass salvage; the obligatory disposal of all clinical cases; and a study of the conditions which should determine the disposition of reacting cattle.

A very considerable amount of discussion on this report was given to the question of remuneration for owners and particularly as to whether this should be regarded as a temporary or as a permanent provision in tuberculosis control work. A number of members held that it must necessarily be considered as a useful preliminary and temporary measure.

Careful consideration was given to the possibility of making either the Ostertag or Bang method of dealing with tuberculosis in the herd, or a combination of the two, feasible in America and Canada for grade herds. This is along the line of finding some method more economical than slaughter for as many herds as possible.

The next meeting of this International Commission will be held in Ottawa.

EDITORIAL

The Dominion Medical Association Conference is over for 1910, and now the Montreal Medical Journal becomes the Journal of the Canadian Medical Association. Many McGill men will regret that their journalistic representation, after doing so much for the advancement of medicine, has now gone out of existence as an independent organ, as however good a journal may be, when it is an official organ it must lose its independence.

The question of Dominion Registration came up at the Conference, but owing to the severe criticism of Dr. Lafferty, of Calgary, nothing definite was accomplished, it being evident that the members were anything but satisfied that the individual provincial rights had been safeguarded in the amended bill brought up for their acceptance. Now that matter is settled for a year, Western Federation can occupy our attention without interruption from local and other bodies. It might even be wise for the three western provinces to unite and have a common standard as, at present, they have no medical schools and part of the curriculum of their provincial university in each instance will be medical. Manitoba is very much handicapped by the private corporation—the medical school and its affiliation to the provincial university. This affiliation causes the university to be reluctant to give up its examining powers for license that rightfully belong to the College of Physicians and Surgeons, thus making this Council a nonentity. Yet the profession of Manitoba have to pay the members of Council $10 a day for each meeting and mileage for country members, and most absurd of all a proposal is now being made to pass a by-law to examine on all subjects when in reality they have no power to examine on any.

Dr. Flexnor, as a result of his investigation of medical education in the United States, reports that one of the banes

of the medical profession is the private incorporated Medical School instituted for personal gain and influence.

The elections of the College of Physicians and Surgeons are close at hand and there are rumors that no independent medical man is to become a member of the Council. If this be true, medical affairs in Manitoba are going backwards instead of advancing. Let us hope the election result will prove this to be false.

It is hoped that soon arrangements will be completed for a meeting of the representatives of the various provinces to discuss more fully Western Federation.

EXTRACTS.

Prevention of Ankylostomiasis.

The ankylostoma, or miner's worm, has been for two years the subject of experiments at the college of medicine, Newcastle, England, by Sir Thomas Oliver and Hermann Belger. The chief object was to find a way to prevent infection of wet and ill-ventilated mines. On January 21, 1910, Sir Oliver read a paper before the Society of Tropical Medicine. According to the statements in this paper, of the 41 disinfectants, tried by Mr. Belger, the best was sulphate of iron. This costs $39 a ton. A one per cent. solution of it would cover 100,000 square yards of floor 1 cm. deep. It would prevent the development of any eggs that might be present, and kill larvae within a day. Almost equally effective are cinders. Old cinders are better than fresh, because richer in chlorides. Ankylostoma larvae are often found in the grooves at the sides of main entries. These grooves should be filled with cinders. Cinders should be sprinkled round the sanitary palls, both above and below ground. Salt water is a third possible disinfectant; it kills larvae within an hour. Creosote also kills larvae quickly. Hence when the air is moist and there is no danger of fire, the lower end of props should be creosoted to a height of about half a yard. Ankylostoma larvae are fond of climbing, and wooden props easily become reservoirs of them. Managers of collieries and brickfields in cold climates are apt to think that their winter secures them from the ankylostoma, but Oliver and Belger found that larvae frozen for six days revived and were little the worse. Tenholt found larvae in miners' worn boots, although these had not been in the mud in which the men had been working. This suggests that the larvae may migrate in boots from one minute to another. The interval between the infection of a man (through his mouth or skin) and the appearance of eggs in his feces, is 30 to 35 days.

The Nephro-Toxic Action of Flesh-Meat.

Linossier has recently reported to the Académie de Médecine de Paris some interesting experiments with regard to the nephro-toxic action of various meats. By subcutaneous injection of an acqueous extract of hashed meat he has been able to produce albuminuria in rabbits and guinea-pigs. The minimum dose necessary to cause this condition is very variable even when the same kind of meat is used to prepare the extract, a fact which must be attributed as much to a difference in the renal resistance of various animals as to variations in the toxicity of the meat. Albuminuria appears very quickly after the injection, and only lasts a few hours. It is impossible to cause a typical epithelial nephritis or a permanent albuminuria, even with repeated injections, the animal always dying with marked symptoms of anaphylaxis before such a condition is reached. After contact with natural or artificial gastric juice for two hours the nephro-toxic action of the meat extracts is destroyed, but contact with alkaline solutions does not produce this effect. It would therefore seem that the action of the fluid extract is not due to the extractives contained in the meat, since these are unaffected by gastric juice, but to an inherent property of albuminous material itself. It is probable that man acquires toleration to the toxic action of meat, but this does not mean that heavy meals can be habitually indulged in with impunity. The accidental and excessive use of meat by a vegetarian would probably be productive of harm, but it is fair to suppose that regular and properly graduated meat diet would be beneficial to a nephritic.—The Hospital.

CORRESPONDENCE

Child Emigration.

Sir,—While another reform of the Poor Law is under discussion, I beg to suggest that the problem of poverty is almost entirely that of the dependent children—that is, of the children whose parents cannot afford to, or will not, maintain them properly (feeding, clothing, medical care, school and trade education)—and the solution of the problem of child emigration. The neglected children of this generation are the unemployed and unemployables of the next, the potential parents of the unemployed and unemployables of the next again. Moreover, they are the inevitable result of our failure to realize or insist that people possess their freedom to do the best they can for themselves in the individualistic State, on condition that they do not bring about poverty by begetting children they cannot entirely maintain—on condition, that is, that they observe the individualistic law of parental responsibility. Must we not, therefore, if possible, maintain the dependent children, and not leave them to be neglected under any deterrent system of relief?

To maintain them at home is impossible. A moment's reflection on the inevitably continuous increase of children to be maintained and continuous decrease of rich to be taxed must show this. They will naturally expect to be provided with work, certainly with maintenance, as they grow up. This popular proposal, in fact, is based on the non-individulistic assumption that no man has a right to more property than his neighbors. Besides, its adoption would mean at best only a brief palliation of the chronic poverty evil. To individualists, therefore, it is both logically and economically unsound.

To maintain them in the Colonies, however, is not only a possible policy, but in several important ways a highly desir-

able and attractive one. It is not a fact of great significance that at a moment when our statesmen are desperately endeavoring by what are in effect "schemes of redistribution" to make more room at home for our struggling masses, the legislators of our too scantily populated Colonies should, for strategical as well as economical reasons, be eagerly encouraging British immigration? And are not our safety and well-being bound up together? *Let us, then, adopt a policy of* child emigration—a policy to seek out the neglected children, take them from their parents, send them to the Colonies, and maintain them there till they become self-supporting. Surely it were better to pay for their keep abroad for a few years, with every prospect of immediate happiness and of future independence and imperial usefulness, than to maintain them at home, indefinitely and discreditably, simply to produce their unhappy kind. By such elimination—a regenerating elimination—of these potential parents of dependent children, the production of the latter would fall rapidly to the irreducible minimum; while the liability of parents to contribute as far as possible to the cost of emigration would discourage their birth in some cases and their neglect in others. The Poor Law system that embraced some such policy of child emigration would have the novel satisfaction of being really charitable—that is, of curing poverty as it relieved it. Money spent on what would in effect be the conversion of British slums into Colonial farm-cottages would surely be well and cheerfully spent, and the certain decrease in the annual sum required would be a recurring benediction on the good work that is being done—a work with encouraging promise in it of the continued imperial ascendancy of our race.—I am, etc.,

BINNIE DUNLOP, M.B., Ch.B.

London, April 18th. (Taken from British Med. Journal.)

MEDICAL NEWS

Manitoba Medical Association elected the following officers for 1910-11: President, Dr. F. S. Keele, Portage la Prairie; 1st Vice-President, Dr. H. M. Speechly, Pilot Mound; 2nd Vice-President, Dr. F. S. Schaffner, M.P., Boissevain; Secretary, Dr. Halpenny, Winnipeg; Treasurer, Dr. Roche, Winnipeg. Executive. Dr. Matheson, Brandon; Dr. Gordon, Portage la Prairie; Dr. Ross, Selkirk; Dr. Montgomery, Deloraine; Dr. Harrington, Dauphin. Dr. J. H. O'Donnell, Winnipeg, was elected honorary life member of the Association.

A movement has been started in Germany for the cultivation of ambidexterity. The idea is that the development of this power means the development of the intelligence in general and the memory in particular.

In the final medical examination for McGill, the prize for the highest aggregate in all fourth year subjects was won by A. MacMillan, of Victoria, B. C., and the Wood gold medal for the best examination in all chemical branches by Sidney B. Peele, of New Westminster, who also won the Woodruff gold medal for special examinations in ophthalmology and Otolaryngology.

Other Western men who took their M.D. were: A. L. Crease, Nelson, B. C.; C. Ewert, Gretna, Man.; H. H. Hepburn, Edmonton, Alta.; H. McMillan, Vancouver; W. J. McAllister, Winnipeg; H. W. McNaughton, Moosomin; K. L. A. Patten, Armstrong, B. C.; Sidney B. Peele, New Westminster; George T. Wilson, Vancouver.

A twenty thousand dollar addition is to be made to the General Hospital of Medicine Hat, Alta.

28 candidates sat for the semi-annual examination for registration as medical practitioners in British Columbia. The examiners were: Drs. Proctor, Walker, Sutherland, Tunstall, Fagan, Jones and Glasgow, the latter being a Seattle Homeopathist.

Dr. Pollard left for Chicago. He will be away about two weeks.

By arrangement with the provincial government, Mr. Ed. T. Judd, a well-known dairy expert of Salem, Oregon, will address a series of farmers' meetings through the Fraser River Valley and the interior. He pointed out the by the adoption of a sanitary milk supply at Rochester, N. Y., the infant mortality had been reduced over 65%. He commented on the absence of any Dominion, Provincial or City ordinance, providing for inspection of the milk supply.

The directors of the Royal Columbia Hospital, New Westminster, have decided to erect the new hospital at Sapperton.

At a meeting of the General Medical Council, Premier McAllister referring to the forthcoming conference in Canada regarding the possibility of federal action in respect to medical registration said that should that conference lead to the establishment of a Canadian Medical register, the question of reciprocity between Britain and Canada would be greatly simplified. He expressed the hope that this would be speedily obtained. The Council resolved that anyone who held a license of the educational council of the P.E.I. should be entitled to be registered on the Colonial list of the medical register.

The Women's Auxiliary of the Royal Jubilee Hospital Society, Victoria, propose to rebuild the main portion of the hospital to the late king. Hospital Day was instituted by the late king.

Dr. W. W. Musgrove, who was sent to Steinbach and Gruenthal, in the Municipality of Hanover, where the typhoid outbreak occurred recently, reported that the people in the district had not the slightest idea of sanitation disinfection or precautions against the spread of infectious diseases. Dr. Musgrove recommended that Health Officer be appointed and strongly backed by the Provincial Health Officer. Also that a Coroner be appointed.

It is getting to be the unanimous opinino in Vancouver as in other western cities that the hospitals should be public institutions under municipal control, accepting and benefiting

by charity, if offered, but not entirely dependent on it.

That it was time to seek aid from municipal and provincial governments in order to enable poorer persons to have their teeth properly cared for was one of the chief points brought up for discussion at the recent Dental Convention. Reference was also made to the Conservation Commission having a Department of Public Health and it was urged that it was the duty of the dentists to take part in that movement.

It has been decided to locate the Vancouver Isolation Hospital on the Military Reserve opposite Barnet.

The Medical Health Officer of Vancouver is preparing a Lodging House By-law.

Dr. Geo. Porter, of Toronto, secretary of the Canadian Association for tuberculosis, is visiting the West and giving a series of lectures.

In New York two women have committed to them the duty of discovering what is the matter with the children who cannot keep up with the work of their grades. One, Miss Farrell, is a student of the Children's Minds, the other, Dr. Smart, is a specialist in nervous and mental disorders.

At the Canadian Medical Conference recently held, the report of the Milk Commission was presented. Dr. Hastings said that the reason for the existence of the Commission lay in the lamentably large infant mortality and the fact that at least 50% of those who die under the age of five years do so from some preventible disease and under the age of two years the proportion was 90%. Pasteurized milk was the only safe way. Two years ago a pint of certified milk could not be purchased in Toronto, while now 470 quarts were sold daily as well as 36,448 quarts of officially pasteurized milk. 4,956 quarts pasteurized cream and nearly 200 quarts from the plant of the Hospital for sick children—altogether almost half of the milk supply.

The B. C. University Site Commission are now investigating the claims of the various cities which are desirous as a location for a university. This is very important from a medical standpoint, as more than probable the Tropical School of Medicine for the Dominion will be at the same place.

PERSONALS

Dr. and Mrs. Mansell have returned from California.

Dr. Kerr, of Alberni, is isiting the Coast.

Dr. and Mrs. J. H. Jones and Children have gone to the East for the summer.

Dr. McPherson, of Vancouver, who has been visiting Ottawa, has returned home.

Dr. Sutherland has returned to Revelstoke.

Dr. and Mrs. Hosmer, of Hosmer, B. C., have been visiting Vancouver.

Dr. and Mrs. Herman Robertson, of Victoria, are now at Leipsic where Dr. Robertson is taking a special course in the hospitals of that city.

Dr. Barrett, of Dawson, is visiting Vancouver.

Dr. MacKechnie is visiting the Okanagan Valley.

Dr. and Mrs. R. G. Montgomery, of Winnipeg, have gone East for a holiday.

Dr. Matheson, of Brandon, has returned from hospital work at Chicago.

Dr. La Chance has been elected coroner for St. Boniface.

Dr. Dubuc has been elected Medical Officer of Health for St. Boniface.

Dr. Seavery, of Port Townsend, is visiting Vancouver.

Dr. Brigante Colonna, of Tracha Valley, is visiting Vancouver.

Dr. and Mrs. Higgins, of Hosmer, are visiting Victoria.

Dr. and Mrs. Hutchinson, of Winnipeg, have gone on a visit to Toronto and New York.

Dr. Pennington, Moose Jaw, has gone for a vacation in the Rockies.

Dr. Irving, of Yorkton, has resigned the coronership and has gone East for a holiday.

The following attended the Canada Medical Conference: Drs. Lafferty, Camseli, Irving, Hutchinson, Halpenny, Gunn, Blanchard, Fagan, Tunstall.

Dr. Hastings, of Dttawa, head of the Milk Commission, operating under the auspices of the Canadian Medical Association, is in Vancouver conferring with the local authorities on the "Pure Milk" question. It is understood that the federal authorities contemplate legislation that will give civic authorities control over the milk supply in their respective jurisdictions and Dr. Hastings is obtaining all possible information in order that Ottawa may be advised as to the best regulations to be adopted.

VITAL STATISTICS

Winnipeg, May, 1910.

Diseases.	Cases.	Deaths.
Typhoid Fever	8	—
Scarlet Fever	48	—
Diphtheria	24	3
Measles	201	1
Tuberculosis	17	8
Mumpt	5	—
Erysipelas	4	1
Whooping Cough	1	—
Chicken Pox	2	—
	310	13

Births: Male, 174; Female, 167.
Deaths: Male, 71; Female, 77.
Marriages: 169.

A Very Grave Error

The experience of many of the best men of the profession, not only of the United States but also in this country, has established the clinical value of antikamnia tablets. Among those who have paid high tributes to their value and who occupy positions of great eminence, may be mentioned Dr. J. Acheson Wilkin and Dr. R. J. Blackham, practitioners of London. They have found these tablets of value in the neuralgias and nervous headaches resulting from overwork and prolonged mental strain, the pains of sciatica and locomotor ataxia, painful menstruation, la grippe and allied conditions. Indeed the practitioner who has such cases as the latter come under his observation, and who attempts their relief by opiates and stronger drugs, when such an efficient and harmless an agent can be used, commits a grave error. Experience goes to prove that two antikamnia tablets taken in a wineglass of sherry, every two to four hours, will carry the patient through a painful menstrual period with great satisfaction.--*MEDICAL REPRINTS, London, Eng.*

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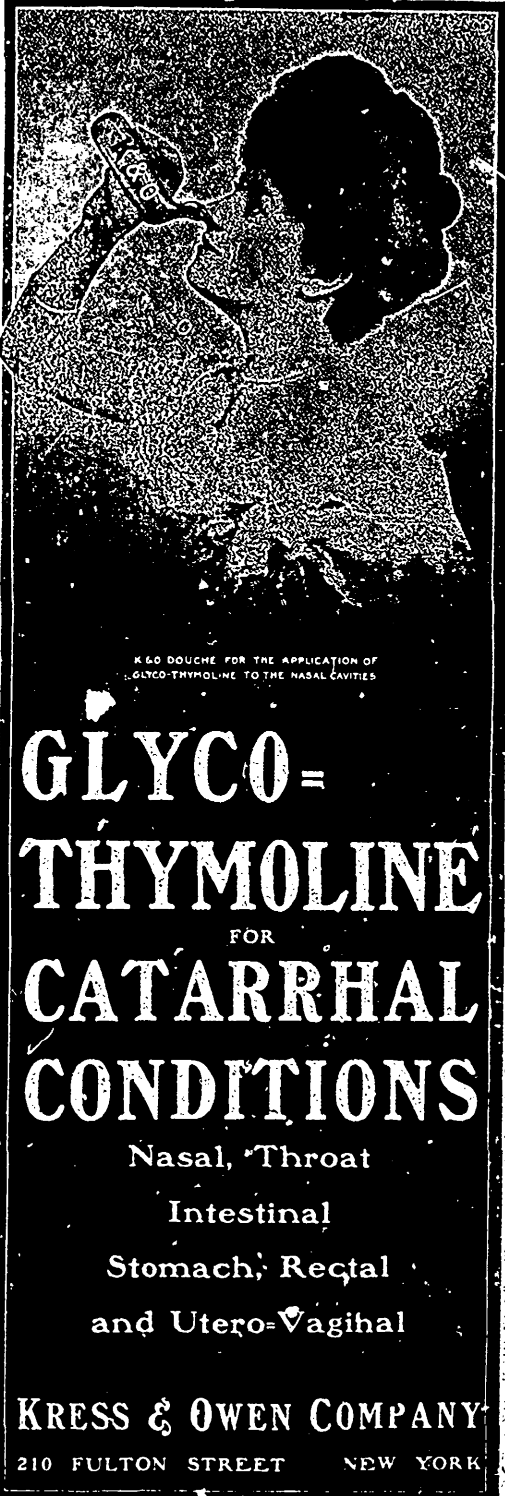

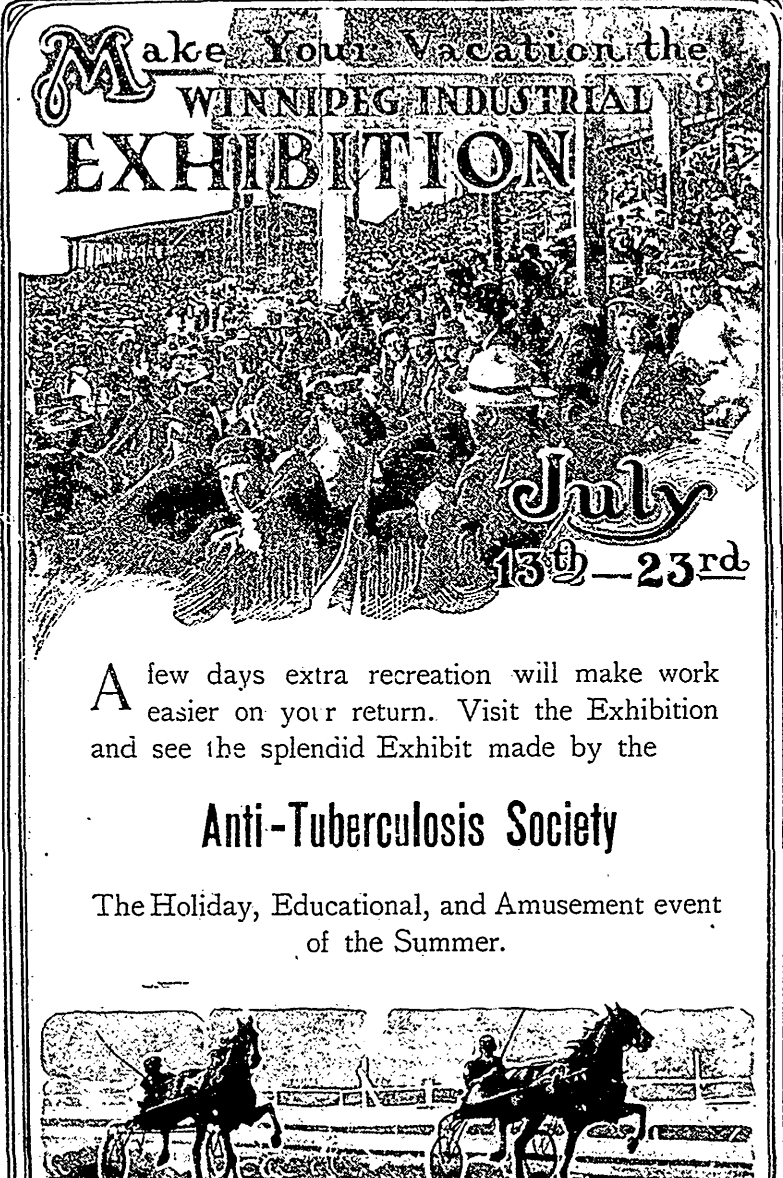
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Application for entry must be made in person by the applicant at a Dominion Land Agency or Sub-Agency for the district in which the land is situate. Entry by proxy may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned *solely by him, not less* than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(3) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming lands owned by himself must notify the Agent for the district of such intention.

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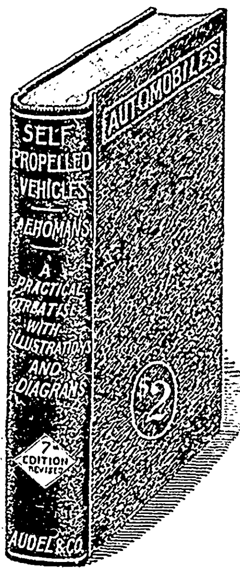

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