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Original Articles

PRESIDENT'S ADDRESS.—CANADIAN MEDICAL ASSOCIATION, 1904.*

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Mr. Chairman and Gentlemen,—I feel that my first duty to-night is to offer you my very hearty thanks for the honor you have conferred upon me in electing me President of the Association for the ensuing year.

When I recall the names of those who have preceded me in this chair, I can only ask your indulgence for the deficiencies you may find in me, of which I am very conscious, and express the hope that under my presidency the interests of the Association may in no wise suffer nor its honor be in any way tarnished.

The present occasion is no ordinary one. In the appointment of a President from among the members of the Association whose home and work lie in this far distant portion of the Dominion, and in our meeting here to-day at the Doorway of the West, a new departure has been made.

I am far too modest to suppose for an instant that any particular merit of mine has induced the Association to make this departure; rather I conceive it to be due to a general recognition of the claims and standing of the western members as a whole, and of the growing importance of this fair Western Province.

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I should be performing my duties but poorly did I not seize this opportunity to thank you on behalf of my western confreres, and on behalf of the people of this Province in general, and of this city in particular, for the compliment you have paid us in selecting this Province and this city as the place of meeting for this year, and I feel I am only expressing their wishes in tendering you a hearty western welcome to our midst, and their hopes that your brief stay among us will be both pleasant and profitable to you all.

To many of you, probably to most of you, the rapid progress and general development of this young Province will come as a surprise. It does to most of our visitors from the older parts of the Dominion who know how recent has been the settlement of the West. And certainly, looking round one, it does seem scarcely realizable that the site of this rapidly expanding city, of which its citizens are so justly proud, and the very spot on which this building stands, surrounded by so many comforts and refinements of modern life, was, less than two decades ago, a wild and almost impenetrable virgin forest, the haunts of the bear, the deer and the primitive savage.

It is less than a score of years by two that the incorporation of this city took place, and yet to-day it will compare favorably with many cities of the older Provinces twice and thrice its age. From the medical standpoint it is reaching after a high ideal.

The incomparable water supply, which is brought in close steel conduits, from the bosom of the mountains to the north of us; the sewerage system, with its septic tanks, that deliver their effluent into tidal waters; the paved streets, with their array of cleaners; the cement sidewalks which are now throughout the city rapidly replacing the earlier and cruder planking; the public and private hospitals; the General Hospital, which is now being built, and which, when finished, will be the peer of any hospital of its size, all make it clear that we are endeavoring to keep abreast of the times, as well in sanitary as in other matters.

It is no idle boast, then, if I say that in the West events move rapidly. Time is no sluggard here, and we see history fashioning itself before our eyes. The whole of this great Province was in undisputed possession of savage aborigines a half century ago. The closing years of the first half of the nineteenth century saw the first real settlement made on Vancouver Island at a place called Camosum, in the native tongue, now Victoria, the capital of the Province.

A few years later, in 1858, an Act was passed in the Home

Parliament to provide for the government of this new colony, thereafter to be known as British Columbia. From this date the real settlement of the Province begins. The discovery of gold in the Fraser and Cariboo soon made these districts as famous and as widely known as Sacramento or Ballarat and a great inrush of population was the result. But a very few years later the conception of that colossal and momentous undertaking, the building of the Canadian Pacific Railway, began to shape itself in men's minds, and was finally carried out. You are all, doubtless, familiar with the history of this great undertaking and know the almost insuperable difficulties its earlier promoters had to contend with, and how in the end, in spite of political, natural and every other obstacle and hindrance, they successfully carried through the scheme and made possible the union of British Columbia and the great North-West with the rest of Canada, and gave us as a result that splendid heritage, that united land which stretches from ocean to ocean, from the rising of the sun to the going down thereof—a land of which all her sons and daughters are so proud—our beloved Canada.

It is gratifying to the profession to know that it has been ably and honorably represented among those history-makers in the persons of Drs. Helmcken and Tolmie, who were the first medical men to settle in the colony, about the middle of the last century. Both took prominent parts in the earlier events of the Province. The former still remains with us; the latter has gone to his rest. Prior to their advent the native Medicine-man had it all his own way.

There is a significance, not without interest to my mind, in the fact that this Association, representing as it does to-day in its various members the highest medical knowledge of this enlightened part of the world's history, should meet here in this new country, where Shamatism, or the cult of the savage Medicine-man, so recently prevailed, and does to some extent still prevail. The old and the new order of things are thus brought into suggestive contrast and juxtaposition, and we are led naturally to reflect upon the stages and steps we have passed since the days when all medical knowledge was comprised in the superstitious and rude practices of our savage prototypes; and in spite of our sometime failures and our lack of knowledge, still in certain directions the reflection on the whole is a pleasant and gratifying one, both to ourselves and humanity at large. It certainly would not be the least interesting of subjects were I to attempt on this occasion a general survey of the march and progress of medical

science from the days and practices of the primitive Medicine-man as we find him even in this Province, down to the times and discoveries of Lister, Pasteur, Virchow and their followers.

But it is not my intention to undertake such a task to-night, interesting and appropriate as it might under the circumstances be, although I cannot leave the subject without calling your attention briefly to a fact of which all of you may not be aware, and which gives pertinence to my reference to the old-time Shaman or Medicine-man. We are all familiar with hypnotism, but there are few of us, perhaps, aware that in the employment of hypnotism as a therapeutic agent we are returning to primitive methods, to the practice of our savage prototypes. Those who have made special study of the practices and customs of 'savage races' inform us that the primitive doctor, or Medicine-man, was not that self-conscious fraud and humbug, knowingly duping his credulous patients, he is thought to have been, but a person who had a real belief in his own powers and cures; and that those powers and cures were, when genuine, generally, if not always, attributable to hypnotism, especially to that phase of it known as suggestion. A state of hypnosis was induced in his patient by the monotonous droning of his medicine song and the noise of his rattle, and when in this condition his attempt to extract the spirit of the disease from the patient's body, and his statement that he had presently accomplished it, acted suggestively upon the imagination of the patient and effected the cure. "Extremes meet," and "there is nothing new under the sun," we are told, and the school of Nancy, which is founded upon the suggestive phase of hypnotism, is not a new practice, but an unconscious return, or rather I should say it is an unconscious modification and extension of these primitive methods which were in vogue among our savages here up to a few years ago, and may be to this day, for aught I know to the contrary.

But enough on this head. It is my intention rather to bespeak your consideration to-night of a point or two which I, in common with many of the members of the profession, have very much at heart, and which I deem of such importance as to merit our most careful consideration and endorsement.

I have reference, in particular, to: 1. The Canadian Medical Protective Association. 2. The Federal Health Bill. 3. The Dominion Medical Council. 4. The Treatment of Inebriates.

With regard to the first, The Canadian Medical Protective Association, I would desire to urge upon members the strong claims this Association has upon the profession. I am among those who believe in the need of such an Association, and that it

may be made a valuable means of assisting and protecting members of our profession from wrongful actions-at-law, to which we are all of us at all times liable; actions brought by irresponsible persons for alleged malpractice, or by unscrupulous persons for the purpose of obtaining money under threats of injury to our professional character.

It is well known that a medical man's professional prospects depend to a very large extent, if not entirely, upon his professional reputation, and it is not difficult, therefore, for unprincipled persons to attempt to levy blackmail upon him by threatening to bring action against him for malpractice or professional incapacity, which action, though wholly groundless and undeserved, may have the most disastrous effects upon his career and pocket.

During the past two years the Association has fought out several such cases successfully, and has amply demonstrated its usefulness and justified its existence. It is, therefore, a matter of wonderment to many of us that the Association has thus far received so little encouragement or support from the profession as a whole. Out of a possible 5,500, the total membership last year was only 252. This is altogether too small a number to make the aims and work of the Association effective or sustain it in a solvent condition, and I welcome this opportunity to invite your earnest co-operation in enlarging its membership and strengthening the hands of the Executive, and would to this end suggest that a special committee be struck during the Convention for the purpose of considering how best to enlist the sympathies and support of our brethren who are not yet members. I cannot but think that a large increase in the membership must inevitably result if the aims of the Association be once rightly understood.

The objects of the Association are such as all can subscribe to. It is not intended to defend or assist in defending unworthy members, or those who are actually guilty of malpractice, or who have brought discredit upon the profession. It aims rather to assist the worthy, those of its members who are wrongfully charged and whose character and reputation are placed at stake; and also to deter irresponsible and unscrupulous persons from bringing action against members of the profession for the purpose of spiting or injuring them, or of exacting a bribe for their silence; and it is only by uniting ourselves together in such a way as this Association offers that we can hope to secure the support of our brethren and become immune to many attacks which would otherwise be made upon us.

I feel, therefore, that we have but to devise some plan of arousing the interest of our brethren in the matter to ensure their support and co-operation.

And now a word or two as to the Federal Health Bill. Thanks to the energetic efforts of the special committee appointed to attend to this matter considerable progress has been made towards the attainment of our desires in this behalf. The interest and sympathy of the Ministers of the Crown have been secured, and the Minister of Agriculture, the Hon. Mr. Fisher, under whose department the matter more directly falls, has taken the matter up most courteously and is thoroughly alive to its urgency and need. For the information of those not familiar with this subject, I would briefly say that the Association, at its meeting in Montreal in 1902, placed itself on record by resolution to the effect that it is expedient that a Department of Public Health be created by the Dominion Government and administered under the authority of one of the existing Ministers of the Crown, thus bringing all general questions relating to sanitary science and public health under one central authority to be known as the Public Health Department. There is no need for me to dwell upon the importance or desirability of this step; it must commend itself to every member of the profession.

Thus far the Government has not seen its way to grant the desired measure. The work is not yet accomplished, and the need of pushing the matter still exists. I sincerely hope the meeting will not dissolve without first passing a strong resolution in favor of the measure, and thus encourage and strengthen the hands of the committee who have this work in hand.

And now I desire to touch upon my third point, which I regard as of the highest importance. I refer here to the Dominion of Canada Medical Act, which was assented to in the Federal House in 1902. We are under a deep debt of gratitude to the members of the special committee, and especially to Dr. T. G. Roddick, for his untiring efforts to get this measure placed upon the statutes of the country, and it is with great regret that I notice so much misapprehension as to the scope and powers of this Bill still exists in certain quarters. It has been thought that it would encroach upon the rights and privileges of the different Provincial Medical Boards and interfere with their autonomy, and I gladly hail this opportunity to say a few words which may help to remove this misapprehension. It was, and is, not in any way intended to interfere with existing provincial rights or in-trench upon the prerogatives of Provincial Medical Boards. As an instance, in my own native Province, Québec, our French-

speaking brethren will have the right of examination in their own language.

Provincial registration and Provincial Boards will still continue to exist, and each Province will be at liberty to fix whatever standard it pleases for its own practitioners. They can, where they wish, continue as examining boards with power to grant provincial licenses, as they do now, and in any case in their hands will be left all matters relating to taxation and professional discipline.

The Bill is a purely permissive one, and though it has been placed upon the statutes of the country, it will be necessary, before it can become operative, to have the consent and cooperation of all the Provincial Medical Boards. Each Provincial Board will have to seek a slight amendment to its present Medical Act. This is all that is now required to make this most desirable measure effective, and I sincerely trust that this consent and cooperation will not be long wanting, for the aims and scope of this Act are such as should commend themselves to every member of the profession. Briefly, I would say that the main purpose of this Bill is to establish a Central Medical Council of Canada, with power to examine candidates and grant licenses, the possession of which shall ensure to the holders thereof such a medical status as will enable them to practise not only in all parts of the Dominion, but in the United Kingdom as well, or, indeed, in any portion of His Majesty's Empire, in short, to do away with those mortifying disabilities under which a medical man trained in Canada now labors, and put him upon a footing of professional equality with his brethren in other parts of the Empire. This is assuredly a laudable and most desirable object, and one which, in my humble opinion, should call forth the best efforts of each one of us to bring about its accomplishment; and I sincerely trust that some concerted action will be taken in this matter before the meeting closes.

It is the least, I think, we can do to show our appreciation of the strenuous efforts exerted in securing the passage of so important a measure.

This brings me to my fourth and last point, "The Treatment of Inebriates." A conviction has been steadily growing in the minds of most medical men of late years that something should be done for the care and control of dipsomaniacs and inebriates in the form of founding establishments combining the main features of a hospital and an insane asylum, where drunkards could be legally confined under medical authority and treated in a systematic and enlightened manner. The practice, hitherto, of

treating them as criminals subject to a fine or short periods of confinement in the common prisons of the country, has been shown to be wholly unsatisfactory and often productive of the greatest evil to themselves and those who may be dependent upon them.

There can be no doubt, I think, that the care and treatment of those unfortunate members of society is a question of the gravest and most vital importance, and should command the interest and attention of medical men as a subject, which, coming well within their province, affects so seriously the general commonwealth.

A movement towards this end has already been taken in Ontario, and a Bill drafted, the principles of which have received the endorsement of the Toronto Medical Society, and also of our own Association; but what we want is a Dominion Act affecting the whole country; and it would be the source of the greatest satisfaction to me if this meeting would take this question up seriously and nominate a committee to draft a measure that could be submitted to the Federal authorities. This could be done either on the lines of the Ontario Bill or any others that might commend themselves.

Speaking, personally, I may say that I shall be only too glad to help in drafting such a measure and giving any other assistance in my power, for I am convinced that the adoption and carrying out of the provisions of a bill of this kind will do much to diminish the volume of sickness, pauperism, vice and crime that now stains the annals of our country and restore to lives of usefulness and self-respect many of those poor unfortunates whom it is the design of such a measure to control and help.

Before closing my address, I wish to express to our visiting brethren my appreciation of the kindly feeling and interest which have actuated them in taking part in the deliberations of our National Association, and to hope that their stay may be fruitful of pleasant reminiscences.

And now, gentlemen, I must thank you for your kind reception of me as your President this year, and for the patient and courteous hearing you have given to my remarks, and trust that the suggestions I have ventured to offer may meet with your approval and receive your support.

TREATMENT OF PROSTATIC HYPERTROPHY.*

BY T. K. HOLMES, M.D., CHATHAM, ONT.

Prostatic hypertrophy is so common in advanced life and so surely undermines the health and embitters the declining years that its treatment must always appeal to medical men very strongly.

Until quite recently the use of the catheter afforded the chief and almost the only means of relief. This is only palliative, and so often leads to infection of the bladder, with all its concomitant evils, that I have no hesitation in saying that it should never be resorted to by any unskilled person. I have never known a patient to use a catheter himself for any considerable length of time without causing infective cystitis and its resulting train of distressing and dangerous sequelæ.

Within the past few years various operative measures have been tried for the cure of this ailment, and the accumulated experience resulting from these have enabled surgeons to estimate pretty accurately the value of each. Castration, vasectomy, prostatectomy, and the Bottini operation are the only radical methods of dealing with prostatic hypertrophy advocated at the present time. There are undoubtedly cases in which castration or vasectomy has proved beneficial, but there are obvious objections to these operations, and the results are so uncertain that they are not likely to be adopted in many cases. I have tried both several times, but probably from lack of skill in the selection of cases, none of them were cured, and I soon abandoned these modes of treatment. Prostatectomy was formerly considered an operation of much danger and difficulty, but modern technique has overcome these to a great degree. The mortality in skilled hands is quite low, and the results when recovery takes place are so good, that it is likely to be the operation of choice in a large number of cases. Men who have not had their general health injured much by the disease, whose kidneys are sound, and in whom general anesthesia would be safe, bear prostatectomy well. On the other hand, the Bottini operation, which can be performed under local anesthesia, is well suited to men of low vitality, to whom general anesthesia would be dangerous, whose kidneys may have undergone

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organic change, and whose general condition would render them incapable of prolonged confinement in bed. This operation has also given excellent results in younger prostatics whose general condition is good, so that I feel sure it has a wide scope of usefulness when skilfully carried out. I have spoken to many surgeons both in Europe and America about the Bottini operation, and have found that it is generally looked upon with disfavor, but I have further observed that the unfavorable opinions expressed are by men who have had little or no experience with it. The chief objection raised is that the operation is done under circumstances that render the destruction of the tissue uncertain in extent; that drainage, which is important when there is cystitis, is not well secured, and that the operation is not entirely free from danger. These objections have been largely overcome by improvement in the Bottini apparatus, and by the careful and systematic use of the cystoscope to determine the size and character of the enlarged gland, preliminary to treatment. Whatever plan of radical treatment be adopted, it is desirable to first endeavor to secure as healthy a condition of the urinary apparatus as possible. This can be done by suitable diet, by irrigation of the bladder, and by the administration of urotropin, in doses of eight or ten grains, three times a day.

In prostatectomy, the gland may be reached through a suprapubic opening, or by a perineal incision, or by a combination of both. In my own practice I have found the perineal route so satisfactory that I have always adopted it. The operation of suprapubic lithotomy has convinced me that in a man with thick abdominal walls it would be far from easy to reach the gland with the finger to enucleate it, whereas in a similar case the gland can be easily drawn down into the perineal wound and enucleated with great facility. If a patient has passed the age of sexual vigor, the plan of operation recommended by Darker Syms I believe to be the most satisfactory. The various steps in the operation are as follows: Place the patient in the lithotomy position with his hips well elevated; introduce a grooved sound; make a median skin incision about two and a half inches long, terminating posteriorly near the anus and deep enough to divide the tissue covering the muscles; retract the muscles and divide the recto-urethralis transversely near its anterior attachment and retract this muscle backward towards the rectum. This will expose the membranous urethra, which may be opened by cutting down in the grooved sound, and the incision should be continued until the gland is reached

and slightly incised through its capsule. Now remove the sound and explore the bladder with the finger and determine the size and shape of the part to be removed. If a stone is present, remove it with stone forceps. Syms' rubber bag should now be introduced into the bladder and moderately distended with water and the stem clamped with forceps. Traction on the bag will now bring the gland within easy reach, and while the left hand retains it in this position, the right index finger can be insinuated between the gland and its capsule at the point where it has been divided, and by gentle means the whole gland, or one lobe of it, can be enucleated. During the enucleation of the deeper part, it facilitates the operation to seize the gland with lobe forceps and make moderate traction.

Having removed one lobe, the other is dealt with in the same way. Instead of cutting backward through the capsule when the urethra is opened, I have sometimes found it more convenient to snip the capsule of one lobe with scissors, enucleate it in the usual way, then deal with the opposite lobe in the same way. The bag may now be allowed to collapse by letting the water escape, when it can be easily withdrawn from the bladder, and all blood flushed out by hot saline or boracic acid solutions. There is not much hemorrhage if care be taken to avoid the plexus of veins in the capsule. In this operation the only muscle cut is the recto-urethralis, and so very little injury is done to the perineum. The superficial part of the wound may be closed anteriorly by cat-gut sutures. At first all the urine passes through the perineal wound, but this gradually closes, generally in from three to seven weeks. When there has been much cystitis the prolonged drainage through the perineum is advantageous. Before enucleation begins a bar can often be felt at the neck of the bladder between the lateral lobes, which disappears when these have been removed, which shows it to have been merely a ridge or normal tissue. Of course, if there be a middle lobe of gland tissue, it must be taken away also. This operation can be done quickly, generally in ten to fifteen minutes, and there is little hemorrhage and no shock. In this operation the ejaculatory ducts which open into the urethra just near the apex of the gland are usually injured or destroyed, but if the sexual function has disappeared this is immaterial. In younger men the injury to these ducts may be avoided by adopting a plan devised by Dr. Young, of Baltimore. This consists in making a small opening in the membranous urethra, without extending the cut backwards to the gland. A metal tractor, which was exhibited, is then introduced into the bladder

through the incision in the urethra. One blade is made to revolve 180 degrees, and fixed there by the screw. By this means the two blades may be made to engage the lobes of the gland, and by pulling downwards the parts to be removed are brought prominently into the wound and the operation performed under visible control. With the gland drawn prominently into the wound by the tractor held in the left hand, an incision on each side of the urethra is made through the extravescical capsule nearly the whole length of the lobe. Between the incisions is a bridge of tissue covering the urethra in that part of its course, and containing the ejaculatory ducts, and by enucleating the lobes through these two incisions the ducts are left intact. After the lateral lobes have been removed, the median lobe, if one be present, may be pushed into one of the cavities by pressure, with the fingers inserted in the opposite cavity, aided by one blade of the tractor, and removed in that way.

I have found rather more difficulty in Dr. Young's method than in the use of the rubber bag, but he has acquired such facility in this branch of surgery that what would be difficult to less experienced surgeons is very easy to him. Dr. Young advises continuous irrigation of the bladder for several days if there has been much cystitis. This is accomplished by a double tube introduced through the wound in the urethra and connected with a reservoir, which is kept filled with a warm salt solution, and the return flow is conducted into a receptacle on the floor through the return flow tube.

In two operations recently performed I irrigated the bladder for a few minutes with hot boracic solution until it returned free from blood, and used no further irrigation. Neither of these cases had any trouble from omitting the continuous irrigation, and both made excellent recoveries.

In suitable cases the Bottini operation, as performed by Dr. Young, is one of the most satisfactory in surgery, and has some advantages that must always commend it. It can be done under local anesthesia; it is comparatively painless; a patient can be out of bed in two days; the results are excellent, even a feeble patient bears it well, and there is little constitutional disturbance during convalescence. It is in this operation that the skillful use of the cystoscope is all-important, for by its use the surgeon is guided as to the size of the cautery blade to be used and the length of the cut to be made. I here exhibit both the cystoscope and the cautery apparatus. Having decided by the former and by digital examination per rectum which blade is adapted to the case in hand, the patient is placed in the dorsal

position, with the knees drawn up and the feet supported by stirrups. The bladder is now washed out with warm boracic acid solution and an ounce of a 4 per cent. solution of cocaine injected so as to anesthetize the whole mucous membrane, especially the part to be incised and also the urethra. From four to eight ounces of boracic acid solution is next injected into the bladder, the instrument introduced, and the beak turned backwards, where its point can be felt by a finger in the rectum. A stream of cold water is kept flowing through the instrument during the time the blade is heated. The instrument having been placed so that the blade when moved from its slot by the screw in the other end of the instrument comes in contact with the part of the gland to be incised, and all connections having been previously made and tested, the switch on the transformer is moved far enough to bring the blade to a white heat, and it is gradually forced into the gland by the screw which moves it. The blade is thus moved into the substance of the gland at the rate of one centimetre per minute until sufficient tissue has been destroyed, when the current is turned off and the instrument moved in order to make the second cut. Usually three cuts are made, one posteriorly and one on each side. It is well to keep the current on and the blade hot while moving it back into the slot, as it destroys more of the gland and prevents hemorrhage. Dr. Young makes the lateral cuts first. In a case with a pedunculated middle lobe there is risk of destroying the pedicle and leaving the lobe loose in the bladder, but such a condition seldom exists, and can be recognized by the use of the cystoscope. It need scarcely be added that asepsis throughout is essential.

To avoid tedious repetition and to curtail the length of this paper, I shall report two cases, one a prostatectomy and the other a Bottini operation, as they furnish fair examples of the kind.

CASE I.—A man at 63 years of age, good family and personal history. Had noticed a growing discomfort in the urinary organs for seven years. At first there was increased frequency in urination and a diminution in expulsive power, with dribbling at the end of urination. These symptoms gradually grew worse, until at times the urine came only in drops or in a very weak stream. The rest at night was disturbed; there was an unpleasant aching sensation about the bladder and perineum all the time. He had never used a catheter, and the urine was normal. There were two ounces of residual urine. Cystoscopic examination showed moderate enlargement of the lateral lobes and a bar joining them. There

was no cystitis. The sexual function was uninjured. Pressure on the gland per rectum gave pain, and a considerable enlargement could be felt by the examining finger.

The Bottini operation was performed as described above, three cuts being made almost without pain. The patient remained in bed two days, after which he remained up and moved about freely every day. There was considerable pain in urinating at first, but this gradually became less, and in three weeks disappeared altogether. There was no acceleration of pulse or rise of temperature at any time during convalescence, but the urine contained blood for several days, and small sloughs continued to pass at intervals for nearly three weeks.

Several months have now elapsed and he remains well, not requiring to rise at night, and passing urine about from four to six times a day. The stream is normal in size and force, and he expresses himself as perfectly well.

CASE 2.—A man at 76 years, with good history, began to have the usual symptoms of prostatic hypertrophy nine years ago, but was not obliged to use a catheter until four years ago, since which time he has had a most distressing cystitis, and has to use a catheter several times a day. In October last he had a severe attack of orchitis, and it was for this that he consulted me. I found the urine ammoniacal and loaded with pus, the testicle swollen and painful, and the prostate large and tender. There were eight ounces of residual urine. I administered urotropin, and as far as possible aimed at improvement of his general constitution, irrigating the bladder night and morning with warm boracic solution. Finding it impossible by this means to get rid of the pus, after a trial of three weeks, I decided to remove the gland, which I did by the Parker Syms method, as already described. The operation occupied fifteen minutes and was followed by no shock whatever. In this case, instead of incising the urethra backwards into the gland, I merely cut backward far enough to reach it, then with blunt scissors snipped an opening into the capsule of each lobe, and enucleated them in succession. There was no median lobe, but merely a collar stretching from one lobe to the other across the neck of the bladder. When the lateral lobes were removed this collar disappeared. The temperature rose to 100 deg. F. the first evening, but remained normal after that. He remained in bed a week, and the perineal wound was entirely closed at the end of three weeks. A month after the operation he urinated without difficulty every two or three hours, and his general condition was greatly improved. I

here exhibit the gland. The large lobe was removed from the left side, and the smaller one from the right side. At present, six months after the operation, there is no residual urine, and that passed is normal in appearance and in constituents.

A GROUP OF CASES OF MALIGNANT DISEASE-- INFECTION OR COINCIDENCE?*

BY R. N. FRASER, M.D., C.M., M.R.C.S. (ENG.), THAMESVILLE, ONT.

It may be safely stated that nothing is yet definitely settled as to the etiology of malignant growths. Many theories have been advanced, but all lack sufficient evidence to substantiate them beyond reasonable doubt. It is pretty generally accepted that heredity plays an important part, but it must be remembered that many influences besides blood relationship similarly affect all members of a family, such as place of residence, diet, intimate association, care for each other in time of sickness, etc. The female sex, especially, would be apt to feel the effects of these influences, and we find cancerous disease much more prevalent among them than among persons of the opposite sex, though it is said to descend as readily from father as from mother. A few years ago the ravages of consumption in certain families were considered sufficiently explained when it was said that "it runs in the family." Now we have learned that just such influences as I have mentioned furnish the favorable conditions under which that disease is contracted one from another, and that heredity only supplies the suitable soil for the cultivation of the bacillus. True, malignant growths occur, as a rule, long after the family has been broken up and its members separated, but mere lapse of time would not in itself be conclusive evidence that such influences had nothing to do with the result. We know that the periods of incubation of known infectious diseases vary greatly, and it may be possible that there is a class of unknown infectious diseases in which this period is very greatly prolonged, and the process much complicated. The weight of opinion, however, is pretty strongly

*Read at annual meeting Ontario Medical Association, Toronto, June, 1904.

opposed to any theory of infection, and certainly if any form of malignant growth is infectious, it must be so only under certain peculiar conditions and upon principles not at all, as yet, understood. The half dozen cases which I am about to relate, and with all of which I was directly or indirectly concerned, seemed to be in some way linked together. I know of no means of tracing the connection, nor of any theory which would explain it if it did exist. Heredity certainly had nothing to do with these cases, as the family histories were all clear up to the commencement of the series.

CASE 1.—E. T., aged 69; family history good; previous health good. In the autumn of 1894 began to complain of indigestion and distress at the stomach. His general health gradually failed, and he was obliged to quit work early in the summer of 1895. A tumor then developed, and a diagnosis of cancer of the stomach was made by his attending physician. The remainder of his illness was characteristic of that disease, and he died August 8th, 1895. There was no autopsy, and consequently the growth was not subjected to microscopic examination.

CASE 2.—This case was reported very fully by me in a paper read before this Association in 1899, and was somewhat remarkable in that, notwithstanding the very malignant nature of the growth, as evidenced by its frequent recurrences, as well as by microscopic examinations, the case ended in recovery. F. G. A., aged 40, married; druggist; family history good; previous health good. Had an attack of mumps in 1883, with orchitis and partial wasting of the testicles. During the fall of 1894 there was slight soreness of the right testicle when he was much on his feet. In July, 1895, he visited at the home of E. T. (Case 1), for a few days, and again returned a few days before the death of the patient, who was his step-father. After the funeral he slept one night in the room in which Mr. T. had died, and which had been occupied by him and his wife during the whole time of his illness. Little, if any, change, had been made in the bed and bedding after the patient's death. In September, 1895, he had a pretty severe attack of pain in the right testicle, and similar attacks afterwards occurred about once a month. There was also some enlargement, which did not completely subside between the attacks. In August, 1896, the testicle became greatly enlarged, and there was constant, though not very severe, pain. It was removed October 16th, 1896, and was found to be the seat of malignant disease. There was soon a recurrence in the cord and infiltration of the cicatrix,

and at this period the case was placed in my care. I amputated the end of the cord December 17th, but there was again a recurrence in January, 1897. I now adopted Coley's method of treatment, but the tumor gradually increased in size and soon began to fungate and bleed. In order to delay the period of fungating, and not from any hope of permanent benefit, I removed the growth on February 8th, and the wound again healed nicely; but a month later another small tumor was detected. Toxine treatment was resumed, but by April 12th the size of the growth having increased until it extended from a little above the external ring to the lowest part of the scrotum, I again removed the whole mass. On May 20th, two small nodules were removed from just beneath the pubic arch. In June, 1897, I began the internal administration of arsenic, together with electrolysis and cataphoresis, according to the method of Dr. J. McFaddon Gaston, of Atlanta, Ga., who had succeeded by this method in saving the life of a boy who had been pronounced incurable by some of the best surgeons of the South. This boy remains well at the present time, and several other cases have since been reported by Dr. Gaston, Jr.

At the time of commencing this line of treatment, the malignant growth had been five times removed by the knife; there was a small rounded tumor at the side of the scrotum, while infiltrated tissue extended for eight inches in length and more than an inch and a half in breadth, and the glands in Scarpa's triangle were slightly enlarged. In less than a month there was a noticeable lessening of the infiltration and diminution in the size of the glands, though the tumor showed no sign of improvement. I varied the applications of electrolysis somewhat, but still the mass continued slowly to enlarge, and it was therefore removed with the knife on August 30th. A week later treatment by cataphoresis was resumed, and on September 21st another small tumor was removed by the knife. Again, on December 31st, 1897, a soft mass, the size of a walnut, together with some infiltrated cicatricial tissue, was removed. This time no ligatures were required, the wound healing by primary union, but there was a good deal of thickening in the line of the cicatrix, which lasted for some weeks, and from previous experience we expected a recurrence, but the thickening gradually lessened, the tissues assumed a normal appearance, and since that time there has been no recurrence. Electrolysis and cataphoresis were continued uninterruptedly until the patient had passed the three year limit, and he was also kept under the medicinal treatment the greater part of that time.

The new growth consisted of adeno-carcino-sarcoma, and was reported upon by Drs. J. Caven and H. B. Anderson, of Toronto, and Dr. T. Cullen, of the Johns Hopkins Hospital. The patient is now, six and a half years after the last operation, an active and useful member of society, and weighs twenty pounds more than before his illness.

CASE 3.—Mrs. E. T., widow of E. T. (Case 1), aged 69, family history good; was twice married; had six children by her first husband, and had a miscarriage in the early months of pregnancy after her second marriage, at the age of about 43. Suffered from menorrhagia after this until the menopause, which occurred at about 55. Otherwise her general health was good, with the exception of occasional "sick head-aches." She was the principal attendant upon her husband during his illness with cancer of the stomach in the summer of 1895, and she made a lengthy visit to her son, F. G. A. (Case 2), during the spring and summer of 1897, while he was in the worst stage of his illness. In the summer of 1898, she began to complain of flatulence and abdominal distress, and upon examination the uterus was found enlarged and almost filling the pelvis. About the middle of October she was taken with pains similar to labor pains, with some loss of blood. A moderately large fleshy mass was found protruding from the os, and this was easily detached and removed. Other masses could be felt within the uterus, and two of the larger of these were removed with a placental forceps, after which the pain and flowing were greatly diminished. The uterus, however, continued to enlarge, the bowels became obstructed, and the patient died November 6th, 1898. The tumor was examined by Dr. H. B. Anderson, of Toronto, who pronounced it a round-celled sarcoma, probably originating in what was originally a myomatous tumor.

CASE 4.—Mrs. M., aged 50, married; mother of quite a large family; daughter of Mrs. T. (Case 3), and sister of F. G. A. (Case 2). Family history good up to the occurrence of the cases here mentioned; previous health good; was much in attendance upon E. T. (Case 1) during his illness in the summer of 1895, and was for some weeks with her brother (Case 2), during the summer of 1897. She also attended her mother (Case 3), during the early part of her illness. On the death of her mother, Mrs. M. moved into the old homestead, and occupied the sleeping-room which had been used by Mr. and Mrs. T. (Cases 1 and 3), also making use of their bedding and other household goods.

In the summer of 1899 she began to suffer distress about

the rectum, and noticed a discharge of mucus and slime, which she for a time attributed to piles. She was placed under my care in October, and I asked Dr. J. F. W. Ross, of Toronto, to see her with me. Cancer of the rectum was found to be so far advanced as to render surgical interference useless. In view, however, of the success which had attended my treatment of her brother, she was anxious that something should be attempted. Therefore, at her own request, I did a preliminary colotomy, and followed this by removal of the lower part of the rectum. The diseased tissue was found to extend beyond the reach of the operation, so that only part of it could be safely removed. The wound did as well as is usual in such cases, and the patient was soon up and around again. Electrolysis and cataphoresis were resorted to, while arsenic was administered internally, but very soon the abdominal glands and liver became involved, and she was advised to return to her home, where she died in June, 1900. Unfortunately, the tumor was not subjected to microscopic examination.

CASE 5.—J. T. M., aged 40; physician; family history good. Irreducible inguinal hernia and undescended testis on the left side. Had suffered one or two attacks of renal colic on the right side. Was my chief assistant in all operations mentioned in Cases 2 and 4 of this paper.

In the spring of 1901 he noticed an enlargement in the region of the left kidney and had several attacks of hematuria, gradually lost weight, and was obliged to quit work in August. The enlargement continued to increase, and an exploratory operation was advised. He therefore went into the hospital at London, where he was kept under observation from September 8th to 27th, when Drs. Wishart and Meek cut down upon the kidney. Very extensive adhesions were found, and upon laying open the pelvis of the kidney a lot of soft tissue somewhat resembling blood clots was removed. Dr. Cullen, of Johns Hopkins Hospital, made a microscopic examination of this, and found it to consist of giant-celled sarcoma. The Dr. was soon after taken to his home, but the wound never entirely healed. The new growth rapidly extended along the sinus to the surface of the back, and became a fungating mass, requiring a great deal of care and attention on the part of his attendants. He died April 6th, 1902.

CASE 6.—Mrs. J. T. M., widow of Dr. J. T. M. (Case 5), aged 30; family history good, previous health good. Was the chief attendant upon her husband during his last illness, and herself looked after the daily dressings of the bleeding,

fungating mass upon his back. A short time before the death of her husband she had a small abscess at the lower margin of the vagina, to which no importance was attached.

In November, 1902, she entered the hospital at Ottawa for a course in training as nurse, and about the 1st of December she noticed a small lump in her groin. She therefore consulted Dr. J. Fenton Argue, to whom I am indebted for notes of her case, which I give largely in his own words. Dr. Argue examined her on December 7th, and found a small tumor about the size of a walnut, freely movable, not tender on pressure, nor was there any reddening about it. It looked very much like a sebaceous cyst. However, on cutting down, it looked more dangerous. The tumor and surrounding tissues were removed as widely as possible, and on microscopic examination it was found to be a sarcoma of the small round celled variety, in which were a few spindle cells. The patient made an uninterrupted recovery, and resumed her nursing duties in about four weeks. Two weeks after this, on examination there was found slight thickening in the line of the cicatrix. She was put to bed and treated with X-rays. In spite of this the mass enlarged, and the only benefit derived from the rays was in the lessening of the pain. Coley's fluid was also used, but no definite results were obtained, and at the end of February, 1903, she was removed to her home, where she died about six weeks later. Thus the whole course of her illness, from the first observable symptom to her death, did not exceed four months.

PAIN IN THE UPPER ABDOMINAL ZONE—ITS CAUSES AND DIAGNOSIS.*

BY GEO. HODGE, M.D.

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By the upper abdominal zone, I mean that portion of the abdomen bounded below by a line drawn horizontally through the umbilicus and above by the dome of the diaphragm.

Pain in this region may have its seat in organs or tissues

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situated without this zone, or in organs or tissues situated within it.

I. WITHOUT.

1. *Pleurisy*.—The pain of pleurisy may be localized in the hypochondriac or epigastric regions. A careful examination of the chest will serve to recognize the cause of this pain.

2. *Pneumonia*.—In this affection the pain may be felt wholly in the abdomen. The mode of onset of the illness, the temperature, the disturbed pulse, respiration ratio, and the physical signs should enable us to recognize the true nature of the illness.

3. *Gastric Crises of Ataxia*.—One of the early symptoms of locomotor ataxia may be severe pain in the epigastrium, with severe and intractable vomiting. These attacks are often recurrent, sometimes periodical. Examination will reveal one or more of the well-known symptoms of tabes dorsalis, viz., lightning pains in the legs, loss of knee-jerks, Argyll-Robertson pupils, optic neuritis, Romberg's sign, etc.

4. *Caries of the Dorsal Vertebrae*, at a point corresponding to the origin of the intercostal nerves that terminate in the upper abdominal zone, *i.e.*, from the 6th to the 10th. This condition is indicated by continuous and severe pain along the course of these nerves, exaggerated knee-jerks, weakness of the legs, rigidity of the muscles of the back, and tenderness over the affected vertebræ.

5. *Uremia* is occasionally attended with severe pain in the epigastrium. An examination of the urine will reveal the presence of albumen and casts. About three years ago, I saw a woman in the eighth month of pregnancy, who was suddenly seized with excruciating pain in the epigastrium and vomiting. The urine contained albumen in large quantities, epithelial and granular casts. A few days afterwards she was seized with convulsions.

6. *Appendicitis*.—During the early stage of appendicitis, the pain may be referred to the upper abdominal zone. Examination will reveal tenderness over McBurney's point, rigidity of the right rectus muscle, and other symptoms of appendicitis.

7. *Cardiac Affections*:

(a) *Pericarditis*.—The pain of acute pericarditis may be felt only in the epigastrium. On auscultating the precordia, a to-and-fro friction sound may be heard not synchronous with the heart sounds. If there is effusion, the symptoms and signs of this condition may be found if sought for.

(b) *Angina Pectoris*.—While the pain of angina pectoris is usually found in the precordial region radiating to the arm and neck, yet there are cases in which it may be referred almost wholly to the epigastrium. An examination of the heart and arteries, with a careful consideration of the mode of onset of the pain and other symptoms, will serve to reveal the true nature of the pain.

8. *Aneurism of the lower part of the Thoracic Aorta* may so compress and destroy the vertebræ as to produce symptoms similar to those of caries of the vertebræ, with the added symptom of a pulsating tumor in the back.

Acute Rheumatism.—Pain in the upper abdomen is frequently associated with rheumatism, especially in children. The pain is of short duration; recurs. The diagnosis will depend on the recognition of other symptoms of rheumatism.

II. WITHIN.

1. *Localized Subphrenic Peritonitis*.—I wish here to speak only of a suppurative form, which is usually due to the perforation of a gastric or duodenal ulcer.

Diagnosis.—A history of gastric ulcer can usually be elicited. The onset is generally sudden, with severe pain and vomiting. Later there are chills, fever, and rapid pulse. The respiration is greatly embarrassed, and there is marked rigidity of the abdominal muscles.

Physical Examination.—Dr. Sidney Martin, in Gibson's "Practice of Medicine," says: "Physical examination shows the following points: In many cases the heart's apex-beat is displaced horizontally away from the diseased side. The side is but slightly bulged, and the respiratory movements are deficient. In some cases abdominal respiration ceases, in others it is present. A thrill may be elicited over the abscess in some cases by a sudden jerking movement given to the abdominal wall. The liver may be displaced downwards, even to the level of the umbilicus. Over the lower part of the chest there is a tympanitic note, the upper limit of which is sharply marked off from the resonance obtained over the lung. The liver dulness may be completely absent, a tympanitic note being obtained over it.

"The physical signs of percussion are frequently obscured by the presence of consolidation of the lung, or by fluid in the pleura. Auscultation gives valuable signs. Vesicular breath sounds are heard over the lung down as far as the edge of the

abscess, while over the tympanitic resonance the breath sounds are replaced by amphoric breathing, and over the area of the dulness they are absent. The bell-sound may be obtained."

He might have added that a peritoneal friction rub may be heard below the tip of the 10th costal cartilage.

2. *Diseases of the Stomach.*

(a) *Hyperacidity.*—The repeated occurrence of pain in the region of the stomach or the recurrence of attacks of pain at regular intervals a short time after eating, particularly, if the pain is relieved by eating a little nitrogenous food or taking an alkali, may lead us to suspect hyperchlorhydria. If a test meal be given and the stomach contents be removed two or three hours after and found to consist of a small quantity of fine, well-digested, thin masses of food, containing a great deal of free HCl, the suspicion will be confirmed. We must now decide whether we are dealing with a purely nervous form of the disease, or whether there is an ulcer of the stomach. This will be referred to later.

(b) *Hypersecretion*, or excessive flow of gastric juice, occurs in two forms, viz., intermittent and chronic.

(1) The intermittent form is characterized by the appearance of more or less severe pain in the region of the stomach, usually spasmodic in character. Vomiting occurs, at first consisting of particles of food, later of yellowish green, acid fluid. The attack may last for hours or even days. As soon as the attack ceases the patient feels quite well. After a few weeks or months another attack may occur. Examination of the vomit shows that it contains HCl and pepsin.

(2) Chronic hypersecretion is characterized by pain occurring either during the period of digestion or when the stomach is empty. There is no pain immediately after eating, in fact, pain if present before eating disappears when something is eaten. When the pain first comes on it is slight, but gradually increases in intensity, and finally may become very severe. The pain generally comes on during the night.

The stomach contents should be examined after a period of fasting. To this end the stomach should be thoroughly washed out the evening before, and the patient should not be permitted to take anything during the night. The following morning the stomach contents should be aspirated, and if 100 c.c. or more of fluid is removed without any admixture of food particles, continuous secretion of gastric juice is indicated.

(c) *Gastric Ulcer.*—Pain is the most prominent symptom of this disease, and may be the only one. If the pain is confined

to a circumscribed area of the gastric region, if at the same time there is a painful pressure point at the back one inch to the left of the 10th to the 12th dorsal vertebræ, and if the attacks of pain occur regularly at the height of digestion, there is probably an ulcer of the stomach. If vomiting occurs, it usually does so at the height of the paroxysm of pain, *i.e.*, within two, or at most three, hours after eating, and gives immediate relief to the pain. If, in addition to the pain just described, the examination of the stomach contents reveals the presence of increased HCl, the diagnosis of ulcer is rendered more probable. Severe pain and increased HCl may be present in hyperacidity; however, in ulcer the cardialgic attacks occur more regularly than in hyperacidity. If, in addition to the pain, the vomiting and increased HCl, there is hematemesis, the diagnosis of ulcer of the stomach is almost positive.

(d) *Gastric Cancer*.—The diagnosis of this affection may be very difficult, especially in the early stages. If all the important symptoms, as pain in the epigastrium, vomiting, belching, emaciation, cachexia, tumor, absence of free HCl, and presence of lactic acid, with coffee ground vomit are present, the diagnosis is easy. In other cases it may only be possible to arrive at a diagnosis by keeping the patient under observation for a considerable time, and by making repeated examinations of the stomach contents. Carcinoma may be mistaken for chronic gastritis, severe anemia, or nervous dyspepsia. The following points must be carefully weighed in arriving at a conclusion in a case of gastric disease: The age of the patient; state of nutrition; presence or absence of cachexia; pain, its situation and characters; vomiting, time of its occurrence and its nature; whether or not there is blood in the vomit; the peptic powers of the stomach; its motor power; whether free HCl is repeatedly present or absent; whether free lactic acid is present; whether the Boas-Oppler bacillus is present; and lastly, whether or not a tumor can be palpated in the region of the stomach.

3. *Diseases of the Liver.*

(a) *Abscess of the Liver* is usually attended by pain in the region of the liver over the lower portion of the thorax. The pain may be referred entirely to the abdomen, or may radiate to the scapula. The temperature is usually intermittent or remittent, so that this affection may be mistaken for malaria. The exacerbation is sometimes preceded by a chill or chilly sensation. Sweating follows the exacerbation of temperature, and drenching perspiration may occur independently of the rise of

temperature, especially during sleep. Anorexia is almost always present.

The right lobe is more frequently the seat of abscess than the left, and usually towards its convexity, hence the increase in size is upwards and to the right. When there is upward enlargement of the liver, we get a dome-shaped increase of the hepatic dulness in the axillary or scapular line, whereas in empyema the upper limit of the dulness is more horizontal. Examination of the blood will show increase of the leucocytes and absence of the plasmodium malarie.

(b) *Carcinoma of the Liver* is usually secondary to cancer elsewhere; hence in every suspected case, malignant disease should be looked for in some other part of the body. Pain is not a constant symptom, however it is usually present either in the region of the liver or in the epigastrium or shoulder; emaciation is marked and progressive. Cachexia develops early and advances steadily, dyspeptic symptoms are common. There is a jaundice in about 50 per cent. of the cases. In many cases there is pyrexia.

Physical examination reveals enlargement of the liver, which descends with each inspiration. The surface is usually irregular and nodular. When the growth is diffuse, the liver may be very large and quite smooth. Ascites is frequently associated.

(c) *Hanot's Hypertrophic Cirrhosis of the Liver* is frequently attended by paroxysms of pain in the region of the liver. There is moderate enlargement of the liver, and also of the spleen. The disease may last for years. Jaundice is always slightly present, and undergoes periodic intensification, associated with pain in the upper abdominal zone.

I have had a patient under observation for some years, who has hepato-splenomegaly and slight jaundice, with recurrent attacks of pain in the region of the liver, and nausea and vomiting. Following these painful attacks there is very marked deepening of the jaundice. This case I look upon as one of Hanot's cirrhosis.

9. *Diseases of the Gall-bladder and Bile-ducts.*

(a) *Cholecystitis*.—This disease is commonly associated with gall-stones, and also occurs as a sequel of typhoid fever. Its onset is usually sudden, with severe paroxysmal pain in the region of the gall-bladder or epigastrium. Rigidity of the upper abdominal wall and tenderness over the gall-bladder are marked. In the more severe cases there are nausea, vomiting, prostration, rapid pulse, and increased temperature. In many

cases a tumor, which is smooth, tense, tender, non-fluctuating, and slightly movable from side to side, may be felt.

(b) *Cancer of the Gall-bladder* is not easily recognized in the early stages. When the portal glands become involved, jaundice and ascites make their appearance. A tumor, which is hard and uneven, may be felt.

(c) *Gall-stones*.—So long as gall-stones remain in the gall-bladder, they give rise to no symptoms unless inflammation is superadded as a result of infection. The symptoms are then those of acute cholecystitis.

Acute obstruction of the common duct by a stone is indicated by severe pain in the epigastrium or right hypochondrium, radiating to the back and breast, nausea, vomiting, marked jaundice, fever and chills. As soon as the stone passes from the common duct into the duodenum, or is returned to the cystic duct, the symptoms suddenly subside.

In chronic occlusion of the common duct by a stone, there are no symptoms till infection is added to the obstruction. The following case, which was referred to me by Dr. Hutchinson, of St. Thomas, last October, will illustrate the symptoms of this condition.

Mrs. H., aged 49 years, was ten years ago suddenly seized with severe pain in her right side, which was soon followed by jaundice. At the same time a "lump" appeared at the edge of the ribs on the right. The lump lasted about three weeks, then disappeared, and has never since returned. From the time of this attack, patient has had frequent attacks of epigastric pain, but never severe till two years ago last July. The pain was very severe at this time, and was felt chiefly in the epigastrium and right hypochondrium. Six months after this she had another severe attack, which lasted for about six weeks. Between these severe attacks patient has had "spells" of less severe pain, lasting for a day or two each time. In July, 1903, she had another very severe attack, which lasted for five weeks, and was attended with jaundice. Since this time patient has never been well except for a day or two at a time, and for the ten days before I saw her she suffered almost continually. The pain always comes on quite independently of food, usually in the afternoon or evening, and is very severe, "almost sends the patient wild." Pain so severe that it requires morphia, 1 grain, hypodermically to relieve it. During the severe attacks there is profuse perspiration, and often nausea and vomiting. The pain begins in the epigastrium, then passes to the right hypochondrium, where it is most severe, thence to the right

shoulder, and to a lesser degree to the left shoulder. The skin is very itchy, especially after an attack. There is little or no jaundice; appetite has been poor for months. Stools often, but not always clay-colored. During the acute attacks she has chills, fever and sweats. Patient has emaciated a great deal.

On October 28th Dr. Meek operated on the patient. He found a large calculus in the diverticulum of Vater, which was removed through an incision in the common duct. There were many strong adhesions binding the liver and the gall-bladder to the duodenum and bowels. Gall-bladder was atrophied and divided into two parts by firm adhesions.

II. Diseases of the Spleen.

(a) *Movable Spleen*.—In wandering spleen pain of a dragging character may be felt in the epigastrium and left hypochondrium. The recognition of the organ in an abnormal position will suffice for the diagnosis of this condition. Should the organ rotate on its pedicle this will be indicated by severe paroxysmal pain in the left hypochondrium, persistent vomiting and shock. The pulse becomes rapid and feeble.

(b) *Infarct and Abscess of the Spleen* usually follow infective endocarditis and septic conditions, and is indicated by pain and tenderness in the splenic region, on pressure, and swelling of the organ.

(c) *Spleno-Medullary Leukemia* is commonly attended by pain and tenderness in the left hypochondrium. The diagnosis will depend on the presence of enlarged spleen and marked increase of leucocytes.

7. Diseases of the Pancreas.

(a) *Acute Pancreatitis*.—Many points in the symptomatology as well as in the etiology of this affection are as yet obscure, which makes its recognition difficult. Its onset is sudden and violent, resembling much an acute intestinal obstruction, or a calculus obstruction of the common duct. Pain is the earliest symptom, and is said to be more intolerable than that of gall-stones. The pain is felt in the epigastrium, and is usually paroxysmal in character. Severe vomiting accompanies the pain, as also do rapid pulse, dyspnea, cyanosis, and hiccough. Localized distension of the epigastrium, resonant upon percussion, is an early sign. The temperature rises in the course of 24 hours, and many range from 100 to 104 deg. F. throughout the disease.

(b) *Chronic Pancreatitis*.—The symptoms are not distinctive. They may be similar to those of gastric catarrh, viz., loss of appetite, nausea, vomiting, belching, pyrexia, and a sense of

epigastric fulness and weight. The enlarged pancreas may press upon the common bile-duct and give rise to jaundice. Glycosuria may be present.

(c) *Pancreatic Cyst* is indicated by the presence of a tumor beginning in the left hypochondrium, between the costal cartilages and the median line, and gradually increasing in size. This tumor is slightly movable, and separated from the liver and spleen by a resonant area. Along with the tumor there are epigastric pain and digestive disturbance, accompanied by loss of flesh and strength.

(d) *Cancer of the Pancreas*.—Osler summarizes the most important features of this disease as follows: (1) Epigastric pains often occurring in paroxysms; (2) jaundice, intense and permanent, and associated with dilatation of the gall-bladder; (3) the presence of a tumor in the epigastrium; (4) symptoms due to loss of function of the pancreas, fatty diarrhea, clay-colored stools, and diabetes; (5) a very rapid wasting and cachexia.

7. *Diseases of the Bowel.*

(a) *Duodenal Ulcer*.—The symptoms are similar to those of the gastric ulcer.

(b) Impaction of feces in the transverse colon may cause either ulceration of the bowel or a slight localized peritonitis, and thus give rise to pain. A soft, movable, doughy tumor may be felt either above the umbilicus or at either the hepatic or splenic flexure of the colon. A few doses of castor oil will serve to determine the nature of such a tumor.

8. *Diseases of the Kidneys.*

(a) *Nephroptosis*.—Occasionally movable kidney gives rise to severe abdominal pain, vomiting, chills and fever, and these are known as Dietl's crises. When these symptoms occur the organ may be felt in an abnormal position, and is tender on pressure.

(b) *Nephrolithiasis*.—The diagnostic phenomena are those which attend renal colic. The attack begins with sudden, sharp, paroxysmal pain in the renal region. The pain may radiate along the ureter to the testicle or inner side of the thigh, or it may pass towards the chest and shoulder. Attacks are usually attended with nausea and vomiting, profuse perspiration, and feeble, quick pulse. Micturition is frequent, and the urine usually contains blood.

(c) *Perinephritic Abscess* is attended with dull, aching pain in the lumbar region. At times the pain is intense, and aggravated by pressure. The thigh of the affected side is partially

flexed. Examination will show bulging of the loin, and occasional fluctuation and edema are noticed. There is usually fever of a septic type.

(d) *Tuberculosis of the Kidney.*—Tuberculous kidney may give rise to severe pain in the loin. The symptoms may resemble those of calculus pyelitis. The diagnosis will depend on the history of the illness, on the presence of tubercle elsewhere, and of tubercle bacilli in the urine. Hectic fever and emaciation are usually marked.

THE ENLARGEMENT OF THE PROSTATE.

BY F. W. E. BURNHAM, M.D., WINNIPEG.

The frequency of prostatic enlargement, occurring as it does in 30 per cent. of men over 50 years of age, would make it seem that it forms a not unusual, if not a necessary, complement of advancing years.

Between those prostatitics who suffer some degree of mechanical inconvenience, and those who do not, there are those cases, including frequently some with a very considerable prostatic enlargement, which are only discovered post mortem. It is hardly necessary to remark, then, that though a person may possess an enlarged prostate, this by no means implies that he is either to suffer from it or require assistance.

The analogy, histological and pathological, between the uterus and the prostate is very striking. In 40 per cent. of women who have reached the age of 50, there are found myomata, resembling more or less the normal uterine parenchyma. In 30 per cent. of men who have reached the same age, growths are found resembling the former histologically and in their course, and which are included under the more comprehensive but faulty term of hypertrophy.

In each the effect is mechanical, resulting in the production of hemorrhage in the one, according to its proximity to the uterine mucosa, and in the other of urinary obstruction, more or less complete. Clinically, this analogy is further seen in the proportion of cases which are only discovered post mortem, and were unsuspected during life.

If a large number of enlarged prostates be examined, it will be found that they can be divided into five distinct varieties:

(a) A projecting middle lobe, pedunculated or sessile.

(b) A pedunculated growth springing from a middle lobe. In the formation of the pedunculated variety there is a further resemblance to the uterine fibrous polypi, which were originally interstitial, and finally became pedunculated.

(c) The lateral lobes alone.

(d) A middle lobe, with lateral lobes, forming three distinct projections.

(e) A uniform circular projection surrounding the internal orifice of the urethra, a variety which is commoner than supposed, and which was first described by Sir Benj. Brodie. This latter form, though common clinically, is not seen to advantage in anatomical preparations, in consequence of the loss of support of the base of the bladder on its removal. As a middle lobe, as such, does not normally exist, a growth in this situation, whether pedunculated or sessile, is comparatively rare.

It seems that the commonest condition found is a uniform enlargement of the whole gland, with obliteration of the median notch, in fact, an obliteration of this notch clinically indicates a uniform enlargement of the lateral lobes.

The effect, in a general way, upon the urethra of this enlargement of the prostate is elongation and increase in the normal curvature. If the enlargement affects both lobes, the urethra is flattened laterally; if it is confined to one lobe, the urethra is distorted to the opposite side. The growth encroaches upon and may fill the greater portion of the cavity of the bladder, the capacity being thus diminished. In this instance the frequency of micturition would be directly the result of diminution of capacity rather than to the presence of residual urine. The condition of the bladder depends upon the degree and duration of the obstruction, and the freedom from urinary infection. If under the influence of cold, or some diuretic action distending the bladder, more or less complete retention is established, dilatation of various degrees follows. But in the great majority obstruction comes on slowly, accompanied by hypertrophy of the walls of the bladder, which may contract, and by reducing the capacity, give rise to another cause of frequency of micturition. In the contracted form the mucous membrane is thrown into folds, which frequently become encrusted with phosphatic deposit.

Hypertrophy and separation of the muscular fasciculi result from attempts on the part of the bladder to overcome the obstruc-

tion. Small slits or pits, usually transverse, appear from indentation of the mucous membrane between the separated muscular fasciculi. Each pit, as it enlarges, becoming a saccule, which grows indefinitely, the rate of growth depending upon hydrostatic pressure, and may eventually form a sac larger than that of the bladder itself. These sacculations form almost independent reservoirs for the retention of decomposing urine, favoring the formation of calculi, and the growth of neoplasms. It can readily be seen that the expulsive efforts of the bladder would be directed towards the increase in size of these herniæ vesicæ.

This condition of affairs is accompanied by similar dilatation of the upper urinary tract, the effects on the upper urinary tract, as in the bladder, depending upon the degree of obstruction, which is greatest in the pedunculated growths of the so-called middle lobe, acting as a valve or trap-door over the internal urethral orifice.

Let us for a moment consider the mechanism of micturition in these cases. Where there is a so-called pedunculated middle lobe, this is washed forwards, and acting as a valve, effectually prevents any escape. In the collar-like projection surrounding the urethra, the force of the urine striking on the edge of the collar acts as a circular valve, also effectually closing the urethra, so that whether it be a pedunculated growth or a uniform enlargement or otherwise, the valve-like action is always present. In the act of micturition, so long as muscular contraction is maintained nothing escapes, but the minute that relaxation occurs the valve-like action disappears, and the urine dribbles away.

The cause of residual urine, or that which remains after the completion of the act of micturition, has been ascribed to the altered relations existing between the urethral orifice and the most dependent portions of the bladder. From an examination of a great many specimens, I have not satisfied myself that the cause of residual urine in all cases is the formation of a cul-de-sac posterior to the internal urethral orifice.

In some cases, the existence of the post-prostatic pouch is a certainty, but there are other cases with residual urine in considerable amount, in which no such pouch or sacculation is present, and in these cases I rather think that the cause of residual urine is reduced tonus, resulting on the one hand in inability to expel completely the contents, and on the other in the greater tolerance to the presence of a certain amount of residual urine. An analogous condition is found in the ali-

mentary canal, when its walls fail to respond to the accustomed stimulus. There is a failure to expel the contents on one hand, and on the other an increasing tolerance of their presence.

The fact that all prostatics do not suffer from obstruction has been repeatedly demonstrated in the post mortem room, so that when a patient is found with enlarged prostate and with residual urine, it is to be viewed in the light of a broken compensation.

The patient has reached this point in his career with possibly little inconvenience, but the obstruction and residual urine are increasing apace. It is in this stage when the general condition is good—the upper urinary tract normal—when the blackler has not yet sustained much of that damage which comes later—when the urine is not infected—that a large number of cases present themselves for advice. Should surgical treatment be advised, or should he be introduced to what is popularly known as catheter life, with all its annoyances and dangers? There is here a grave responsibility, a responsibility which is not generally appreciated, because the danger is not immediate.

I am quite satisfied that the dangers of a few ounces of residual urine are nothing as compared with that of persistent catheterism, as it is performed by the majority of patients, who cannot by any amount of instruction be taught the necessity of cleanliness in its performance. Follow the history of anyone living a catheter life, and there will always be found a time when, either from sepsis or instrumental intolerance, that the treatment completely breaks down. The cause of this is easily explained. The healthy mucous membrane of the bladder is resistant to the action of a considerable quantity of pathogenic micro-organisms. This power of resistance, quite naturally, with the assistance of local conditions, diminishes with advancing years, so that a quantity of micro-organisms, which would, say at the age of 50, produce no effect whatever, would, because of the before-mentioned reduced power of resistance, cause at the age of say 70 a violent cystitis. Occasionally, it is true, a case is reported in whom a catheter was successfully used during a long term of years, but for every such case can be shown hundreds who have died from surgical kidney.

This temporizing treatment of a removable surgical affection, fraught with a certain and disastrous break-down, is unscientific, and, in my opinion, has not been sufficiently condemned.

It is noticed, then, that the health of those who rely on the catheter, slowly, but steadily, deteriorates, and that the orthodox treatment of enlarged prostate at some time, from some cause

or other, breaks down. We will now consider the principal surgical procedures which have been devised to overcome the difficulty.

White, having in view the atrophy of the uterus after removal of the ovaries, performed experiments on the lower animals, to determine the influence upon the prostate of the removal of the testicles, and, as a result of this investigation, concluded that a very considerable atrophy followed such a procedure. After the publication of these results, accompanied by some cases in the human subject, reported also by the same author, castration and section of the vasa deferentia were very extensively performed, with very encouraging results. The immediate relief which was described by some operators as occurring in these procedures, is pathologically impossible, and, therefore, clinically highly improbable. It is interesting to note that this indirect treatment, which was reported by so many observers as being so successful but a few years ago, is now discarded, and only remains as a matter of history. The direct treatment has been more successful than the indirect.

Bottini attacked the growth through the urethra by means of a very ingenious galvano-cautery which he devised. The treatment was based on faulty pathology—upon the assumption that there was a bar at the commencement of the urethra, the division of which would remove the difficulty. In the hands of the originator and his followers the use of the instrument has been attended by no inconsiderable success, limited to about 30 per cent. of the cases, those in which there is a collar like projection surrounding the urethra. It is unfortunate that this simple treatment has not a wider range of application.

In the radical removal of the growth, which is the only rational treatment, Albarran, of Paris, selected the perineal route. This method was adopted by Guyon and Socin, and is still preferred by the French operators. The most potent objection to this route is that it fails in 30 per cent. of the cases; it requires more time in its performance; is accompanied by greater hemorrhage from the prostatic venous plexus, and consequently is followed by greater shock in a class of patients who are not able to withstand any great degree of shock.

It would seem from the situation of the gland that the perineal route would be the proper one by which to remove it. This expectation has not been fulfilled, and it is inadvisable to select a method which promises failures in 30 per cent. at the outset.

The performance of a suprapubic cystotomy by McGill, of

Leeds, in 1899, followed by removal of the enlarged prostate, marked the greatest advance made in genito-urinary surgery since the first removal of a vesical calculus. It was one of those epoch-making discoveries, which come from time to time to reward the labors of the patient investigator. Rarely has an operative procedure, after a lapse of years and a fuller investigation, stood as originally performed in all its entirety. McGill's technique was so complete that it has substantially not since been modified. We have in this a safe method applicable to all cases, one which permits thorough exploration of the bladder, and provides efficient drainage.

Let us consider the failures of the various procedures. In catheterism there are failures, amounting to 100 per cent., no less certain because deferred. With Bottini's method in the hands of the originator, cures followed in 32 per cent. of the cases. It is needless to say that the galvano-caustic treatment in the hands of one less enthusiastic, does not meet with that measure of success which was hoped for it by the originator of the galvano-cautery. The perineal route is applicable to 70 per cent. of the cases, whereas the suprapubic method is applicable to all cases. It permits of the radical removal of the cause of the obstruction, affords opportunity for thorough examination, and is followed by efficient drainage.

Too much cannot be said in condemnation of the temporizing treatment of this affection, accompanied, as it certainly is, by increasing difficulty of catheterism, and by those serious pathological conditions of the bladder and upper urinary tract, the result of obstruction on the one hand and of infection on the other, and that determine the prognosis rather than the size of the prostate, or the duration of the enlargement.

The early radical treatment of prostatic enlargement, based as it is upon sound pathological principles, will increase the expectation of life of the subjects of this most deplorable contingency of advancing years who are, in following the temporizing treatment, beset with all the annoyances and dangers incident to catheter life.

MUSKOKA FREE HOSPITAL FOR CONSUMPTIVES.*

BY C. D. PARFITT, M.D., M.R.C.S., L.R.C.P

Physician-in-Charge Gravenhurst Free Hospital for Consumptives.

Mr. President and Gentlemen,—Since the Free Hospital for Consumptives at Gravenhurst was opened two years ago last April, no communication regarding the work done there has been made to the profession of the province, save through the yearly reports of the National Sanatorium Association, which are sent to all medical men. It is my purpose, in the few minutes I have to-day, to tell you something of what we are trying to do, and how we are trying to do it, and perhaps give you a better understanding of how we can be of use to your patients, and how you can best help us.

The more conspicuous aim of this institution is the cure of tuberculous patients; but its founders had also in mind the dissemination of information about the prevention and treatment of the disease. As our work has developed thus far, this latter missionary purpose has been perhaps better fulfilled than the former more evident aim, both because of the class of cases received and because of the short time they have been kept. Comparatively few really suitable sanatorium cases presented themselves, while there were very many patients in advanced and far advanced stages of the disease who greatly needed the care and training of the hospital, and were admitted, in some cases only to die, in many cases to improve in health, and in all cases to spare to the community the lives of households endangered by the presence of the ignorant consumptive. Of 169 cases of patients remaining in the hospital one month or more, only 30 cases, or 18 per cent., were in the incipient stage; 91 cases, or 54 per cent., had advanced disease; and 48, or 29 per cent., were far advanced cases. I may say here that in our various statistics we exclude cases remaining less than one month, since no material benefit can be gained in so short a time. Of the 35 cases we have had for such short periods during these two years, several have died, and others have left or have been discharged for some personal reason. We have also omitted in our tabulations re-admissions (4 in all), and 8 cases of doubtful evidence of disease. In asking your consideration

*Read at the Meeting of the Ontario Medical Association, June, 1904.

of the results shown by figures, I must explain that three different physicians have contributed to them, and it is impossible to make an arbitrary classification. We have followed Dr. Trudeau's terminology and definition. In all, 261 cases had been admitted up to the close of our second year, on April 21st, and 216 of these had been discharged and are to be reported on. Excluding 47 cases, as I have explained, the remaining 169 were classified on discharge as follows: 34 cases (20 per cent) disease arrested; 57 cases (34 per cent.) much improved; and 78 cases (47 per cent.) unimproved. By our terminology, the phrase "apparently cured" should be used only of patients who have been entirely free from the rational signs of phthisis for at least three months. It is impossible for us at present to keep cases long enough to be warranted in using such a term, so our class of "arrested" cases includes several who, in all probability, are actually "cures" according to a proper understanding of that word.

If you compare our classification on discharge with that on admission, you will see that some advanced cases have done very well, considering that the average length of stay for all the cases reported on was only 163 days—some five months—whereas many incipient cases even require as much as nine months to come to the stage of arrest. The hospital has as yet been open for too short a time for me to be able to say anything in regard to the permanency of the results obtained, but we have received many very encouraging letters from patients who keep well and who are at work again, either at their former occupation or at some new one better suited to them, and also from other patients who are faithfully and successfully carrying out at home the hygienic principles learned at the hospital. They all spread abroad the encouragement and teaching of the institution for the benefit of the many other consumptives who are their friends, neighbors or relatives.

The institution is intended for the poor of the Dominion. Naturally, the large majority of our cases, especially in the first year, before the place became known, have been from the Province of Ontario. Twenty have come from other provinces, including Newfoundland, Nova Scotia, and the North-West Territories. One reason why this number is so small is that applications for patients who have very long journeys to make are passed upon with special strictness, both because of the risk and the possible fruitless expense. In all cases the proportion of city dwellers to country people has been two to one.

Considerable misunderstanding exists in the minds of both

I.

169 cases remaining over 1 month.

Condition on Admission.	Condition on Discharge.			
	Arrested.	Improved.	Unimproved.	Total.
Incipient	18 = 60 per cent.	9 = 30 per cent.	3 = 10 per cent.	30 = 18 per cent.
Advanced	15 = 16 "	35 = 38 "	41 = 45 "	91 = 54 "
Far Advanced	1 = 2 "	13 = 28 "	34 = 70 "	48 = 29 "
	34 = 20 per cent.	57 = 34 per cent.	78 = 47 per cent.	169

Average duration of symptoms of disease prior to admission 12 months.
 Average duration of stay 163 days.
 141 patients made an average gain of 11 pounds.
 18 patients had an average loss of 4 pounds.
 10 patients were not weighed.

II.

49 cases remaining from 1 to 3 months.

Condition on Admission.	Condition on Discharge.							
	Arrested.		Improved.		Unimproved.		Total.	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Incipient	1	3	1	2	2	..	4	5
Advanced	1	1	6	2	4	7	11	10
Far Advanced . . . . .	..	..	..	1	9	9	9	10
	2	4	7	5	15	16	24	25

III.

120 cases remaining over 3 months.

Condition on Admission.	Condition on Discharge.							
	Arrested.		Improved.		Unimproved.		Total.	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Incipient	3	11	5	1	1	..	9	12
Advanced	6	7	15	12	15	15	36	34
Far Advanced . . . . .	..	1	4	8	3	13	7	22
	9	19	24	21	19	28	52	68

public and profession in regard to our name—*Free Hospital*. The hospital is absolutely free to those who are actually in need of a place to go to, at no cost to themselves; but those who can afford to contribute something are expected to do so; 157 patients have been maintained at no cost whatever to themselves or their families; 93 of these have been partly maintained by the cities of Toronto and Hamilton at the rate that they allow the general hospitals—40 cents per day; 176 patients have in part maintained themselves or have been paid for by families or friends. Apparent discrepancies in my numbers are explained by the fact that a patient may contribute something to his own support for a time, and later, when no longer able to do this, be put on the free list. The cost of maintenance averages a little over \$6.00 per week per patient. No fees are exacted of anyone, but since the public must bear the burden of the support of the institution, inquiries are made in order to avoid imposition on the part of those who are able to help themselves somewhat.

The life at the hospital is generally a very happy one. Most of the patients look very well, and feel well, as tuberculous patients so often do. Hours are, of course, carefully regulated for rising and retiring; the patient's rest and exercise are individually prescribed and enforced; he is trained in the observation of the effect of exercise upon his temperature; his meals are watched by a trained nurse, and loss of appetite or any other irregularity is reported to the physician. The patient is thus always under close supervision. He may have daily attention from the physician, if necessary, and he is, of course, examined frequently enough for his case to be followed closely. In the large wards and the roofed tents the patients have fresh air always, and in them and on a well sheltered verandah, where there are reclining chairs, with plenty of blankets and cushions, he may live the open air life when it is necessary for him to take prolonged rest, or the weather is too inclement for the natural Muskoka life in the woods or on the water. Boating, a rifle range, a billiard table, a piano with automatic piano-player attachment, and various games, supply a sufficient amount of diversion. The table is, of course, an important matter for the tuberculous invalid, and our food is of excellent quality. I wish that our funds would admit more variety, but fruits and vegetables, for example, are hard to get at most seasons. Bread, butter, meat, milk, and eggs, are all good and abundant. The best proof of this is in the average gain in weight of our patients.

141 patients made an average gain of 11 pounds; 18 lost weight, an average of 4 pounds; and 10 were not weighed.

The medical equipment is complete in essentials. There is a good dispensary, a well-equipped room for the local treatment of disorders of the air passages, and a good clinical laboratory. The medical staff consists of two physicians, a nurse, and an assistant nurse.

The number of patients in the institution is now 50. A few months after the hospital was first opened, the press of patients for admission was so great that our accommodation was enlarged, and for a time we cared for 75; but the funds forthcoming were not enough to support so many, and a year ago our numbers were reduced to 50. It accordingly became necessary to establish a time limit for the stay of each patient, since the waiting list is always considerable, and this was fixed at first at six months and later reduced to only four months. This is a great misfortune, for, curable as tuberculosis is in the earlier stages, it is, nevertheless, as we have said, a long process, and it is hard to know that the good obtained from a half year spent in sanitarium in Muskoka may possibly be quickly lost by too early a return to work. It is the hope of all who are intimately acquainted with our work that we may soon be enabled to increase our numbers again, and also to lengthen the stay of the patients. With a view to the latter need, we are trying to find occupation for patients at the hospital after their time limit has expired. At all times patients who are physically able to do light work of some kind, are required to do small services for the hospital, and it would be to their advantage if there were more ways of using them. A limited number of patients are now kept on at the hospital after their time is up, and four hours of service per day are required in lieu of their board. A poultry yard has been started to help make room for these patients, while furnishing the hospital with fresh eggs and fowls economically. At some sanatoria in the States the institutions are at least half manned by graduate patients, and work is found for them in truck gardens, etc. This will be possible at Gravenhurst when we can get the money, and can keep our patients long enough to make them really well.

These problems, however, have comparatively little interest for you. But methods of admission and a discussion of our class of cases are important matters for consideration here. Our present method of admission leads to a lack of uniformity in our class of cases. Various examining physicians have been appointed in different centres, and their recommendations are

usually accepted without question. Other physicians than these official examiners fill out examination forms, which are referred to the physician-in-charge at the hospital to accept or reject. These filled-out forms often are lacking in necessary data, and sometimes misrepresent cases.

Another thing which helps to make our class of cases unsatisfactory is the fact that from the wage-earning classes we cannot hope to get cases as early as from more prosperous classes, and their disease is often advanced when they present themselves for treatment.

For this hospital to do the work that it is best fitted to do, viz., cure patients who have fair chances for recovery if placed under proper conditions, a much better selection of cases is necessary. The worst class of cases will be cared for in hospitals especially provided for that purpose. I am glad to say that our class of cases is already gradually improving, and that the patient with only a few days or weeks of life before him comes to us much less frequently now than formerly. But I feel that with the scope of the institution better understood by physicians at large, immediate improvement can be secured, and I therefore earnestly beg your co-operation, and ask your attention to a brief general statement in regard to cases suitable for admission.

Cases in whom disease has existed but a short time and who are not running an acutely febrile course, are nearly always acceptable. Those of good vitality, in whom disease has existed for some months, even though the lungs have been considerably involved, unless some serious complication exists, such as diarrhea or extensive laryngeal involvement, or unless the daily maximum temperature is over 100.5 deg., will usually do very well, indeed. However, in several cases where there were laryngeal infiltrations, both with and without ulcerations, the combination of sanatorium life with daily local treatment has given the most satisfactory results. These cases are generally refused at sanatoria, but I believe that when the local laryngeal disease is limited and the general condition good, they stand a very fair chance. Cases who run a temperature above 100.5 deg. should be kept at rest at home for a considerable time, until the active febrile signs have been reduced, when they may prove to be suitable candidates for admission. Since the hospital is for the treatment of incipient tuberculosis, we have not the necessary help at hand to undertake the care of patients in the acute stage of the disease. Casual illnesses often

make the nursing of twelve or fifteen patients necessary for varying, and sometimes prolonged, periods. With the routine of supervision added, the nursing staff has its hands full. A judgment founded upon the careful consideration of the general constitutional state of the patient and the temperature record for a number of consecutive days, would, quite apart from the question of the amount of local disease, help to exclude many of the undesirable cases who press for admission.

A number of physicians have visited the hospital from time to time, and we are very glad to show them all we can of our work there. I wish that more of you could come. It would put you more thoroughly in touch with our purposes and problems than any paper can hope to do.

A large clinical experience with migrainous patients (George M. Gould, in *J.A.M.A.*) shows that their headaches are of an apparently amazing variety of kinds, and seemingly of causes. An examination of the literature also illustrates the same fact, each of these kinds by one or by others being called or described as migrainous. The mere index or enumeration of these kind of headaches would fill many pages. In the first place, there is a long list of headaches, plainly due to organic and systemic diseases, such as tumor and traumatism of the brain, meningitis, fevers, infectious diseases, etc. These are, of course, excluded. They are few in numbers compared with the non-symptomatic and functional cases, but in many treatises they fill most, if not all, of the field of vision. Of the functional kind, one may likewise construct a huge list: The nervous, sick, periodic, hereditary, constitutional, dietary, hemicranic, menstrual, ocular, nasal, dental, constipational, bilious, indigestional; those from intellectual overwork, physical exhaustion, worry, lack of food, from study, bad light, bad ventilation; from coryza, influenza, rheumatism, uterine disease, pregnancy, hysteria, anemia, diseases of the spinal cord, syphilis, and so on and so on. And, finally, there is a very large class which cannot be ascribed even to the vaguest and most far-off cause. Any one, two, or dozen of the kinds may be mixed in all proportions in any one case, and only omniscience—not possessed, at least, by young practitioners—could discern the explanation and dissolve the mystery. Lastly, the location, character, and degree of the ache in, about, on and below the head, in spots, in halves, or of the whole, make confusion worse confounded.

The Physician's Library

P. BLAKISTON'S, SON & Co. sold during last year 15,487 copies of Gould's Medical Dictionaries, making the total sales to date 166,083.

IN printing all the copies of "Deaver's Surgical Anatomy" so far demanded by its most successful sale, there will have been used 2,340 pounds of ink, 188,002 pounds or 84 tons of paper, and the printing press will have made 3,455,000 impressions. On and after July 1st, 1904, the price of this work will be advanced to \$30.00 in half morocco, and \$33.00 in half Russia binding.—P. Blakiston's Son & Co., Publishers, Philadelphia.

The Gazette Pocket Speller and Definer, English and Medical.
Second Edition. New York: The Gazette Publishing Co.

This handy little volume is intended primarily as a speller; but in revising it for the second edition, the aim has been to enlarge its usefulness without increasing its dimensions. The words are defined briefly, being mainly synonyms. The work is the production of The Gazette Publishing Co., publishers of *The Diatetic and Hygienic Gazette*, one of our most valued exchanges.

Epilepsy and Its Treatment. By WILLIAM P. SPRATLING, M.D., Superintendent of the Craig Colony for Epileptics at Sonyea, N.Y. Handsome octavo volume of 522 pages, illustrated. Philadelphia, New York, London: W. B. Saunders & Company. 1904. Canadian Agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Cloth, \$4.00 net.

This work by Dr. Spratling is of unusual interest for many reasons: It is the first complete treatise on epilepsy since the appearance of Echeverria's work, published over thirty-three years ago, and represents the practical experience of Dr. Spratling as Superintendent of the Craig Colony for Epileptics at Sonyea, N.Y., during a period of ten years. The great progress

made in the knowledge of epilepsy and its treatment during the past fifteen years certainly demanded an accurate and careful work which would include these latest advancements. Dr. Spratling has given us all that could be desired. Of particular interest are the chapters on the psychologic and melico-legal aspects. An entire section is devoted to the all-important seizure type—Status Epilepticus; and treatment, general, educational, medical and surgical, is discussed with wisdom, thought and conservatism. The subject is bountifully illuminated by the citation of illustrative cases; and, indeed, for the entire work we have nothing but praise. General practitioners, as well as those especially interested in epilepsy, will find the book of great value.

Diseases of the Intestines and Peritoneum. By DR. HERMANN NOTHNAGEL, of Vienna. The entire volume edited, with additions, by HUMPHREY D. ROLLESTON, M.D., F.R.C.P., Physician to St. George's Hospital, London, England. Octavo volume of 1,032 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company. 1904. Canadian Agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Cloth, \$5.00 net; half morocco, \$6.00 net.

This new volume in Saunders' American edition of Nothnagel's practice is the eighth to be issued, and appearing within two months after the publication of the volume on tuberculosis, gives evidence that the publishers intend completing the series at an early date. This, one of the most valuable volumes in the series, is by the famous clinician, Dr. Hermann Nothnagel himself, and is as exhaustive as it is practical. The distinguished editor, Dr. Humphrey D. Rolleston, of London, Eng., has used his pen most profusely, almost every page giving generous evidence of his careful editing. The editorial additions include sections on intestinal sand, sprue, ulcerative colitis and idiopathic dilatation of the colon. Appendicitis and peritonitis have been given unusual space, treatment and diagnosis receiving exhaustive consideration. The section on intussusception has been greatly enlarged by the invaluable additions of D'Arcy Power, of England, who has made this subject his own. There are twenty inserts of great merit.

International Clinics. Volume II. Fourteenth Series. 1904.
Philadelphia: J. B. Lippincott Company.

Among the contributors to this volume we notice the name of Dr. John McCrae, of Montreal. Dr. McCrae writes on the recent progress in Tropical Medicine. There are other excellent articles on Diseases of Warm Climates, Treatment, Medicine, Surgery, Pediatrics, and Rhinology. There are a goodly number of illustrations throughout the text. As a means of keeping one abreast of the advances in the domain of medicine, "International Clinics" certainly fills the bill.

Diseases of the Nose and Throat. By D. BRADEN KYLE, M.D.,
Professor of Laryngology and Rhinology, Jefferson Medical College, Philadelphia; Consulting Laryngologist, Rhinologist and Otologist, St. Agnes' Hospital. Third edition, thoroughly revised and enlarged. Octavo volume of 669 pages, with 175 illustrations, and six chromo-lithographic plates. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Toronto: J. A. Carveth & Co., Limited, 434 Yonge Street. Cloth, \$4.00 net; sheep or half-morocco, \$5.00 net.

In presenting to the profession the third edition of this work the general plan of the previous editions has not been materially altered. The entire book has been carefully revised and such additions have been made as were rendered necessary by recent medical progress. The most important alterations and additions have been made in the chapters on Keratosis, Epidemic Influenza, Gersuny's Paraffine Method for the correction of Nasal Deformities, and in the one on the X-Rays in the treatment of Carcinoma. The etiology and treatment of Hay Fever have been partially rewritten and much enlarged, as has also the operative treatment of Deformities of the Nasal Septum. In the chapter devoted to general considerations of Mucous Membranes and Hay Fever the author records the results of his experience in the chemistry of the saliva and nasal secretions in relation to diagnosis and treatment. The literature has been carefully reviewed, and a number of new illustrations added, thus bringing the work absolutely down to date.

Obstetric and Gynecologic Nursing. By EDWARD P. DAVIS, A.M., M.D., Professor of Obstetrics in the Jefferson Medical College and in the Philadelphia Polyclinic. *12mo* volume of 402 pages, fully illustrated. Second edition, thoroughly revised. Philadelphia, New York, London: W. B. Saunders & Company. 1904. Canadian Agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Polished buckram, \$1.75 net.

The usefulness of this book to the nursing profession is manifest by the fact that a second edition has been called for. It is necessary for an obstetric nurse to possess some knowledge of natural pregnancy and of its consequent diseases; and as gynecologic nursing is really a branch of surgical nursing, special training and instruction are required to meet the conditions arising. This book just fills the need, everything that the obstetric and gynecologic nurse should know being included. The second edition shows evidence of having been carefully revised throughout, and considerable new matter has been added. It would be well if every trained nurse possessed a copy of this book, for it certainly is of inestimable value.

The Mother's Manual. A Month by Month Guide for Young Mothers. By EMELYN LINCOLN COOLIDGE, M.D., Visiting Physician of the Out-Patient Department of the Babies' Hospital, New York; formerly House Physician of the Babies' Hospital, New York; Physician-in-charge of the Babies' Clinic of the Society of the Lying-in Hospital of the City of New York. Illustrated. New York: A. S. Barnes & Company.

We have examined carefully the 253 pages of this little volume. It is designed to be placed in the hands of young, unexperienced mothers, and as a consequence we cannot very well see why the author employs medical terms. There are instructions to use bismuth subnitrate, Liquid Peptonoids, "Lassar's" Paste, and a host of well-known proprietary foods. Our own opinion is that it would be better were all these names left out, and that plain hints be given, minus those terms which smack of a knowledge of which the young mother is best left in ignorance. Apart from this the book might serve some good purpose.

Diseases of Metabolism and Nutrition. By PROF. DR. CARL VON NOORDEN, Physician-in-Charge to the City Hospital, Frankfort. Authorized American edition; translated under the direction of BROADMAN REED, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Hygiene and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia. Part V., Concerning the Effects of Saline Waters (Kissingen, Homburg) on Metabolism. By Prof. Carl von Noorden, Frankfort, and Dr. Carl Dapper, Bad Kissingen. New York: E. B. Treat & Co.

As announced in the author's preface, this publication is the second edition of a thesis, published eight years ago, by Dr. Carl Drapper, from the clinic of Prof. von Noorden. It confirms the original observations. Prof. von Noorden authoritatively decides those mooted questions concerning the influence of the sodium chloride waters on digestion as well as in gout, diabetes and other diseases of nutrition. He thus places the medical profession under obligation to him. The exact and scientific manner in which these observations are herein set forth is the striking feature of the book.

Manual of Medicine. By THOMAS KIRKPATRICK MONRO, M.A., M.D., Fellow of and Examiner to the Faculty of Physicians and Surgeons, Glasgow; Physician to Glasgow Royal Infirmary, and Professor of Medicine in St. Mungo's College; Formerly Examiner in the University of Glasgow, and Pathologist to the Victoria Infirmary. Canadian Agents: Chandler & Massey Limited, Toronto, Ont.

The above is the title of a very handsomely bound little book, very kindly handed to us by Messrs. Chandler & Massey, who have shown their customary enterprise and good judgment in securing the selling rights for Canada of such a valuable work as Monro's Manual of Medicine, which covers practically the whole ground taken up by many of the larger and more voluminous works of prominent authors on the same subject. This volume specially recommends itself to the busy practitioner, as well as being an excellent assistant to the medical student on

account of the clear, concise, and, yet thoroughly scientific manner in which this work has been produced, being exceedingly practical, and in every way up-to-date. It will be found a very valuable work of reference, both in regard to diagnosis and subsequent treatment. Treatment, as a matter of fact, occupies a very important part, it being the object of the author to point out the indications through which the cause of each and every trouble can be reached, so as to effect a cure when possible. This volume bears particularly on the practical side of professional work, and its careful examination satisfies us that it will be found a very valuable addition to the text-books in this department.

Tuberculosis and Acute General Miliary Tuberculosis. By DR. G. CORNET, of Berlin. Edited, with additions, by WALTER B. JAMES, M.D., Professor of the Practice of Medicine in the College of Physicians and Surgeons (Columbia University), New York. Handsome octavo volume of 806 pages. Philadelphia, New York, London: W. B. Saunders & Company. 1904. Canadian Agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. Cloth, \$5.00 net; half morocco, \$6.00 net.

This is the seventh volume to be issued in Saunders' American Edition of Nothnagel's Practice, and the remaining four volumes are in active preparation for early publication. The American edition of Professor Cornet's exhaustive work appears at a time when the subject of tuberculosis has a peculiar claim upon the attention of mankind. Within a few years both professional and general public interest in the disease has taken enormous strides. In almost every civilized community societies for the prevention of tuberculosis are being organized, and these are composed, not only of physicians, but of laymen, while governments themselves are taking an active part in the movement. Under these circumstances, and at this time, the work is of interest to practitioners, for there is no other treatise which gives an equally clear and comprehensive view of this subject. The article on Acute General Miliary Tuberculosis has been admirably written and gives a thoroughly clear understanding of this disease. The importance of the chemistry of the tubercle bacil-

lus and its bearing upon immunity have warranted a thorough treatment of this subject. The work is complete and logically arranged, and the editor has made additions where necessary to bring it down to date.

Materia Medica for Nursing. By EMILY A. M. STONEY, Superintendent of the Training School for Nurses in the Carney Hospital, South Boston, Mass. Beautiful 12mo volume of 300 pages. Second Edition, thoroughly revised. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Toronto: J. A. Carveth & Co., Limited, 434 Yonge Street. Cloth, \$1.50 net.

This little work on *Materia Medica* has proved of great value to the nursing profession, evidenced by the demand for a second edition. The statements are not only clear and definite, but the information given can be relied upon as being accurate. In making the revision for this new second edition, the entire text shows evidence of having been gone over with the greatest care. All the new drugs which have been shown to be of actual therapeutic value have been included, their preparations, uses, and doses being clearly and fully described. A valuable feature of the work is the Appendix, containing such practical matter as Poison-Emergencies, Dose-Lists, Weights and Measures, etc., as well as a Glossary of the terms used in *materia medica*. There is no doubt in our minds but that this little work is the best of its kind.

International Clinics. A Quarterly of Illustrated Clinical Lectures, and especially prepared original articles. Edited by A. O. J. KELLY, A.M., M.D., Philadelphia. Volume I. Fourteenth series. Philadelphia: J. B. Lippincott & Co. Canadian Agents: Mr. Charles Roberts, 1524 Ontario Street, Montreal. 1904.

International Clinics, a quarterly production of the medical department of the Lippincott Press, is certainly now most favorably known to the Canadian medical profession. It is an authority upon up-to-date treatment, medicine, surgery, neurology,

pediatrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners of medicine. Leading members of the profession the world over have contributed to its volumes as they are regularly issued; and when the editor has such co-laborers as Osler, Musser, Stewart, Murphy, McPhedran, Rotch, Clark, Walsh, Ballantyne, Harold, Landbolt, and Kretz, they cannot fail but keep the production in the very front rank. The present volume deals with the progress of medicine in 1903, a most valuable department, compact, concise. The other departments are devoted to treatment, medicine, surgery, gynecology and neurology. A work of such recognized worth should be found in the library of all. Canadian practitioners can order it through Mr. Charles Roberts, 1524 Ontario Street, Montreal.

A Text-Book of Mechano-Therapy (Massage and Medical Gymnastics). For Medical Students, Trained Nurses and Medical Gymnasts. By ALEX. V. GRAFTSTROM, B.Sc., M.D., Attending Physician to the Gustavus Adolphus Orphanage, Jamestown, N.Y. Second edition, revised, enlarged, and entirely reset; 12mo of 200 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company, 1904. Toronto: J. A. Carveth & Co., Limited, 434 Yonge Street. Cloth, \$1.25 net.

The second edition of this useful little work has been entirely rewritten, reset, and very much enlarged. Two chapters have been added—one on Massage of the Eye, Ear, Nose, and Throat, and the other on Pelvic Massage. Seventeen new illustrations have also been added. The author states that his object has been to present a work that would be useful as a text-book to students, trained nurses, and medical gymnasts, and as a reference book for the general practitioner, and in our opinion he has fully accomplished his purpose. It is certainly a practical and clear consideration of the subjects of massage and medical gymnastics, and it is with pleasure that we recommend it to our readers. The mechanical get-up is all that could be desired.

Progressive Medicine. Vol. II., 1904. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia; assisted by H. R. M. LANDIS, M.D., Assistant Physician to the Out-Door Department of the Jefferson Medical College Hospital. Philadelphia and New York: Lea Brothers & Co. Price, \$6 per annum.

The small outlay of \$6 per annum to keep one abreast of modern medicine and surgery, should be readily expended in this direction, as *Progressive Medicine* is now in its sixth volume and is recognized as one of the leading productions before the medical profession to-day. The present volume has for its contributors John G. Clark, William B. Coley, Edward Jackson and Alfred Stengel. The reputations of these well-known authors insures the profession that whatever is contained herein is handled in an authoritative manner. It treats of Surgery of the Abdomen, including Hernia; Gynecology, Diseases of the Blood; Diathetic and Metabolic Diseases; Diseases of the Spleen; Thyroid Gland; Lymphatic System; Ophthalmology.

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And Ontario Medical Journal

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THE VANCOUVER MEETING OF THE CANADIAN MEDICAL ASSOCIATION.

That Vancouver, nearly three thousand miles away from the leading medical centres, could muster over 260 in actual attendance, the third largest meeting in the history of the organization, surely proves that the national medical organization was never so popular with the Canadian medical profession than at the present day. There was not a single province that was not represented, and the only regret expressed, if we leave out getting down on the programme and never appearing, was the decidedly slim attendance from Toronto. Indeed, the Vancouver profession, as well as the entire West, censured Toronto very severely for its lack of interest and attendance. It is to be regretted that so many form good intentions and send in their names early for a place on the programme, and never appear to read their papers. It has become so flagrant of late years that many notice and remark upon it, and something will assuredly have to be done in future to provide for an intact programme.

As the Secretary suggests, it is more and more becoming imperatively important that reorganization take place, and that right away. The Association is too worthy an organization to go drifting along year after year, whose prime reason for existence is the reading and hearing read of scientific papers. There are vital questions of medical politics, always to the front, which need the strong support and guidance of the most important of medical bodies in the country, which can best be given by a properly organized body. The constitution and by-laws need shaking up; they need to be regenerated, modernized, made workable. Through the Canadian Medical Association the Canadian profession have the means in their hands of making a strong, forceful and powerful organization. The matter requires the most careful consideration, and especially so as there was a notice of motion to amend the constitution presented at Vancouver.

We wish to congratulate our friends in the Maritime Provinces at their splendid showing, fully a dozen being present. Prince Edward Island, with a medical population of 90, sent 3. Toronto, with a medical population of 450, sent 4. Next year we meet in the extreme east, at Halifax, when no doubt Toronto will endeavor to make amends for this year's poor showing.

To next year's Executive Council and Programme Committee we would respectfully suggest the advisability of an entire afternoon or evening session for the full and free discussion of all matters of a general nature which come up annually, so that important questions of medical politics will not be hurried along off the table without proper consideration.

OSLER.

All Canadian medicine takes pride in the distinctions conferred upon that brilliant son of Canada, Dr. William Osler. When Dr. Tunstall, the President of the Canadian Medical Asso-

ciation, sitting in the same chair, at Vancouver, which Dr. Osler had formerly occupied—the proudest position in the gift of the Canadian profession—read out the following telegram from Dr. Wolfred Nelson, New York, there were round after round of applause, and hearty cheers for Osler: “Thanks for kind invitation. I greatly regret cannot attend meeting. The press here, medical and lay, refers triumphantly to Osler’s appointment as Regius Professor of Medicine at Oxford. King Edward approved it. Osler has accepted for next year. God bless dear old Canada, McGill and Osler.” Whatever other honors fate may hold in her hand for Dr. Osler, none, we feel satisfied, will be treasured more truly than the thought that for long he has enjoyed the confidence, love and esteem of the medical men of the land of his birth. And how truly he deserves all which has come to him for he has always stood for all that was great and noble in the profession of his choice. Unassuming and of a most lovable character with a splendid capacity for work, the key-note of his success, he combines a magnanimous spirit, which makes his life an ideal, fitted to rank side by side with any and all of the glorious names in medical history.

It will prove interesting, in this connection, to reproduce here from *The Toronto News* of August 20th, the details of this famous chair, as furnished that newspaper by Professor Goldwin Smith:

“This chair was one of five founded by King Henry VIII. in 1546, to each of which a yearly stipend of £40 was assigned. King James I. augmented the Professorship of Medicine by annexing to the chair, in 1617, the Mastership of the Hospital at Gwelme, in Oxfordshire. Later the Aldrichian Professorship of the Practice of Medicine, with an emolument of about £130 a year, was annexed to the chair. Dr. Osler, in addition to his duties as lecturer, will act as an examiner in all examinations for degrees in medicine granted by the University. Previous holders of the chair were: 1546, John Warner, D.M., Warden of All Souls; 1554, Thomas Francis, D.M., Ch.Ch.; 1561, Walter Bailey, B.M., Fellow of New College; 1597, Bartholomew Warner, D.M., St. John’s; 1612, Thomas Clayton, D.M., Baliol,

Principal of Broadgates Hall, Master of Pembroke; 1647, Thomas Clayton, sometime Fellow of Pembroke; 1665, James Hyde, D.M., Principal of Magdalen Hall; 1681, John Luffe, D.M., St. Mary Hall; 1698, Thomas Hoy, D.M., Fellow of St. John's; 1718, Joshua Lasher, D.M., Fellow of St. John's; 1729, William Beauvoix, D.M., sometime Fellow of Pembroke; 1730, William Woodford, D.M., Fellow of New College; 1759, John Kelly, D.M., Student of Ch.Ch.; 1772, William Vivian, D.M., Fellow of Corpus; Sir Christopher Pegge, D.M., Ch.Ch., sometime Fellow of Oriel; 1822, John Kidd, D.M., sometime Student of Ch.Ch.; 1851, James Adey Ogle, D.M., Trinity; 1857, Henry Wentworth Arland, D.M., Ch.Ch., sometime Fellow of All Souls; Dr. John Scott Burdon-Sanderson."

NEWS ITEMS

SIR WILLIAM BANKS, the noted English surgeon, is dead.

ON August 26th there were four cases of smallpox in Belleville, Ont.

DR. W. S. FRALEIGH, College Street, Toronto, is dead, aged fifty years.

DR. GEORGE W. BROWN, Port Arthur, Ont., is visiting friends in Toronto.

DR. E. BENSON, City Coroner of Winnipeg, is dead of a paralytic stroke.

THE death is announced of Dr. John Cascaden, ex-M.P.P., Dutton, Ont., at the age of 64 years.

DR. JOHN A. CONKEY, Indianapolis, a graduate of Toronto University, has been visiting in Toronto.

THERE is a typhoid epidemic in both London and St. Thomas, Ont., each having over one hundred cases.

TORONTO GENERAL HOSPITAL.—During August there were 250 admitted, 243 discharged and 16 died.

R. S. CHEFFEY, M.D., formerly of Alliston and Beeton, Ont., died in Toronto, on the 10th of September.

THE Provincial Board of Health of Quebec has approved of the medical inspection of schools in that province.

DR. GORDON BELL, Winnipeg, has been appointed to the Chair of Pathology and Bacteriology in the University of Manitoba.

DR. WILLIAM S. THAYER, Associate Professor of Medicine at Baltimore, will probably be Dr. Osler's successor at Johns Hopkins.

DR. F. MONTIZAMBERT, Director-General of Public Health, has returned to Ottawa, after inspecting quarantine in British Columbia.

THROUGH the efforts of Dr. H. C. Wrinch, formerly House Surgeon in St. Michael's Hospital, Toronto, a hospital has been completed at Hazelton, B.C.

MONTREAL GENERAL HOSPITAL has thirty cases of typhoid fever; the Notre Dame, six; the Royal Victoria, over thirty, 25 per cent. more than last year.

THE TORONTO FREE HOSPITAL FOR CONSUMPTIVES, near Weston, is now receiving patients, and provision has been made for at least twenty-five from Toronto.

SWAT CHWAN YIN, a Chinese graduate of the Medical Faculty of Toronto University, has become a licentiate of the Royal College of Physicians, London, Eng.

OTTAWA ISOLATION HOSPITAL.—The County Judge of Carleton will investigate charges of irregularity and negligence in connection with the Ottawa Isolation Hospital.

THE *Lancet*, London, Eng., says of Dr. Osler: "We heartily congratulate the Crown upon its choice, and no less heartily do we felicitate the University upon adding to the number of its professors so brilliant an exponent of science."

DR. FERGUS BLACK and family have moved to Springfield, Elgin County. Dr. Black has purchased a large practice at Springfield. The doctor has been a resident of Port Colborne for about ten years, and has always been a very estimable citizen.

TORONTO BRANCH, VICTORIAN ORDER OF NURSES.—The annual meeting of the Toronto Branch took place recently in this city, and apparently from the reports submitted this Branch is in a very flourishing condition. Dr. Harley Smith presented the annual medical report. The visits paid by the nurses numbered 5,802. It was announced that of the \$52,500 subscribed in Toronto towards the Cottage Hospital Fund, that \$32,000 had been collected.

ANNUAL MEETING OF THE EXECUTIVE HEALTH OFFICERS OF ONTARIO.—The nineteenth annual meeting of the Association of the Executive Health Officers of Ontario was held at Sarnia on July 13th, and in the absence of the President of the Association (Dr. Hall, of Mallorytown), Dr. Lane, of Chatham, filled the chair. Papers were read by Dr. Hodgetts, Secretary of the Ontario Board of Health; Dr. Bryce of Ottawa; Geo. Nasmith, M.A., Ph.D., of Toronto, and others. During the course of the meeting the regular quarterly meeting of the Ontario Board of Health was held, at which a resolution was adopted recommending that an Order-in-Council be passed, making it obligatory upon physicians to report all cases of tuberculosis to the local health officer.

MARITIME MEDICAL ASSOCIATION.—The Maritime Medical Association met in Halifax, N.S., on July 6th and 7th. It was decided to hold the next annual meeting at Charlottetown, P.E.I. The following officers were elected: President, Dr. S. R. Jenkins, Charlottetown; Vice-President for New Brunswick, Dr. G. C. Van Wart, Fredericton; Vice-President for Nova Scotia, Dr. G. E. DeWitt, Wolfville; Secretary, Dr. T. D. Walker, St. John, N.B.; Treasurer, Dr. Huntley Macdonald, Antigonish, N.S.; Secretary of Local Committee of Arrangements at Charlottetown, Dr. H. D. Johnson. It was decided to ask the Canadian Medical Association to meet in Halifax in 1906. Among the visitors present were: Dr. E. W. Cushing, Boston; Dr. C. Simon, Baltimore; Dr. Thos. Cullen, of Baltimore; Dr. Walter Chipman, Montreal; Dr. F. A. Codman, of Boston; Dr. F. W. Hamilton, of Montreal.

FOURTH PAN-AMERICAN MEDICAL CONGRESS.—The next meeting of the Pan-American Congress will be held in Panama the latter part of December. The Pan-American Congress meets every three years. It was started by Dr. William Pepper, of Philadelphia, Dr. C. A. L. Reed, of Cincinnati, Dr. Albert Van der Veer, of Albany, and Dr. R. L. E. Johnson, of Washington. The first meeting was held in Washington in September, 1893, the second in 1896. The third was to have been held in Venezuela in 1899, but was given up on account of the war in that country. The place of meeting was changed to Cuba, but had to be postponed until 1901 on account of the fever there. These meetings have always been well attended, and it is thought that Panama will be an interesting place for the convention. Further particulars will be sent out from time to time to the journals together with notifications of the different officers appointed to represent this and other countries.

ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW BRUNSWICK.—The twenty-fourth annual meeting of the Medical Society of New Brunswick was held in St. John, on the 19th and 20th of July, under the Presidency of Dr. J. Douglas Lawson. The following delegates were present from the Maine Medical Association: Dr. G. M. Woodcock, Bangor; Dr. Augustin S. Thayer, Portland, and Dr. Daniel McCann, of Bangor. Several very interesting papers were read and valuable discussions ensued. The officers elected for the ensuing year were: President, Dr. A. R. Meyers, Moncton; 1st Vice-President, Dr. E. T. Gaudet, St. Joseph; 2nd Vice-President, Dr. G. N. Pearson, Sussex; Secretary, Dr. L. R. Murray, Sussex; Corresponding Secretary, Dr. W. H. Irvine, Fredericton; Trustees, Drs. J. M. Deacon, Moncton; J. McNichol, Bathurst; J. C. Mott, St. John. St. John was selected for the next place of meeting. A paper which excited a good deal of discussion was one by Dr. T. Morris, of St. John, on the relationship existing between the physician, druggist, and patient, which resulted in the appointment of a special committee to consider the whole subject and report at the next annual meeting. This committee consists of Dr. Meyers, of Moncton; Dr. Morris, of St. John, and Dr. Pearson, of Sussex.

Obituaries

V. H. MOORE, M.D.

The death took place suddenly on the afternoon of June 8th of a physician who was widely known throughout the Dominion of Canada, Dr. V. H. Moore, of Brockville. It was well known that Dr. Moore had not enjoyed the best of health for some years past, but latterly had improved and had expected to take the trip to the Canadian Medical Association to Vancouver. Deceased was 56 years of age and was a graduate of the class of 1870 of Queen's University. He was for many years the representative for Queen's on the Ontario Medical Council and was president in 1890. He was also a past president of the Canadian Medical Association. Queen's conferred on him the degree of LL.D. in 1903.

ROLLO CAMPBELL, M.D.

Dr. Rollo Campbell, of Montreal, son of Dr. F. W. Campbell, Dean of the Medical Faculty of Bishop's, Montreal, died recently in that city of typhoid fever. He was about forty years of age, and was graduated from Bishop's in 1886, with honors, and studied later in Edinburgh. From the time of his graduation he was connected with the teaching staff of Bishop's and was for many years on the consulting staff of the Montreal dispensary. He was also one of the assistant surgeons at the Western Hospital.

Special Selection

CHOREA AND ANEMIA.

BY ROSHIER W. MILLER, M.D., PH.G., BARTON HEIGHTS, VA.,

Lecturer on Nervous and Mental Diseases, and Professor of Theory and Practice of Pharmacy, University College of Medicine, Richmond, Virginia.

In the etiology of chorea nothing is noted relative to anemia. It is simply accounted as an accompanying symptom of the condition. Medical literature emphasizes the relation between rheumatism and chorea, with anemia as an important symptom. After observation of several cases, I am strongly of opinion, however, that anemia as a causative factor is worthy of investigation.

Anemia of toxic origin presents pathological conditions, which favor the production of choreaic affections. It is true that simple anemia is, as a rule, of secondary origin, and, viewed in this light, it may be argued that of chorea arises, it is the result of the primary and not of the secondary conditions—thus agreeing with the admitted etiology. This argument, however, will not satisfactorily explain those cases of chorea which arise remotely from the primary condition, but recently from the secondary effects.

I submit three cases in which symptoms, treatment, and recovery seem to intimate at least a possible relation between anemia and chorea.

CASE I.—A female child of eight years gave a history of typhoid fever eight months prior to my visit. According to the mother's statement, the child had made a quick and good recovery, gaining rapidly in weight and exhibiting the energy of her former life. Six months later she became irritable and pale, with pain in her arms and legs, which condition was soon followed by gastric disorders and irregular spasms of the muscles of the face. Simple anemia was in evidence from objective and subjective symptoms alone, but was unquestioned in the light of the results obtained from blood examination—the red blood element being present to the extent of barely 3,000,000 red corpuscles per c.m.

This case was treated with two teaspoonfuls of Pepto-Mangan (Gude) and two drops of Fowler's solution, three times a

day. After gastric symptoms had abated somewhat, two raw eggs per day were added to the diet. The patient was discharged in five weeks, completely recovered.

CASE 2.—A female child of 10 years of age; gave history of malaria (a well-defined case of intermittent fever) one year previously. The pallid condition of the child induced the mother to solicit my aid. Upon examination, I found slight choreaic movements which had escaped the mother's eye, though she did admit that the child "could not sit still very long at a time," and "was constantly working her fingers." The blood examination revealed no plasmodium. The red cells were reduced to 2,800,000 per c.m., with a proportionate decrease of hemoglobin.

Pepto-Mangan (Gude) alone was employed in doses of two drams in a glass of milk three times a day. The blood examination four weeks later showed red cells present to the amount of 3,900,000 per c.m., at which time I dismissed the case completely recovered.

CASE 3.—A female child of 13 years. Two months before my visit, the mother informed me, the child became peevish and pale, and was reprovved at school for her inability to write neatly. She was taken from school, but she grew rapidly worse. Morning nausea, vomiting, headache, and anorexia were her daily companions. I found her with pronounced histrionic spasm with involvement of the upper and lower extremities. Hemic murmurs were plainly apparent, but no endocardial irritation could be determined. The blood count showed reduction in red cells to 2,100,000 per c.m. The hemoglobin was reduced to a degree greater than the red cells. A curious feature of the case was the morning nausea. Immediately upon awakening, she experienced nausea, which was followed by vomiting. I discovered, however, that this condition was superinduced by odors from the kitchen, and directed that a small sponge, moistened with creosote water, be placed over the nose and mouth before the preparation for breakfast began. The annoying symptom was promptly checked by this simple method. The anemia in this case may have been produced by malnutrition, but even this view is mere speculation.

The irritability of the stomach in this case was so pronounced that I did not deem it wise to give nourishment—not to speak of medicine—by the stomach. During the first four days rectal alimentation was employed. A nutritive enema, consisting of four ounces of peptonized milk and two drachms of Pepto-Mangan (Gude) was given every six hours. Small amounts of peptonoids with creosote on ice were given by the stomach. Egg

albumin was taken in all the water she drank. After four days, the stomach was tested with small amounts of milk and Pepto-Mangan (Gude). Beginning with four ounces of milk and one dram of Pepto-Mangan (Gude) every four hours and four drams of Pepto-Mangan (Gude) three times a day. This diet, plus three raw eggs a day, together with the above treatment, was all that was employed for six weeks. The blood examination at this time showed a highly gratifying condition—the red cells being present to the extent of 4,100,000 per c.m. The bloom of youth once more tinted the cheek, and the shrine of St. Vitas lost a visitor.—*Virginia Medical Semi-Monthly*.

Notes from Our Exchanges.

The site of an intestinal obstruction (Abrams, *Medicine*), the differentiation of gas, an exudate, or fecal matter may be facilitated by the intestine's reflex.

Gangrene of the lower extremities (Ricketts, *Buffalo Medical Journal*), associated with typhoid fever, is, indeed, rare, compared with the great number of cases of typhoid fever throughout the world. There is no known cause; climate, habits, occupation, and general environment do not offer any solution of the problem. It appears to be due to the bacillus typhosus, but this has not been proven. The disease occasionally attacks the lips, tongue, cheeks, and genitalia. It has also been observed involving the fingers, hands, arms, toes, feet, and legs.

Tyson (Review of Medicine in *Maryland Medical Journal*) is satisfied that the operation (decapsulation of the kidney for chronic Bright's disease) is a serviceable one, and that many lives may be saved and prolonged, and even cures obtained, by its judicious application, although it is obviously taken for granted that the operation should not be performed until the usual medical measures of treatment have been thoroughly applied. On the other hand, the operation should not be deferred until the patient is moribund. He considers cases of parenchymatous nephritis more favorable for operation than cases of interstitial nephritis, while obviously less satisfactory results are to be expected where there are extensive cardio-vascular changes.

Certain acute symptoms, appearing in the mother, according to William A. Northridge (*Brooklyn Medical Journal*), call for weaning for her sake. These are principally faintness, vertigo, palpitation, weakness, night sweats, languor, tremor and cough. On weaning being accomplished they quickly disappear. In my experience these symptoms come on so late in the nursing period that weaning can be done with little danger to the nursing.

According to Jesse S. Meyer (in charge of *Internal Medicine, Interstate Medical Journal*), Boas does not believe that a tube can be passed through the sigmoid flexure, and states that he has never succeeded in passing a tube further than 15 to 20 cm. In those cases in which it is claimed that the tube was introduced, a half meter or more, it has simply been coiled up in the rectum. This he has demonstrated, not only upon the living, but also upon the cadaver.

Doubtless disease is often the result of draught (A. N. Bell, in *The Sanitarian*)—that is to say—of the passage of a current of cold air sharply across or against a portion of the body that is exposed to it; but the danger of this is greatly enhanced by too close confinement. Persons who habitually expose themselves to an abundance of fresh air rarely suffer from such causes. Some there are, however, on account of apparently inexplicable reasons who are supersensitive to such conditions. But these, above other persons, find their best protection in habituating themselves to a plenary supply of fresh air under all circumstances; by woollen clothing and by particularly avoiding small bedrooms and all such conditions as are engendered by them.

We have endeavored to ascertain (McCrae, Fysche and Ainley, Acute Lobar Pneumonia, *Montreal Medical Journal*) what proportion of the population of Montreal is employed in outdoor work, and this we find difficult, because of the great differences of conditions, due to climate, between summer and winter of 444 cases, 126 (28.4 per cent.) were engaged in outdoor work, 318 (71.6 per cent.) in indoor occupations; if we allow that one-fifth of the population is engaged in outdoor work (this figure is probably too high), the outdoor worker has suffered $1\frac{1}{2}$ times as frequently as the indoor worker; if we allow that 1-10 only of the population is so employed, the outdoor worker is $3\frac{1}{2}$ times as liable. In any case, our figures tend to show that the outdoor worker is more frequently attacked.