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Original Articles.

ADDRESS IN SURGERY.*

By Ingersoll Olmsted, M.D., Hamilton, Ont.

Mr. President and Gentlemen,—The honor of being chosen to deliver the address in Surgery at the meeting of this Association is one I had not expected. After looking over the names of the distinguished gentlemen who have filled this honorable position, I feel any words of mine quite inadequate to express my gratitude to you, and it is with mingled feelings of pleasure and anxiety that I attempt to speak of the advances which surgery has made during the last few years. Not having had the extensive clinical experience of many of the gentlemen who have addressed you in the last few years, I shall only attempt to draw your attention to some of the most important work which has been done in different countries.

In surgery especially, has the English speaking people contributed more than their share of good work, and America particularly, should be proud to be favored by the visits of distinguished surgeons from abroad.

Great advances have been made in the surgical treatment of diseases, yet in many instances our hopes have not been realized. Thus when the tetanus bacillus was isolated and a serum prepared, it was thought a treatment had been found that would ward off the usual fatal termination of this disease. This has

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now been found to be erroneous, and, in fact, the use of antitetanic serum has almost been abandoned in the treatment of cases of tetanus. Fortunately, however, the serum is almost a certain preventative of the disease. Thus, in 1903, in the United States, there were 406 cases of tetanus reported, following accidents received during the Fourth of July. In the present year, only 73 cases were reported. This marked improvement is attributed to more careful treatment of the wounds, and the administration of the antitoxin. In a recent discussion of this disease before the Surgical Society of Paris, Berger stated that during the last seven years all patients, with one exception, entering his wards with wounds in which there was a possible infection with the tetanus bacillus, received a small dose of antitetanic serum. The one patient who had not received the serum was the only one that developed tetanus.

It is now the rule in many hospitals in America, to give the serum in all cases having wounds which could have become soiled by dirt, manure, or other foreign substance. The serum should be repeated, as a single dose will not always prevent the disease. Suter and James Bell have each reported a case where tetanus developed forty-seven days after a single prophylactic dose of the serum had been given.

Although hemophilia is a comparatively rare condition, it comes to our attention at times in a very realistic manner. It is very disagreeable for a surgeon to be called to operate on some acute surgical condition, when the patient is affected with this interesting blood state. The use of calcium chloride and subcutaneous injections of gelatine, although at times very useful, fail to check the copious oozing in subjects of this disease.

Hemophlia is presented in two distinct etiological conditions, first accidental, and second hereditary. In the accidental variety there is no history of heredity, or injury, or previous serious disease. Its course is more or less benign, and occurs at less frequent intervals, and requires a more serious injury for its production. In the hereditary variety, on the contrary, the tendency to hemorrhage follows the slightest wound, owing to the fact that coagulation is very much retarded. Emile Weil has shown that fresh human or animal serum introduced into the system of patients affected with hemophilia produces a marked increased coagulability of the blood in the hereditary variety, and in the accidental variety the coagulation becomes normal. This followed the intravenous injection of 20 cubic centimeters of animal blood serum. The change in the blood occurs about

twenty-four hours after the introduction of the serum. Locally the serum has much the same action.

It appears that in the accidental form of hemophilia there is an absence or diminution of the ferment which causes coagulation, while in the hereditary form there seems to be some anti-coagulating substance. If the antidiphtheritic serum be used, and this is the most easily obtained, it should be fresh. Numerous observers have confirmed the beneficial effects of this method of treatment, and it certainly should be given a trial. If the serum be given subcutaneously 20 or 30 c. cm. should be used.

With our present methods, the brain may be examined with comparative safety, yet there is still much to be desired. The unfortunate results which have formerly followed cerebral hemorrhage in the newborn, can, by the intermusculo-temporal operation, be frequently relieved. In most of these cases the labor is protracted, and the child is asphyxiated as a rule when born. Even the most desperate cases should be given a chance. There are usually localizing symptoms, yet one should not hesitate to open both sides of the skull if necessary. This is also indicated in fracture of the base. Undoubtedly many cases have died from compression, which would have been saved had the skull been opened. The convalescence is much quicker, and the recovery better. I can recall several cases of fracture of the base with extensive hemorrhage that were relieved by this means.

In case of papillary œdema due to cerebral compression, a decompression operation will ward off the symptoms. In one case operated on for Dr. Osborne, the sight, which was rapidly failing, made rapid improvement after the operation. An early interference is necessary in order to forestall atrophic changes in the nerve, and a large sized disk should be removed.

For severe cases of tic douloureaux, the evulsion of the sensory root of the Gasserian ganglion removes the pain, and leaves no bad after effects. Cushing has operated on 54 cases of this disease with only two deaths. This operation is simpler than removing the ganglion, and the results are really better. Where the attacks of pain are not so severe, Charles H. Mayo exposes the nerves at the points of exit from the foramina, extracts them by slow evulsion, cuts them off, and then plugs the bony openings by driving in small silver nails. This is an operation devoid of danger and easy to perform.

The injection of 70 per cent. alcohol into the nerves is also very effectual in many cases of intractable neuralgia. In spasmodic tic, the facial nerve may be resected and anastomosed with

the spinal accessory. The result in a case I saw, which Cushing had operated on, was extremely satisfactory.

Since operations on the thyroid have become frequent during the last few years, attention has been drawn to the importance of the parathyroid bodies. Although these structures were first accurately described by Sandstroom in 1800, their function remained a secret for many years. It was then found that when these bodies were removed a true tetany developed, which led often to a fatal termination. These parathyroid bodies are often difficult to distinguish during the removal of the thyroid, being situated usually where the thyroid vessels enter the gland. They get their blood supply apparently from the thyroid vessels, and hence, if a complete thyroidectomy be made, the main trunk of the vessel should not be ligated, but rather the branches as they enter the gland. Halsted usually leaves the upper pole of the thyroid where the superior thyroid enters. One of the dangers of this procedure is the liability of secondary hemorrhage. Dr. Charles H. Mayo leaves the posterior capsule of the gland, believing by this procedure that the parathyroids will be uninjured. Halsted, who has had an unfortunate experience in one of his cases, does not think that Mayo's procedure will preserve the integrity of these important bodies. He has successfully transplanted parathyroids in the spleen of a dog, and also into the opposite half of the gland. Von Eiselberg had two cases of grave tetany following thyroidectomy during the past four years, and in both cases the administration of the dry parathyroids successfully relieved the condition. In one case of tetany of long standing, he transplanted into the abdominal wall, a parathyroid gland taken from a patient operated on for goitre. The result was very good indeed, as the tetanic symptoms were very much improved. The rectus muscle and spleen are eminently suitable structures for such transplantation.

If only one-half of the gland be removed, together with the isthmus, the destruction of the parathyroids on this side of the body will not influence the health of the patient, yet in this operation I believe these bodies should be preserved if possible, otherwise it would be dangerous to operate later on the other half, a condition, however, which fortunately seldom occurs. Partial thyriodectomy has been very successful in the treatment of exophthalmic goitre or Graves' disease, yet it is an operation difficult of execution, and quite dangerous.

The treatment of the gland with X-rays for some weeks before operation, will, it is said, toughen the tissues, thereby

lessening the danger of hemorrhage, and perhaps also that of acute thyroidism. This latter danger, is, I believe, the greater of the two, and for this reason the gland should be freely exposed before attempting its removal, and free drainage should be provided.

The treatment of essential epilepsy by resection of the cervical sympathetics has not been attended by sufficient success to warrant the belief that much amelioration will result from it. The reports of cases operated on vary so much, that one unconsciously feels that the reporters in many cases, are not unbiased. In the cases that have been followed for years after the operation, a return of the attacks has been the rule, just in fact, what one would expect where the procedure is lacking in the pathogenic basis.

The excellent experimental work of Carroll has given rise to great advances in surgery of the arteries and veins. Many investigators have now been able to transplant kidneys, thyroids, etc., and it is difficult to say to what extent these experiments may benefit the human being. Arteries are now sutured when injured, and it is found that they heal quite readily. In January, 1903, I closed a small transverse wound of the femoral artery with fine silk sutures, and it healed perfectly, with apparently no thrombus, as the tibials pulsated normally afterwards. The patient, a farmer, lived for about two and a half years, doing his ordinary work, and died from a lightning stroke.

The improved method of treating aneurism by opening the sack, removing the fibrin and clots, closing the vessel openings by sutures, and then obliterating the sack, is now generally employed by surgeons. The sacciform aneurism may be cured by this, the Matas operation, without destroying the usefulness of the vessel. In fusiform aneurism, Halsted has devised a silver band with which he contracts the lumen of the vessel, without completely cutting off the circulation. His experience with this method has been encouraging.

For many years, only the simplest operations were attempted in the thoracic cavity. Now, however, if there is a wound of the heart or lungs, the injured part is exposed and the wound sutured.

We have learned that these tissues heal readily, provided that there be no infection, or infection of a mild grade only. During the last few years numerous cases have been reported where the heart has been successfully sutured, and indeed in many of these cases the patient was in a very dangerous state before the operation.

With Sauerbruch's pneumatic chamber the chest may be opened without shock due to collapse of the lung, and I believe the time is not far distant when every well regulated hospital will be provided with a special room for operating on lung cases. Even at the present time many cases of gangrene and abscess of the lung are cured by an early operation. It is difficult to distinguish between abscess and gangrene of the lung, yet for all practical purposes the diagnosis is unimportant as the treatment is the same in both conditions. The main point is to open early, before extensive changes have taken place. If one waits until the abscess wall becomes very thick, with infiltration and induration of the surrounding parts, or where, through aspiration, other parts of the lung become involved, the prognosis is not nearly so good. An X-ray examination will aid very much in the localization of the disease. The aspirating needle is a dangerous instrument in such cases, as its employment subjects the patient to increased risks of infection.

In the early operation, simple thorough drainage will usually be followed by recovery, otherwise, free resection of the ribs becomes necessary. Where a fistula is left after an abscess has been drained, the lung may be resected. Even the whole lobe has been successfully removed, with cure of the patient. When Sauerbruch's chamber is not available, the careful application of sutures which attach the pulmonary to the parietal pleura should be made. Where further security be desired, and the condition of the patient permits, a weak iodoform gauze tampon may be applied to the pleura, and allowed to remain for one or two days before opening the diseased focus.

An interesting point in connection with the anesthetic, is, that it is only needed at the beginning and end of the operation, as the lung and pulmonary pleura are not sensitive to pain.

Diseases of the stomach and duodenum have been discussed so much during the last few years, that it seems superfluous to say anything about them, yet many of the cases of cancer come too late for a radical operation. Hoffman in an analysis of 665 cases received in the Mikulicz clinic, found that the patients were referred to the surgeon on an average of 10.3 months after the beginning of the disease, and usually they were treated by the physician three months before surgical aid was sought. This should not be. Unless an early diagnosis be made, the result must be unsatisfactory. Take a middle-aged patient with good previous history, or history of old digestive derangements, who begins to complain of stomach trouble, which is not relieved by

the usual remedies, an exploratory incision should be made, and if a suspicious growth be found, a radical operation should be done. A palpable tumor cannot be felt often where the growth has advanced to such an extent that a radical operation is impossible. Frequently, when all of the enlarged hardened lymphatic glands cannot be removed, the operation should still be performed, since in many cases, these enlarged glands are not carcinomatous.

In careful hands the results are very good, and as a rule, the shock is not great. The general practitioner must realize the gravity of these cases, and the necessity of consulting a surgeon before the symptoms are so marked that the diagnosis is evident. The successes of Kocher, Kronelein, von Mikulicz, Terrier, Hartman, Robson, Mayo, Armstrong, and many others, warrant, yes, I may say, demand an operation. When a small tumor is felt in a breast, the patient is almost invariably referred to a surgeon for advice, and why should a doubtful stomach case be left until a positive diagnosis be made?

There are some points in connection with surgery of the stomach, in which the surgeons are not in unison. It appears to me wise to excise an indurated ulcus, for in these cases, a small cicatrix as left by an excision will give less chance for the subsequent development of carcinoma. In one case operated on several years ago by the Y method, there was a return of the symptoms, with hemorrhage three years after the operation. The stomach was not enlarged, hence it may be deduced that the anastomotic opening remained sufficiently patent for its purpose. In a second case operated on for perforated gastric ulcer, the ulcer was inverted. About two years later this patient also had some return of his symptoms. In cases where I excised the ulcer, there has been no return of symptoms. Where a gastro-enterostomy is required in greatly debilitated patients, local anesthesia will, I believe, greatly increase the chances of recovery. Four of my cases of cancer were bed-ridden, and were much emaciated; excision was impossible. A posterior gastro-enterostomy was done under cocaine infiltration, all recovered, and gained flesh.

Hemorrhage from the stomach occasionally occurs after appendicitis. This seems to indicate that toxines formed in the appendix reach the stomach and cause glandular degeneration with perhaps the formation of an ulcer. Where there is catarrhal appendicitis hyperchlorydria is frequently present; and

thus, when an operation is being undertaken for gastric ulcer, the appendix should be examined if possible.

The treatment of disease of the gall bladder is now on a firm basis, and as time goes on I feel sure that we will meet with fewer cases of common duct stones, for the cases will be operated on before the stones get into the common duct, though, of course, there will be some cases where the stones form in the hepatic or common duct.

In cirrhosis of the liver the Thalm operation has been found of great value. In at least 50 per cent. of cases operated on, the symptoms are either entirely relieved, or markedly improved. With a mortality of 35 per cent., great judgment should be shown in the selection of the patients. If this be done, the death rate will undoubtedly be diminished. I believe it is wiser not to employ drainage, as the danger of infection is thereby lessened. Where it is necessary to excise portions of the liver for neoplasms, the hemorrhage is usually effectually checked by sutures of catgut carefully applied with large blunt needles. Only the largest vessels need be ligated. The liver heals quickly.

During the last year exception has been taken by many of the English surgeons to the removal of an apparently normal appendix during an abdominal operation, and I was amused to see opposite views expressed on this point by the Editors of the London *Lancet* and the Edinburgh *Medical Journal*. I agree with the Scot, and would be very much disappointed if a surgeon closed my abdomen without removing the appendix. That some of the Germans favor this view may be gathered from an article of Pankow's, who in referring to the work of Kronig's clinic, says, "Wir bei unseren operationen die appendektomie nicht nur für erlaubt, sondern auch für geboten halten." Of course the appendix is useful in cases of mucous and ulcerative colitis. When brought through the abdominal wall it provides an excellent means of irrigating the colon. I have used it also as a safety valve in a case of obstruction of the transverse colon due to a band where the caecum and ascending colon were tremendously distended.

A number of cases of chronic sigmoiditis causing symptoms of obstruction, and closely resembling carcinoma, have been reported. Mayo considers his cases due to an acquired diverticulitis.

Last spring I operated on a case of acute obstruction due to an acute streptococcic infection of a segment of the sigmoid. An

excision of the part with an end to end anastomosis six weeks later, gave a perfect result. This case is, as far as I can find, unique. There have been eight cases of phlegmonous enteritis reported, but none of phlegmonous colitis that I can find in the literature.

NEURASTHENIA.*

By S. H. McCoy, M.D., St. Catharines, Ont.

Mr. President and Gentlemen,—Perhaps the most widespread trouble we as medical men have to deal with to-day is neurasthenia, entering, as it does, into the homes of the rich and poor, attacking male and female alike, adults, and often children.

If we accept as a definition of neurasthenia what is conveyed to our mind by looking to its derivation, we shall find that it covers a much wider field than that accepted to-day when we use the word.

There are many neurasthenic symptoms appearing as forerunners to more serious maladies, such as melancholia, insanity and disseminated sclerosis; yet we would be wrong in saying that the patient was suffering from neurasthenia.

The term, as accepted to-day, merely means a lowering of nerve potential. The neurons of the nervous system are incapable of being used to the capacity for which they were originally constructed.

It does not mean that there exists organic change in the nervous system, the presence of which causes simulation of neurasthenia for a certain period of time.

The pathology of neurasthenia is largely speculative, but if one looks to the construction of a neuron, and how one such neuron is continuous with a succeeding one only by arborization of the terminal endings of the axis-cylinder around the dendrites, he can see many ways by which lack of power to conduct impulses can be brought about.

A neuron is endowed originally with a certain percentage of power, not only for conductivity, but also for assimilation of its own food.

If from any cause whatever the cell potential is used up

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faster than it is made, it is only a matter of time till the neuron becomes bankrupt, necessitating a cessation of call on its energy so as to enable it to save up for the next inevitable expenditure.

According to the constitution of the nervous system, all conduction is along a neuron or concatenation of neurons in one direction, one set being centrifugal and the other centripetal, calling the cerebrum and cord the centre.

A neuron is made up of a nerve cell with its nucleus and nucleolus. From one end of the cell extends the axis-cylinder, and from the other a number of branched branches called dendrons. The terminal ending of the axis-cylinder arborizes around the dendrons of the succeeding neuron. If the protoplasm of the neuron is lacking in normal quality, or the intercellular substance existing at the synapses is below normal, it is not hard to imagine the conductivity from one neuron to another to be impeded. It is taken as true that an exhausted neuron is an irritable one, yet if the neuron is in an exhausted condition the part first affected should be the terminal fibres; as one sees in a dying or starved tree, the ends of the limbs are first affected. The conductivity may be affected by an increased separation at the synapses or by deterioration in the terminal fibres of the neuron.

Now, if we apply this to what we call neurasthenia, we can explain many of the symptoms which become classical.

By your permission I should like to compare the nervous system to an electrical apparatus composed of a dynamo—connected by wire with two junctions in it to a motor. The motor is capable of calling automatically on the dynamo for a fixed quantity of power per hour. Also the dynamo has material for so many units of energy per day.

So long as the connections are good in the wires there will be no loss of energy, but if these joints become corroded, the supply of energy from the coal or fuel running the dynamo shall run out sooner, and yet the motor itself only received its fixed quantity. The extra amount was lost in jumping the corroded connections.

So with the synopses in an exhausted neuron, not only running to musculature, causing early tiredness, but also in association fibres in the brain producing that irritability of temper so classic in this trouble. This is especially seen in a neurasthenic who, having his mind centred on some work, is suddenly called to direct his energies to something foreign to what he is at. He is almost sure to show irritability, and as his power of inhibition is weakened he may give vent to language more emphatic than

elegant. He feels inhibition would be an effort, so he allows the sail to go with the wind rather than tip the boat.

The symptoms of neurasthenia are many, but there are a few cardinal ones which must be looked for. I shall divide them into: 1. Psychical. 2. Physical.

The psychical symptoms are depression at times, but never without hope. The patient may visit one medical man after another, but he does so to be reassured in his hopeful aspect, and he takes the diagnosis and treatment given him in a straightforward way. He has no fixed idea in his mind regarding his trouble, as we find in hypochondriasis.

Also, one of the first symptoms of this trouble is a tendency to procrastination in one never before guilty of this.

Then there is inability to concentrate the mind long on one subject.

Memory fails.

These are easily explained, since memory is nothing more than that produced by association of ideas, and when the association fibres are exhausted it is not to be wondered at if memory comes slowly. This also affects judgment, since the latter is aided so by memory.

I know a mining broker, who has suffered from neurasthenia more or less five years, and he told me that he has not got one dollar ahead since it began, having made the bulk of his money previous to that time. His judgment is not so good, nor is his grip and power of determination to put into force what his better judgment may tell him.

The power of inhibition being low, explains the ease with which these patients weep; however, this temporary depression is soon followed by hope.

The physical symptoms are:

1. Early fatigue on exertion. As it takes an expenditure of nerve energy to produce muscle contraction, and constant expenditure to keep up muscle tonus, one sees why in nerve exhaustion the musculature should give out early. This fact lays before us clearly one of the great necessities in treatment, viz., muscle rest.

2. Possible loss of flesh—even to a point simulating a hidden malignancy. This is caused by exhaustion extending to the trophic nerves. I have seen flesh leave a patient as fast in neurasthenia as by tuberculosis or malignant disease.

3. Vaso-motor disturbances. This is sometimes well marked. The face and hands may be so flushed that one would imagine the

patient had hyperpyrexia, and yet the legs and feet be quite cold. One hand may be hot and the other one cold. One side of face may be blushing while the opposite may be normal. There seems to be lack of co-ordination in the vaso-motor centre. This also gives us a clue as to the reason for the weakness which accompanies digestive disturbances in neurasthenics.

4. Digestive disturbances. So many of these patients suffer from flatulence, both gastric and intestinal. As the digestive system is a drain on nerve energy, we may rather look for disturbances in that domain in neurasthena, especally if co-ordination is not perfect in the vaso-motor centre.

Constipation, of course, naturally follows, with the tired feeling increased by absorption of CO_2 from bacterial digestion of cellulose.

With the upset digestive tract in neurasthenia we have a vicious circle formed, at each revolution of which the patient is further down the hill.

5. Exhausted nervous system shows itself often in an irritability of the cord, or nerves leaving the cord.

It is common to find two spinous processes in regions of 1st and 2nd lumbar, or in mid dorsal regions, tender to pressure. Pain or numbness may radiate out from the spine, down one or both arms, perhaps down the legs; but the most common location is up the occipital region from back of neck. The patient feels relief on pressing the hand against the back of head. Numbness and tingling in finger may be present. Also, frequently there is present increased patellar reflex and a fine tremor of the fingers on extension of arm and fingers.

Etiology.—A. Predisposing. 1. Heredity. 2. Anything causing constant, excessive expenditure of energy. 3. Alimentary.

B. Exciting. 1. Shock. (*a*) Railway. (*b*) Bereavement. (*c*) Post-operative, with long convalescence. 2. Excessive strain at any one time.

1. Heredity. There is no doubt that high-tension dispositions may be inherited, and such a one is very prone to run into neurasthenia if overworked.

2. Prolonged overwork with anxiety will use up the nerve reserve, producing the trouble.

Nature is at all times trying to compensate for overdrafts made on her bank account, and she is like our every-day bank managers in this respect, that she does not tell us always in audible terms that we are nearing the end of our reserve, until

some day we make an overdraft. And then there is a great fuss. We are immediately put out of business, and politely told that we cannot resume business until we get a working reserve.

3. The constant drain on the nerve reserve in managing an upset digestive apparatus is also a predisposing factor to neurasthenia. There seems to be a constant connection between neurasthenia and a distended viscus, stomach or bowel, so much so, that I do not know of a cured case of neurasthenia who continued to have distended alimentary tract.

Exciting causes. 1. Shock. By railway accident, bereavement or surgical operation, it is possible to have an almost complete explosion of nervous reserve, leaving at one fell swoop the patient bankrupt. It seems to be caused at such times by conscious or unconscious inhibition under trying circumstances.

2. Sudden excessive strain in overwork may be the last straw that broke the camel's back, and leave the patient without nervous reserve.

Referring to post-operative neurasthenia, how often after an apparently simple operation the surgeon has advised the patient to take a stay in the country, and keep in the open, after which he would be all right,—only to find at the end of some weeks that he is as weak as ever. These cases often take a year or more to recover.

In completing a diagnosis of neurasthenia there are four other conditions which must be kept in mind, viz., hysteria, hypochondriasis, melancholia, insanity. In all of these troubles we may find some neurasthenia present, either all through course or as a prodromal symptom, but if there is evidence of the presence of any of the above, we must hesitate before calling the ailment neurasthenia, and give it the name in accordance with the real derangement.

In hysteria we have an inopportune inhibition of some higher centre over lower ones. It is a qualitative interference, whereas in neurasthenia any interference to proper action of lower centres is quantitative, due to exhaustion of nerve force.

If in a patient we find this ataxy of the higher centres instead of slow action due to exhaustion, we should relegate it to the domain of hysteria more than neurasthenia. It is true that neurasthenia in such a patient would predispose to hysterical manifestations, but would not initiate them.

An hysterical patient is very prone to suggestion, and also one capable of severe nerve strain under certain circumstances; not so with the neurasthenic, who cannot stand long strain, very

slow to repair, and who may easily be put beyond possibility of repair. Sharply defined spaces of loss of memory are characteristic more of hysteria than of neurasthenia.

In hypochondriasis I have touched on one cardinal distinction, viz., a fixed idea of their own trouble, whether or not it is compatible with their symptoms. If under argument they are made to admit they are wrong, they merely shift their position, only to take up another equally foolish and to them impregnable. They exaggerate all their symptoms, and may in time even become insane, and end their trouble in insanity. I do not mean to say that hypochondriasis is always a step towards insanity. Self-seclusion is a symptom of hypochondriasis, melancholia or insanity, rather than neurasthenia.

In a neurasthenic with constant melancholia, the prognosis for early recovery is bad. Morbid ideas are fixed and primary..

In insanity, the patient may not be alive thoroughly to his condition, and prolonged rest may merely be followed by exacerbation of some untoward symptom, which is the opposite to that found in neurasthenia. The latter is only too alive to his exhausted condition, and rest always ameliorates his symptoms.

The prognosis in neurasthenia depends on the ability of the patient to carry out thorough and rational treatment. Also any accompanying conditions of the body, such as dyspepsia, anemia, sluggish condition of intestinal tract, etc.

It is a question whether a patient who has lost almost completely his nerve reserve ever regains it completely. He seems to fall down comparatively easily, when an extra draft is made on his nervous energy, and becomes for a second or third time a nervous bankrupt.

Treatment.—To sum this up in as short a space as possible, we treat the nerve bankrupt in the same relative way that we do a financal bankrupt who is anxious to regain his credit in the bank, viz., cut off all controllable nerve expense and live on the minimum amount, laying by the rest as a reserve fund. Now, what are controllable expenses?

As it takes an amount of nerve energy to run the musculature and keep up the necessary tonus, this expense can be reduced by putting the patient in the horizontal position and keeping him there. By the judicious use of massage he is enabled to remain in bed with impunity for a protracted period and handle a large amount of nourishment.

Let me express my disapproval of the extravagant way that so many ladies use that therapeutic agent, massage. They im-

agine that, after severe physical and mental exertion, to which they may have been stimulated, they can be materially aided by an hour's massage on retiring at night. In reality they are burning their candles at both ends.

With very few exceptions massage should not be given in long treatments to neurasthenics, unless such person be kept in bed and it is used to take the place of exercise.

Indigestion, with the subsequent distension of the stomach or intestines, or both, is another source of nerve expenditure. As nature is constantly trying to compensate for deficient performance of function, and as a distended viscus is a weak one, one can see where there must be an extra drain on the nerve force to carry on digestion under such circumstances. Hence necessity for a diet that will be least apt to form gas and still be very nourishing. As cellulose is the substance most apt to form gas, its avoidance in early treatment of neurasthenia with flatulence is imperative. Its digestion is largely bacterial in the bowel, and it is split up into CO_2 and methaue. The former is absorbed and eliminated via the lungs, and the latter remains, distending the intestine until passed by rectum.

In these cases with flatulency, avoidance of fruit and vegetables is soon followed by diminution of gas.

The carbohydrates are supplied by well-cooked whole-wheat bread made from flour in a very fine state of pulverization. I find that coarse bread does not always answer well, and that if wheat be stone ground and bolted, we get a flour very finely ground, and still entire wheat. The rest of the diet may consist of beefsteak, mutton, lamb, fowl, bacon, eggs, fresh fish, milk, custards.

Perhaps the first thing to be done is separation of the patient from the environment which surrounded him when the trouble supervened. By constant association of ideas with surroundings the patient is unconsciously using up nerve energy, which is obviated by removal to a strange environment. This is very important, even in the less severe cases which may not have to be confined to bed for any length of time.

After treatment of this sort has been established for a time, and the patient has improved, an ocean trip may materially assist a cure. I do not advocate travelling for sight-seeing, but merely to go some place to sit down figuratively speaking.

Before a patient gives up with nervous prostration, they have been living at high tension for some time, and as soon as they

cease working or change their surroundings to a quiet one, relaxation immediately sets in, and they feel for ten days or two weeks to be getting daily weaker. After a time they remain *in statu quo*, and then begin to gain. This reserve, however, is slow to accumulate, and a small overdraft may undo weeks of convalescence.

DISCUSSION.

DR. HOWLAND described a new symptom found in many cases of neurasthenia with motor symptoms, as paraplegia.

Ataxia simulating tabes may be present, and while the condition is due in that disease to the loss of the sense of position, in neurasthenia it is probably due to the consciousness of the weakness of control over the legs, due to the nervous asthenia. In both conditions, on examination of the limbs, the muscles will be found strongly contracted, so as to hold the limbs firm at the joints.

By showing the patient this fact, in neurasthenia, and at times in tabes, the gait may be *at the time* greatly improved by evidencing the correct method of using the limbs.

DR. JOHN HUNTER (Toronto).—In many neurasthenics the function of respiration is carried on very feebly. Instruct these patients to fix the shoulders, relax abdominal muscles, and practise deep inspiration and prolonged expiration. Tell him to use his watch and count the number of seconds to which he can extend both acts. It amuses him to find how soon he can increase the time of each act from eight or ten seconds up to forty or fifty seconds. The increased amount of oxygen taken into the blood is of great value. The prolonged expiratory act removes waste products from the system.

DR. D. H. ARNOTT.—This disease is of such widespread character that no member need offer any apology for presenting his ideas concerning it. I think, in fact, we owe it to each other to give our individual experiences, so that in the possession of many points of view we may have a better idea of the trouble generally.

When a so-called neurasthenic presents digestive symptoms, we ought to be sure that a chronic appendicitis does not exist. While the patient was strong this was not of sufficient consequence to need operation, maybe; but when once broken in health and presenting digestive disturbance, the removal of the appendix is often needed to ensure recovery.

The biggest task, and the most exhausting, you can give a neurasthenic is to throw upon him the responsibility of the con-

duct of his own case. To tell him he only has overworked himself and should go away, have a complete change and rest, and he will get well, is a very cruel and mistaken advice. You should assure him he can get well, and from day to day you should take interest enough in each case to visit frequently, assure him, if possible, that his case is progressing satisfactorily, and that you hold yourself responsible for the successful conduct and outcome of the treatment.

One point in the treatment, and an esential one, is that of sufficient sleep. I use bromides, if necessary, for a few weeks, and as a result I find the patients sleep, and that tension so commonly seen has been broken.

DR. MITCHELL congratulated Dr. McCoy on his excellent paper, and particularly on placing neurasthenia on a definite basis, so that it does not cover everything pertaining to a nervous case.

The importance of the psychic treatment, letting your patient thoroughly understand that there was definite cause for their many symptoms, and that they were certainly ill. He spoke of the importance of rest. In treatment he recommended wet packs, either hot or cold, to assist in removing the toxines, and also to promote sleep, as insomnia is a prominent symptom; careful diet, and massage as indicated by the symptoms. Change of scene is useful, but patient must be kept under the personal supervision of a physician, and never allowed to depend upon himself. The doctor must think and direct for the patient in everything.

DR. BURSON.—This is a definite disease, characterized by diminution of nervous energy and subsequent nervous irritability. It is a very important point for us to see that neurasthenia is as much a disease as pneumonia or gonorrhea. I am afraid that I cannot agree with Dr. McCoy on his theory of the pathology of neurasthenia. It is not a lack of power conductivity of the neurons, but a lack of nervous energy. The condition may be compared to a system of steam heating, where the pressure of steam is very low, but the pipe or conveying organs are intact.

A very interesting symptom which was not mentioned in the paper is fear of bodily diseases, or a causeless fear, such as a fear of open places, etc.

With regard to the treatment, Dr. McCoy has covered thoroughly the physical treatment of the malady, but I regret that he has not said anything about the psychical treatment. This psycho-therapy is very important, and the physician who hopes to treat the neurasthenic successfully must pay particular atten-

tion to this branch of the treatment. The usual advice to the neurasthenic, "You are all right, go to work, take plenty of exercise," is not the proper way to deal with these patients. The neurasthenic is a sick man, and he knows it, in spite of whatever the doctor may say to the contrary. The physician who listens to his tale and tells him that he has a definite malady, which he believes can be cured, gives him mental support during his time of trouble and does much toward the successful treatment of the disease.

DR. OLDRIGHT.—In connection with the etiology of neurasthenia, I would refer to the practice of our young people going to so-called evening parties and remaining at them until one or two o'clock in the morning, instead of getting their needed sleep, and this even when the next day's work has to be done as usual. The increased worry and mental strain of our business men, the multiplication of appliances such as the "ticker," telegraph and telephone, are also responsible, as well as the speculative tendencies of the day. When such men come for "nerve tonics," if these are given to tide them temporarily over a pressure period, it should be with the understanding that as soon as possible they must reduce the work and tension, and not whip up the willing horse with a nerve tonic indefinitely and leave no reserve to fall back upon. Insanitary habits in other respects, such as ill-ventilated rooms, errors in diet and eating, etc., contributed to the injury of the neurons as well as other parts of the organism. The speaker would like to ask the reader of the paper whether it was better to make a habit of going to bed regularly at the same hour, even if a somewhat late hour, or to be irregular, by going to bed sometimes an hour or two earlier than at others.

DR. MCCOY.—In answer to Dr. Oldright's question I should say that sleep in this condition should be taken whenever it can, even in the daytime. A patient should never put off sleep in daytime in hope that they may get it at night. After a time sleep may come more regularly, as nerve energy accumulates. In health, regularity in sleep is essential, as is that of all other functions.

A SIMPLE STAINING METHOD FOR THE GONOCOCCUS.

By J. G. Fitzgerald, M.D., and E. H. Young, M.D., Toronto
From the Laboratory of the Toronto Asylum

Preliminary Note.—The method here suggested has been found very useful, and because of its simplicity it must appeal to the busy practitioner, by whom so many laboratory procedures are difficult of performance and require the expenditure of no inconsiderable amount of time.

The gonococcus is stained by any aniline basic dye and is declorized by Gram's method. These facts are taken advantage of by the advocates of the common method of staining where Bismarck brown is used to differentiate the gonococcus.

Our method is simply the application of Nissl's soapy methylene blue solution without any counterstain—the solution is made up as follows:

Methylene Blue B. Patent	3.75
Venetian Soap	1.75
Distilled Water	1000

The smears, which should be made on slides (and care must be taken to have them *as thin as possible*), are fixed in the air and then stained (without heating) for one minute with Nissl's, washed, blotted and are ready for examination with the oil-immersion lens.

The objections to the method are that there is no counterstain, and other pyogenic cocci may be mistaken for the gonococcus. We feel that if the smears are thin so that individual pus cells can be carefully studied this objection will lose weight. The other objection, that any ordinary methylene blue solution would do as well, we have not found to be the case.

For many years Nissl's stain has been a popular differential cell stain in the preparation of tissue of the central nervous system, and although it is unreliable at times for permanent preparations, its value in the study of sections that are examined at once is of undoubted value, and we have found it is of equal value as a simple laboratory method for the study of gonococcus.

Proceedings of Societies.

CANADIAN MEDICAL ASSOCIATION—THE NEW CONSTITUTION AND BY-LAWS AS ADOPTED AT THE MONTREAL MEETING, SEPTEMBER 11th TO 13th, 1907.

Article I. Title.

This society shall be known as the Canadian Medical Association.

Article II. Objects.

The objects for which the Association is established are the promotion of the medical and allied sciences, and the maintenance of the honor and the interests of the medical profession by the aid of all or any of the following:

(*a*) Periodical meetings of the members of the Association, and of the medical profession generally, in different parts of the country.

(*b*) By the publication of such information as may be thought desirable in the form of a periodical journal which shall be the Journal of the Association.

(*c*) By the occasional publication of transactions or other papers.

(*d*) By the grant of sums of money out of the funds of the Association for the promotion of the medical and allied sciences in such manner as may from time to time be determined.

(*e*) And such other lawful things as are incidental or conducive to the attainment of the above objects.

Article III. Membership.

The Association shall be composed of ordinary and honorary members. Ordinary members must be: (*a*) Regularly qualified medical practitioners, who do not subscribe to any special dogma; (*b*) Those engaged in teaching or research work in medicine or the allied sciences, in some province of the Dominion of Canada. Honorary members must be persons who have distinguished themselves and risen to pre-eminence in medicine, the allied sciences, in literature or in statesmanship.

Article IV. Affiliated Societies or Associations and Branch Associations.

All Provincial, Inter-Provincial Medical Associations or Societies, at present existing in the Dominion of Canada, or

which hereafter may be organized in the Dominion of Canada, may, by special resolution of said Medical Society or Association, become branches of or affiliated with the Canadian Medical Association, by subscribing to its Constitution, By-laws, Code of Ethics, and by securing the approval of the Executive Council. Where such organization does not exist, inter-provincial societies or individuals may unite directly with the Canadian Medical Association, until such provincial or inter-provincial associations or societies are formed and affiliate when their membership will be continued only through such local organization.

ARTICLE V. EXECUTIVE COUNCIL.

The Executive Council shall be the business body of this Association. It shall consist of delegates elected by the affiliated societies, associations or branches, by the Provincial Medical Councils and by the Canadian Medical Association as hereinafter provided for in the By-laws. It shall elect by ballot all the officers for the Association, except the President, Vice-Presidents and Local Secretaries, and transact all the general business of the Association. The President, Vice-Presidents, General Secretary and Treasurer shall be members of the Executive Council.

ARTICLE VI. SECTIONS.

Sections may be provided for by the Executive Council, or as hereinafter provided for in the By-laws.

ARTICLE VII. MEETINGS.

The meetings of the Association shall be held annually, at such time and place as may be determined by the Executive Council, the branch or affiliated organization within whose boundaries the meeting is to take place withdrawing its regular meeting and holding simply an executive session, such session to be held at the same time and place as the meeting of the Canadian Medical Association.

ARTICLE VIII. OFFICERS.

Sec. 1.—The offices of General Secretary and Treasurer may be held by one and the same person.

Sec. 2.—These officers, excepting the President, shall be elected annually by the Executive Council to serve for one year or until their successors are elected and installed in office.

Sec. 3.—The Treasurer shall give a bond to the Finance

Committee for the safe-keeping of all funds in his possession and for their proper use and disposal.

Article IX. Finance Committee.

The Executive Council shall annually appoint five of its members as a Finance Committee, which shall also be a Publishing Committee, and whose duties will hereinafter be provided for in the By-laws.

Article X. Funds.

Funds for the purposes of the Association shall be raised by an equal annual assessment upon each Ordinary member; from the Association's publications, and in any other manner approved of by the Finance Committee. These funds, from whatever source derived, are to be transferred to the Treasurer, by him deposited in some responsible banking institution, and only paid out by him on the order of the General Secretary and the Finance Committee, through its chairman.

Article XI. Amendments.

No amendments to any of the foregoing articles or sections thereof shall be made, unless due notice has been given in writing to the General Secretary at least one month before the annual meeting. Any such notice of motion must be laid by that officer before the Executive Council and sanctioned by a three-fourths vote of that body present and voting before it is submitted to the Association.

BY-LAWS.

Article I. Membership.

Section I. Membership. How Obtained.

A member in good standing of an affiliated medical society or association may become a member of the Canadian Medical Association by presenting to the General Secretary: (1) A certificate of membership in good standing in an affiliated or branch society or association, signed by the president and secretary thereof; (2) Written application for membership on the approved form; (3) Payment of the annual subscription. In the absence of membership in a local association or branch a candidate may be elected to membership by the Council on the nomination of two members from personal knowledge.

SECTION II. MEMBERSHIP. HOW RETAINED.

So long as a member conforms to the By-laws of the Canadian Medical Association, he retains his membership therein.

Any member who fails to conform to the By-laws and whose subscription shall not have been paid on or before the 31st December of the current Association year shall, without prejudice to his liability to the Association, be suspended from all privileges of membership, and at the end of the succeeding year, if the arrears be still unpaid, he shall, *ipso facto,* cease to be a member. No member shall (except in case of his death or expulsion or of his ceasing to be a member under the previous provisions of this article) cease to be a member without having given previous notice, in writing on or before the 1st December in the current year to the Secretary of the Association, of his intention in that behalf, and having paid all arrears of subscription (if any) due by him.

SECTION III. MEMBERSHIP. HOW RESTORED.

Any delinquent member having once failed to comply with the sections of this article, unless absent from the country, shall have his name erased from the Register of Members of the Canadian Medical Association, and shall not be restored to membership until all such dues, as may be determined by the Executive Council, have been paid, and satisfactory evidence produced that he retains his membership in an affiliated society or association, if admitted through such channel.

ARTICLE II. REGISTRATION OF MEMBERS.

No member shall take part in the proceedings of the Association, nor in the proceedings of any of the sections thereof until he has properly registered his name and paid his annual dues for that and previous years.

ARTICLE III. GUESTS AND VISITORS.

Sec. 1.—Medical practitioners residing outside of Canada and other men of science of good standing may be received by invitation of the Canadian Medical Association, the Executive Council, the President, or any one of the sections or at the discretion of any of these on a letter of introduction from an absent member of the Association. They may, after proper introduction, be allowed to participate in the discussions of a purely scientific nature.

Sec. 2.—Medical students may be admitted to either the general meetings or to the meetings of any of the sections thereof, but shall not be allowed to take part in any of the proceedings. They shall be vouched for as such students by some member of the Association to either the General Secretary or Treasurer.

Article IV. Honorary Members.

Honorary members shall be elected unanimously by the Executive Council.

Article V. Association Year.

The Association year shall be the Calendar.

EXECUTIVE COUNCIL.

Article I.

Qualifications for Representatives on Executive Council.

Sec. 1.—No one shall serve as a member of the Executive Council who has not been a member of the Canadian Medical Association for at least two years.

Sec. 2.—Members of the Executive Council shall be elected for one year.

Sec. 3.—Every Branch, affiliated Society, or Association shall be entitled to elect in addition to its President, who becomes an *ex-officio* member, one delegate to serve on the Executive Council for its membership from fifteen to fifty; two delegates for its membership from fifty-one to one hundred and fifty; three delegates for its membership from one hundred and fifty-one to three hundred; and thereafter one delegate for every three hundred of a membership above three hundred; provided that no one delegate shall represent more than one affiliated society or association to which he may belong.

Sec. 4.—At the first general session of each and every annual meeeting of the Canadian Medical Association, fifteen members thereof, who shall be present at that annual meeting, shall be elected by ballot to act on the Executive Council for one year: provided that any one already elected a delegate by an affiliated society or association shall not be at that meeting elected a member of the Executive Council. The President of the Association shall name three tellers to conduct this ballot. The fifteen having the greatest number of votes shall be declared elected.

Sec. 5.—Every three years the Executive Council shall appoint a committee of five to examine the registers of membership of all affiliated societies or associations and so apportion the number of delegates entitled to be elected by each society.

Sec. 6.—Every delegate from an affiliated society or association shall be required, before acting on the Executive Council, to have entered his name on the Annual Register of The Canadian Medical Association, paid his annual subscription to the Association and deposited a certificate with the General Secretary of the Association, duly signed by the President and Secretary of the affiliated society or association, from which he has been elected a delegate.

Article II. Order of Business.

Sec. 1.—The following shall be the order of business in the Executive Council, which can only be changed or departed from by an unanimous vote of that body:

I. Calling the meeting to order by the President.
II. Reading the minutes of the previous session.
III. Reports of officers.
IV. Reports of Committees.
V. Unfinished business.
VI. New business.

Sec. 2.—The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting the sessions of the Executive Council.

Sec. 3.—Ten members of the Executive Council shall constitute a quorum for the transaction of business.

Sec. 4.—It shall be the privilege of chairmen of Committees and members of the Executive Council, to report to the Executive Council, and they shall have the right to discuss their own reports.

Article III. Meetings of the Executive Council.

Sec. 1.—The meetings of the Executive Council shall be held on the dates of the annual meeting of the Canadian Medical Association, but not until after the first general meeting of the Association, and then not at the time of any general meeting of the Association, and shall report at each business session.

Sec. 2.—The Executive Council shall elect its own Chairman, annually, from amongst its members. He shall be eligible for re-election.

Sec. 3.—Special meetings of the Executive Council shall be called by the Chairman of Council, upon a written requisition, stating the objects of such meetings, and signed by twenty members of the Executive Council.

ARTICLE IV. NOMINATIONS, ELECTIONS AND INSTALLATION OF OFFICERS.

Sec. 1.—(*a*) The general officers of the Association shall be a President, a Vice-President, and a Local Secretary, for each of the Provinces of the Dominion of Canada, who shall be the Presidents and Secretaries of the provincial organizations; a General Secretary and a Treasurer. The President shall be nominated by the Council and elected by the Association in General Session.

(*b*) Nominations. Any five members of the Association may hand to the General Secretary, in writing, the name of any member of the Association whom they may wish to nominate for any office, except in the case of the Finance Committee, which shall, in all cases, be elected by and from the members of the Executive Council, or any member of the Executive Council may nominate any member of the Association for any office.

Sec. 2.—(*a*) The President of the Provincial Association, within whose boundaries the Canadian Medical Association is to be held, shall be *ex-officio* 1st Vice-President of the Canadian Medical Association; and the Executive Council shall elect annually the General Secretary and the Treasurer. These officers shall serve for one year or until such time as their successors are elected and installed in office.

(*b*) All elections shall be by ballot and a majority of the votes cast shall be necessary to elect a candidate. Should there be more than two nominees for any position, the one having the lowest number of votes shall be dropped and a new ballot proceeded with. This procedure shall be continued until one of the nominees receives a majority of all votes cast, when he shall be declared elected.

Sec. 3.—The election of officers shall take place at any meeting of the Executive Council, and the exact time for same shall be fixed by the Executive Council.

Sec. 4.—The President shall appoint three tellers to conduct the ballot.

Sec. 5.—The Executive Council shall annually decide on the number of general addresses to be given at the succeeding annual meeting and shall elect the readers to deliver same. In default

thereof on the part of the Executive Council, this duty shall be discharged by the President.

Sec. 6.—Installation. The President-elect shall be installed by the retiring President, at the first general session of the annual meeting of the Association succeeding the one at which he was elected.

OFFICERS AND COMMITTEES.

Article I. Duties of Officers.

Sec. 1.—President. The President shall preside at general meetings of the Association and at meetings of the Executive Council. He shall deliver the annual Presidential Address at either the first or second general session of the annual meeting, held under his presidency, as he may decide. In the absence of the President, the Vice-President for the Province in which the meeting is held shall perform the duties, or, in his absence, the meeting shall select a Vice-President. The President shall appoint annually a Committee of Arrangements consisting of five members who shall reside in the place at which the Association is to hold its annual meeting. He shall also name the Chairman of this Committee.

Sec. 2.—The President shall be an *ex-officio* member of all committees.

Sec. 3.—In case of the death or resignation of the President the Vice-President for the Province in which the annual meeting is to be held, shall become the President.

Article II. Vice-Presidents.

The Vice-Presidents shall assist the President in the discharge of his duties at his request.

Article III. General Secretary.

Sec. 1.—The General Secretary shall also be the Secretary of the Executive Council of the Association. He shall give due notice of the time and place of all annual and special meetings, by publishing the same in the official journal of the Association, or if necessary in the opinion of the Finance Committee, by postal card to each member. He shall keep the minutes of the General Sessions of the annual meetings of the Association, and the minutes of each meeting of the Executive Council, in separate books, and shall provide minute books for the secretaries of

the different sections which he shall see are properly attested by both chairmen and secretaries thereof. He shall notify members of committees of their duties in connection therewith. Where necessary or deemed advisable by the President, he shall conduct correspondence with other organized medical associations or societies, domestic or foreign. He shall preserve the archives, the published transactions, essays, papers and addresses of the Association. He shall see that the official programme of each annual meeting is properly published, and shall perform such other duties as may be required of him by the President or Finance Committee.

Sec. 2.—The General Secretary shall be *ex-officio* a member of all committees.

Sec. 3.—For his services the General Secretary shall receive a salary which shall be fixed by the Finance Committee.

Sec. 4.—The General Secretary may also be elected to the office of Treasurer.

Sec. 5.—All his legitimate travelling expenses to and from the annual meetings and other places ordered by the Finance Committee shall be paid for him out of the funds of the Association.

Article IV. Local Secretaries.

The Local Secretaries shall assist the General Secretary at the annual and special meetings and shall perform the duties of corresponding secretaries for the respective provinces they are elected to represent; these duties shall be performed under the direction of the General Secretary.

Article V. Treasurer.

Sec. 1.—The Treasurer shall receive and collect the annual fees and demands of the Association from the members. He shall be the custodian of all moneys, securities and deeds belonging to the Association, and shall only pay out moneys on an order drawn by the General Secretary and approved by the Finance Committee, whose chairman shall also sign all such orders.

Sec. 2.—The Treasurer shall give to the Finance Committee a suitable bond for the faithful discharge of his duties, and shall receive for his services a salary to be fixed by the Finance Committee.

Sec. 3.—The Treasurer may also be elected to the position of General Secretary.

Sec. 4.—When the offices of General Secretary and Treasurer are filled by one and the same person, it shall be the duty of the Finance Committee to appoint a collector of dues and subscriptions at each annual meeting, who shall be responsible to the Finance Committee.

ARTICLE VI.

All the officers shall discharge the duties of their respective positions until the completion of the business and scientific proceedings of each meeting.

FINANCE COMMITTEE.

ARTICLE I. APPOINTMENT AND DUTIES OF THE FINANCE COMMITTEE.

Sec. 1.—The Finance Committee as set forth in the constitution, shall consist of five members annually appointed or elected from the members of the Executive Council. This Finance Committee shall have charge of all the properties of the Association and of all the financial affairs of the Association. It shall elect its own chairman. The chairman may then appoint any sub-committees that may be necessary or desirable in connection with the finances of the Association. This Committee shall have charge of the publication of the official journal of the Association, and of all published proceedings, transactions, memoirs, addresses, essays, papers, programmes, etc., of the Association. It shall have power to omit, in part or in whole, any paper or address that may be referred to it for publication in the official journal of the Association, by the general meeting, the Executive Council or any of the sections. It shall appoint an editor and a managing editor of the official journal, who may be one and the same person if by them deemed advisable, and shall define the respective duties and responsibilities of each. They shall also appoint such assistants as may be deemed necessary for the proper conduct of this official journal, and shall determine their salaries and the terms and conditions of their employment. The Finance Committee shall have the accounts of the Treasurer audited annually or oftener if desirable, and shall make an annual report on the same to the Executive Council. The Finance Committee may meet when and where they may determine, and the chairman shall call a meeting on the request of three members in writing, and three mem-

bers of the Finance Committee shall constitute a quorum for the transaction of the business of the Finance Committee.

Sec. 2.—The President and General Secretary shall be *ex-officio* members of the Finance Committee and the General Secretary shall act as the Secretary of the Finance Committee.

Sec. 3.—Any donations recommended by the Executive Council shall be paid only with the approval of the Finance Committee.

Sec. 4.—The Finance Committee shall fix the annual assessment, and where feasible make equitable arrangements for commutation with provincial societies according to circumstances.

COMMITTEES.

Article I. Classification of Committees.

Sec. 1.—There shall be (a) Standing; (b) Special and (c) Reference Committees.

Sec. 2.—Standing Committees. The Standing Committees shall be the following: A Finance Committee, a Committee of Arrangements.

Sec. 3.—The Finance Committee shall be appointed by the Executive Council and its members shall always be appointed or elected from amongst the members of the Executive Council.

Sec. 4.—The Committee of Arrangements shall be appointed by the President. They shall be residents in the place in which the annual meeting is to be held, and the chairman thereof shall be named by the President.

Sec. 5.—The Committee of Arrangements shall be required to undertake to provide for transportation; a hall or halls for meetings purposes; a hall for Executive Council meetings; halls for section work; rooms for committees; rooms for general secretary, and other secretaries; room for registration; room or rooms or halls for exhibition purposes.

Sec. 6.—The General Secretary shall act in an advisory capacity to the Committee of Arrangements.

Sec. 7.—The Committee of Arrangements shall have power to add to its numbers and shall name all the Reference Committees as well as the chairmen thereof.

Article II. Special Committees.

Special Committees may from time to time be appointed by the Executive Council; they may be named by the President on

the authority of the Executive Council. They shall perform the duties for which they were called into existence, and shall in all cases report direct to the Executive Council as hereinbefore provided.

ARTICLE III. REFERENCE COMMITTEES.

Sec. 1.—The Executive Council shall at its first meeting appoint all the Reference Committees and name the chairmen thereof. Their titles shall be as follows: (1) A Committee on Sections and Section Work; (2) A Committee on Medical Legislation; (3) A Committee on Medical Education; (4) A Committee on Hygiene and Public Health; (5) A Committee on Amendments to the Constitution and By-laws; (6) A Committee on Reports of Officers; (7) A Committee on Credentials; (8) A Committee on Necrology.

Sec. 2.—The General Secretary shall notify each member of these committees so appointed, of his duties.

Sec. 3.—Committee on Sections and Section Work. The Committee on Sections and Section Work shall secure papers for the sections. It shall report to the President or to the Executive Council when required.

Sec. 4.—Committee on Legislation. To the Committee on Legislation shall be referred all matters pertaining to local and federal Medical Acts. It shall report to the President or the Executive Council when required.

Sec. 5.—Committee on Medical Education. To the Committee on Medical Education shall be referred all matters pertaining to medical colleges and medical education. It shall report to the President and Executive Council when required.

Sec. 6.—Committee on Hygiene and Public Health. To the Committee on Hygiene and Public Health shall be referred all matters relating to hygiene, public health, etc. It shall report to the President or to the Executive Council when required.

Sec. 7.—Committee on Amendments to the Constitution and By-laws. To the Committee on Amendments to the Constitution and By-laws shall be referred all matters relating to the subject, before action thereon by the Executive Council. It shall report to the Executive Council when required.

Sec. 8.—Committee on Reports of Officers. To the Committee on Reports of Officers shall be referred the President's address, the report of the General Secretary and the report of the Finance Committee before submission to the Executive Council.

Sec. 9.—Committee on Credentials. To the Committee on

Credentials shall be referred all questions regarding the registration and credentials of delegates, before submission to the Executive Council.

Sec. 10.—Committee on Necrology. To the Committee on Necrology shall be assigned the duty of collecting, as far as possible, the obituaries of members dying since the last annual meeting. These shall be duly filed by the General Secretary. The committee shall report on the call of the President at the last general session of each annual meeting.

Sec. 11.—Three members shall constitute a quorum of any Reference Committee, and all reports shall be made as hereinbefore provided.

SCIENTIFIC WORK.

ARTICLE I. GENERAL MEETINGS.

Sec. 1.—Date of Meetings. The date of each annual meeting shall be fixed by the President on the advice of the Committee of Arrangements.

Sec. 2.—Time of Meetings. The general meetings or sessions shall be held at 10.30 a.m., and 7.30 p.m., of the first day of any annual session and at 7.30 p.m. on the subsequent days. The President shall preside at all general meetings, and in his absence, or at his request, one of the Vice-Presidents.

Sec. 3.—The President shall deliver his annual address at one of the general meetings of the first day, as he may determine. The time of the deliverance of all other general addresses shall be arranged for by the Committee of Arrangements.

Sec. 4.—The order of business of the first general session of each annual meeting shall be as follows:

1. Calling the meeting to order by the President.
2. Prayer; by some one designated by the President.
3. Addresses of welcome and response.
4. The report of the Committee of Arrangements.
5. Reading the minutes of the last general session.
6. The report of the General Secretary of the last annual meeting.
7. Election of the Association's members to the Executive Council.
8. Presidential or other addresses, if decided on by the President and Committee of Arrangements.

Sec. 5.—The order of business for all subsequent general sessions shall be the same as that for the Executive Council.

Sec. 6.—All addresses delivered at any annual meeting shall immediately become the property of the Association, to be published or not, in whole or in part, as deemed advisable, in the official journal of the Association. They must, as soon as they have been delivered, be handed to the General Secretary, who shall refer them to the Finance Committee. Any other arrangement for their publication must have the consent of the author or of the reader of same and of the Finance Committee.

Article II. Sections and Section Work.

Sec. 1.—The sections to be held at any annual meeting shall be determined by the Executive Council. In default of their so determining the duty shall be discharged by the Committee of Arrangements, who shall also appoint or elect the chairmen thereof and the vice-chairmen and secretaries. These section officers shall serve for such meeting only, but any of them, if deemed advisable by the Committee of Arrangements, may be appointed for the following meeting in proper course.

Sec. 2.—Duties of the officers of sections. The chairman shall preside at each meeting of any section, or in his absence or at his request, the vice-chairman shall preside. The secretary of each section shall keep a correct account of the transactions, and shall record them in a special section minute book provided by the General Secretary. The chairman and secretary of each section must verify and sign the minutes.

Sec. 3.—Each section shall hold its first annual meeting at 2 p.m. on the first day of each annual meeting; and each subsequent day of the annual meeting at 9 a.m. and 2 p.m. until the programme of that section is completed. No section shall hold a meeting that will in any way conflict with a general meeting of the association.

Sec. 4.—Honorary members of this Association shall have the privilege of presenting papers before any section and taking part in any of the scientific discussions.

Sec. 5.—All papers, essays, photographs, diagrams, etc., presented in any section, shall become the property of the Association, to be published in the official journal of the Association or not as determined by the Finance Committee, and they shall not be otherwise published except with the consent of the author and of the Finance Committee.

Sec. 6.—Each author of a paper read before any section

shall, as soon as it has been read, hand it with any accompanying diagrams, photographs, etc., to the secretary of the section before which it has been presented, who shall endorse thereon the fact that it has been read in that section, and shall then hand it to the General Secretary to lay before the Finance Committee for publication, in whole or in part, or otherwise disposed of as may be deemed advisable by that Committee.

Sec. 7.—The order of procedure in any section shall be:

1. Calling the section to order.
2. Remarks by the chairman.
3. Reading minutes of previous meeting.
4. Reading of papers and discussions thereon.
5. Nomination of honorary members of the Association.

Sec. 8.—No paper shall be "Read by Title," except by unanimous vote of the section before which it was to have been read.

Sec. 9.—No business of any description shall be introduced at any meeting of any section except as hereinbefore provided. The time allotted for each paper shall not exceed fifteen minutes, and that for the discussion of such paper, five minutes.

AMENDMENTS.

Article I.

The Executive Council at any annual meeting may instruct the Finance Committee to make or to have made any changes in the articles of Incorporation which may appear desirable, or which may be made necessary by any change or amendment in the constitution and by-laws of the Canadian Medical Association.

Article II. Amendments to By-laws.

No amendment to by-laws shall be made except on a three-fourths vote of the Executive Council; provided that no amendment shall be acted on until the day of meeting following that on which the amendment was introduced, and approved by the Association.

Physician's Library.

American Edition of Nothnagel's Practice.—Diseases of Intestines and Peritoneum. New (2nd) edition, revised. by DR. HERRMANN NOTHNAGEL, of Vienna. Edited, with additions, by H. D. ROLLESTON, M.D., F.R.C.P., Physician to St. George's Hospital, London, England. Octavo of 1,059 pages, illustrated Philadelphia and London: W. B. Saunders Company. 1907. Cloth, $5.00 net; half morocco, $6.00 net. Canadian agents: J. A. Carveth & Co., Ltd., Toronto.

In the volume before us a very considerable number of additions have been made. Nothnagel's "Practice" is such a well-known classic in medical literature that commendation from us is eminently unnecessary. Some alterations in the arrangement and substance of the additions made in the edition of 1904 are an undoubted improvement. The work is so exhaustive in character that to attempt to review each chapter would alike prove burdensome to the reader and unprofitable to the publisher. To those who have not yet perused the work we would like to call attention to the chapters on "Chemic Processes that Occur in the Intestine," "Bacteria of the Intestine," and the very satisfactory chapter on "Ulceration of the Intestine."

A Manual of Diseases of the Nose, Throat and Ear. By E. BALDWIN GLEASON, M.D., Clinical Professor of Otology at the Medico-Chirurgical College, Philadelphia. 12mo of 556 pages, profusely illustrated. Philadelphia and London: W. B. Saunders Company. 1907. Flexible leather, $2.50 net. Canadian agents: J. A. Carveth & Co., Ltd., Toronto.

We have long felt a preference for the compact monograph or manual, especially for use in our "bedside library"—such a book as one can read in bed for an hour without suffering from partial paralysis of the hands and forearms through holding it. Of course we do not choose conciseness at the expense of thoroughness. Such being the case, it is not surprising that this little work of Prof. Gleason's makes such a favorable impression on us. It is thoroughly up-to-date, and quite exhaustive enough in its treatment of the different subjects for the under-

graduate in medicine as well as for the great majority of practitioners. We have been particularly impressed with the chapter on "Diseases of the Accessory Sinuses of the Nose." Altogether the work is one we can highly recommend.

The Major Symptoms of Hysteria. Fifteen Lectures given in the Medical School of Harvard University. By PIERRE JANET, M.D., Professor of Psychology in the College de France; Director of the Psychological Laboratory in the Clinic of the Salpètriere. New York: The Macmillan Company. Toronto: The Macmillan Company of Canada, Limited, 27 Richmond Street West.

This small volume of 337 pages of text deals with a very interesting subject, one which is very much, as it were, taken for granted. It is the collection of lectures of a foreigner delivered before an American class in the fall of 1906. The idea is a new and a good one, provided, of course, it is reciprocal. The lectures, fifteen in all, were delivered in Harvard and Johns Hopkins. The subject is well handled, and adds considerable to the literature.

International Clinics. Vol. III. Seventeenth Series. 1907. Philadelphia, London and Montreal: J. B. Lippincott Company.

This volume presents a number of interesting articles, among which might be mentioned one on "Inoculability of Tumors and the Endemic Occurrence of Cancer," by Leo Loeb, M.D., of Philadelphia, and one on "The Etiology and Experimental Study of Syphilis," by Frederick P. Gay, M.D., Bacteriologist to the Danvers Insane Hospital, Hathorne, Mass.

The Development of the Human Body—A Manual of Human Embryology. By J. PLAYFAIR MCMURRICH, A.M., Ph.D., Professor of Anatomy in the University of Toronto. Formerly Professor of Anatomy in the University of Michigan. Third Edition, revised and enlarged, with 273 illustrations. Price, $3.00 net. Philadelphia: P. Blakiston's Son & Co.

To the scientific student of anatomy, and even the practical one, the development of the human body is each year becoming

of more interest. It is not surprising then that one who has been himself a close and diligent student of the subject should seek to place it in a tangible manner in a separate volume, for the benefit of the student anatomist, nor yet is it any the less surprising that in five years a third edition has been called from the press. The text is clearly arranged; the illustrations are the very best. We have pleasure in heartily endorsing this book.

Gynecology and Abdominal Surgery. Vol. I. Edited by HOWARD A. KELLY, M.D., Professor of Gynecologic Surgery at Johns Hopkins University, and CHARLES P. NOBLE, M.D., Clinical Professor of Gynecology at the Woman's Medical College, Philadelphia. Large octavo volume of 851 pages, with 405 original illustrations by Mr. Hermann Becker and Mr. Max Brodel. Philadelphia and London: W. B. Saunders Company. 1907. In two large volumes. Per volume: cloth, $8.00 net; half morocco, $9.50 net. Canadian agents: J. A. Carveth & Co., Ltd., Toronto.

Judging from the first volume of "Gynecology and Abdominal Surgery," a most important contribution to medical literature has been made by the long list of eminent surgeons mentioned in the beginning of this work. In the first place the very title bespeaks a comprehensive treatment of a variety of subjects which have until now so often been discussed separately, but which are clinically so intimately associated. Thus we find certain obstetric or gynecologic-obstetric subjects as puerperal injuries, the treatment of incomplete abortion, ectopic pregnancy and Cesarean operations carefully discussed.

Special chapters are devoted to such important subjects as operations during pregnancy, operations before puberty, conservative operations upon the uterine appendages, and the complications of operations. An attractive feature of the work is a section on medical gynecology to meet the needs of the general practitioner, who will find here the information he requires concentrated in one section, without having to search here and there throughout both volumes. Needless to say, much attention is devoted to modern surgical technic, and much pains have been taken in preparing the large number of excellent illustrations.

A feature which appeals to us is the omitting of elementary matters found in most text-books.

The work also embraces elaborate consideration of the bac-

teriology and pathology of the diseases of women, and an historic resumé of the development of gynecology and abdominal surgery. There are sixteen contributors to this volume, among whom may be mentioned: Brooke M. Anspach (Philadelphia), Henry T. Byford (Chicago), George M. Edebohls (New York), Fernand Henrotin (Chicago), Howard A. Kelly (Baltimore), Beverley MacMonagle (San Frnacisco), Charles P. Noble (Philadelphia), Alexander J. C. Skene (Brooklyn), and J. Clarence Webster (Chicago).

Bacterial Infections of the Digestive Tract, and the Intoxications Arising Therefrom. By C. A. HERTER, M.D., Professor of Pharmacology and Therapeutics in Columbia University; Consulting Physician to the City Hospital, New York. New York: The Macmillan Company. Toronto: The Macmillan Company of Canada, Limited, 27 Richmond Street West.

While this small volume of 351 pages of nice reading text does not claim to be an extended nor yet a systematic study of an important and much-discussed branch of medical science, it yet does contain much which will be new and of a great deal of practical value to the ordinary general practitioner, who ordinarily has a great deal to do in the field of gastro-enteric infection. The part which will appeal most to him is that the author has laid considerable stress in his little work upon the methods worked out in his own laboratory. One may thus take the volume as a practical demonstration from the hands of one thoroughly capable and experienced. We are satisfied that it covers the literature sufficiently well to make it a valuable working hand-book for the every-day general practitioner.

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And Ontario Medical Journal

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COMMENT FROM MONTH TO MONTH.

Rectal Anesthesia.—An interesting paper, by Dr. Noel Bleecker Leggett, of New York, dealing with this subject, appears in the October number of the *Annals of Surgery*. After giving a brief history of the development of this method of anesthesia, and after showing the principal difficulties with which the different investigators had to contend, he brings us down to the paper by Dr. J. H. Cunningham, of Boston, published a few years since in the *Boston Medical and Surgical Journal*, wherein Dr. Cunningham demonstrated the practicability of his method of anesthesia, which may be explained in brief as follows:

"The vapor of ether is forced into the rectum in such a way that there is no condensation, and absorption takes place with such rapidity that it is not possible for fluid ether to be forced into the gut. This is done by keeping the ether heated, yet constantly below 37 deg. C., which is its boiling point, and forcing the fumes into the bowel by means of a rubber hand-bulb." A special apparatus is, of course, required. "The rectal tube is inserted 8 to 12 inches. Ether fumes are then slowly forced into

the rectum. They cause a sensation of fullness so that the patient may have a desire to defecate. This is overcome by opening the exhaust tube, and allowing the gases, which are in the rectum, to escape. This should be repeated as often as may be necessary. It will immediately relieve any possible distress, ... The patient may have for a time a slight discomfort, then becomes gradually drowsy, and the odor of ether appears upon the breath. He falls asleep, and in a comparatively short time has passed into full narcosis."

Dr. Leggatt gives a report of 13 cases he has anesthetized in this manner. In the majority of them, ether was begun simultaneously by the mouth, as well as by the rectum, and as soon as narcosis was reached, it was maintained by the rectal method alone. Dr. Leggatt says:

"Rectal anesthesia may thus be summed up from two standpoints, viz., from that of the patient, and from that of the operator.

"The lessening of nausea, the lessening of irritation to the lungs, and the lessening of the bronchial secretions, which are nearly entirely absent in most of the cases, are certainly all in themselves favorable. Furthermore, a fully and continuously clean field of action in all operations about the head and neck, saving time and loss of blood, and above all, lessening the chance of infection from an ether cone, are all points in favor of the method which must appeal to every operating surgeon."

Criminal Abortion, and the Punishment of those who Practice It.—In a series of articles in one of Toronto's daily papers (from the pen of its able Editor), the honor of the Ontario Medical Council, and, indirectly, that of the whole medical profession of the Province, has been called in question in a most unwarranted manner. Such a stain, it seems to us, calls for more than a passing protest from the members of the profession in question, both for the sake of those whose honor is assailed, as well as for the enlightenment of the public at large, whose interest in the matter is co-equal with that of the medical practitioner.

It may be said without fear of contradiction that the first duty of man, in relation to his fellow-man, is to be strictly honest. Here, at least, is a rule which applies equally to the man who sells stock, manufactures a machine, dispenses drugs, or raises his voice in the endeavor to establish social or moral reform, or to bring a criminal to justice. It may also be claimed that even an honest man should *know* whereof he speaks, before he ventures to make assertions relative to any given subject. In other words, it is no excuse for even an honest man to say, "I did not know," when the veracity of his statements is questioned, or his data are shown to be founded on error.

The writer in question has sought to show that the onus of responsibility for criminal abortion, as practiced by a few members of the medical profession in this province, rests on the Ontario Medical Council, and therefore, indirectly on the members of the profession who elect that council, and furthermore that it is their duty to see that such malefactors are brought to justice. And the reasonable inference one must draw from the fact that the Medical Council is not periodically dragging various and sundry offenders before the bar, is that Council and profession alike are shielding the said offenders. This, we claim, is not only an unfair attitude for this Editor to assume, in so far as it concerns his personal belief, but is also a conscious misapplication of the facts calculated to mislead the mind of the masses.

What are the facts of the case, as he must, or ought, to know them? Doubtless some few practitioners exist here and there, who, for a consideration of gain, will stoop to commit crime. The criminal records of the Province might justify such a supposition. But to imply that these offenders are well known to the profession at large, is at once absurd and unjust. Is the medical murderer—if such one might justly style the professional abortionist—such an inborn idiot that he will proclaim to the world at large, and his professional brethren in particular, his criminal practices? Does he call in any of his confreres to assist him in his nefarious work? Not likely! How, then, are his brethren to *know* of his wrongdoing? (And mark you, he has a right to style himself our "brother," until such time as he has been unmistakably proven to be unworthy of our noble fraternity.) The trouble is, we do not *know* him to be a criminal, and *may* never know him as such in this world. The Editorial writer in question says very glibly, "These men are well known." To whom are they known? Not to us. To the Editor himself? Then if so it is his bounden duty to lay the matter before the officers of the Crown, for this is a criminal

offence, and punishable only by the Crown. Furthermore, if he *knows* who the guilty party is, and does not seek to bring him to justice, he becomes *Particeps Criminis,* and as such should himself be brought to account for his complicity. "Well," he may say, "I do not actually *know* that such and such a physician is guilty, but I have heard—" . . . . ! Then, in common honesty, let him not lead the public to believe that—"such people are well known," at least to the profession. The writer has been in active practice for seventeen years, and during that time has heard vague rumors of a few medical men who are said to do criminal operations, but we do not *know* that such is the case, neither could we possibly prove it. Surely the gentleman would not have us rush to a magistrate with the plea, "I hear Dr. —— is doing criminal abortion!" And if he would have *us* adopt such a foolhardy procedure, can *he,* being honest, refrain from a like course? It goes without saying that the great majority of our profession feel keenly the blot that is put upon our fair name by the unprincipled few, but this does not warrant us in one and all taking up the roll of secret detective; *that* is the province of the proper legal authorities.

The Medical Council of Ontario is doing its utmost to maintain a clean profession in this Province, and is also doing its utmost to safeguard the interests of the people at large, by keeping out Quacks, and God knows what fake "pathies," as well as by keeping up a high standard to which all its graduates must conform. If the public and the press do not possess the brains to appreciate this fact, so much the more are they to be pitied. Such an unwarranted attack on our professional honor is as groundless as it is cowardly; but then, after all, the dog sometimes bites the hand of the master who feeds it!

There is a lot of twaddle heard among the laity about the medical profession being a "Doctors' union," "a close corporation," and what not, all of which is calculated to cast a slur on a profession which is *not* exclusive, but, on the other hand, is open to all, male or female, who choose to comply with the requirements for admission thereto.

It seems to us it were better if the press and the people would spend less time in heaping opprobrium on a profession which has no cause to blush for either its past or present (and which is too busy seeking out means to minimize human suffering to waste time in answering carping criticism, and would devote their energies to a more careful inspection of the cleanliness of their own skirts. Let the wage-earner consider more carefully if he gives value for the money he receives, the minister of the

Gospel be more circumspect in the matter of giving unqualified recommendation for Quack nostrums, of which he knows nought, and the newspaper man be more particular about inserting advertisements of abortifacients, under the guise of "menstrual irregularities cured, *from whatever cause!*"

Let us all refrain from too hastily judging the whole bag of apples of inferior quality, because there happens to be a rotten one on top! Let us all endeavor to be honest, and the Editorial reformer more careful in his statements, remembering that it is *not* the function of the Medical Council to try, sentence, and execute the medical criminal, but rather that this duty devolves upon the legal officers of the Crown.

Canadian Medical Protective Association.—The very satisfactory manner in which the Canadian Medical Protective Association has been managed must especially appeal to those members of the Canadian profession who as yet have not been sufficiently interested in their own individual welfare, to say nothing of the collective welfare of the entire medical body, as to take the necessary steps to become members of that now well-established, keen and progressive organization. That an organization of this character could thrive as it has done and grow in membership steadily from year to year since its inception in Winnipeg in 1901, speaks exceedingly well for its management. Not a single case it has undertaken to defend has been lost; and each year, as its defects in working have been learned of, it has been perfected and thereby strengthened. This, we consider, is most remarkable. Under the Constitution as amended at the recent annual meeting in Montreal, it is now necessary for an applicant seeking membership to be nominated by two members of the Protective Association in good standing; and the qualifications for membership are on the lines of those for membership in the Canadian Medical Association. Its organization was the best work ever done by the parent Association. It is inconceivable that all the members of the latter have not yet become members of the former. However, an Association with a membership of 528 and a bank balance of over $2,000, with the history of having never lost a case, is a great achievement for which the membership may well thank its management.

News Items.

DR. ROBERT S. B. O'BRIEN, Nanaimo, B.C., is dead.

TORONTO is adopting a measure of medical inspection of schools.

DR. NIDDRIE, of Creemore, was badly shaken up in a runaway accident recently.

THE death is announced of Dr. Buchan, for many years in the asylum service of Ontario.

MORE whiskey was drunk and more tobacco smoked in Canada in 1906-1907 than in 1905-1906.

A NEW nurses' home is to be built in connection with the Royal Jubilee Hospital, Victoria, B.C.

ORIGINAL research work in the opsonic theory is to be carried on by the Medical Faculty of Queen's University.

DR. F CAWTHORPE, of Tiverton, has purchased the medical practise of Dr. Kilbourn, on Hastings Street, Parkhill.

VANCOUVER GENERAL HOSPITAL has found it necessary, to avoid hospital abuse, to appoint a collector of accounts.

DR. GRIER, who has had charge of a practice in Quebec for some weeks for another physician, is back in Dundalk again.

DR. F. J. BALL, Rugby, left recently for Regina, Saskatchewan, where he intends making his home for the present.

DR. GALBRAITH, who has been practicing in Dundalk for the past two years, has purchased a business in Western Ontario.

DR. A. K. GIFFORD, formerly of Wingham, has been appointed license commissioner for Welland, to succeed Alex. S. Murray, resigned.

DR. A. K. GIFFORD, formerly of Wingham, has been ap pointed resident surgeon of the London Asylum for the Insane, and commenced his duties on October 1st.

DR. WALTER B. GEIKIE, Toronto, for many years Dean of Trinity Medical College, has received the honorary degree of Doctor of Laws from Queen's University.

DR. WM. OLDRIGHT, Toronto, Professor of Hygiene in the University of Toronto, has returned from several months' visit to the old land.

DR. JOSEPH E. GIBBS, Victoria, B.C., was in Toronto recently on his way home from Vienna, where he was doing graduate work in genito-urinary surgery.

DR. SHEARD, Medical Health Officer, Toronto, favors the establishment of a civic hospital, owing to the hospitals having raised their rates from 50 cents to 70 cents per day.

DR. F. F. WESTBROOK, Dean of the Faculty of Medicine in the University of Minnesota, delivered the annual opening address to the students of the University of Manitoba.

DR. T. S. SPROULE, M.P., has presented to the Markdale Public Library a five volume set in leather of Hansard's Debates and Speeches of the Dominion Parliament for 1905.

DR. EDWARD P. DOHERTY, surgeon in the Maritime Penitentiary, Dorchester, N.B., died at the home of his brother, John A. Doherty, at Moncton, Oct. 2, after two years of failing health.

ASSOCIATE CORONERS recently appointed are: G. F. Johnes, of Webbwood, Algoma; J. E. Godfrey, of Richard's Landing, Algoma; W. A. Graham, of Toronto; Warren Kilborn, of Sharbot Lake.

DR. C. A. LANGMAID, who has been taking a special course in medicine in Glasgow and Edinburgh Universities, is now at Llantwit Major, a town near Cardiff, South Wales, in charge of a Dr.'s practice there.

DR. MONTIZAMBERT, Director-General of Public Health and President of the Canadian Medical Association, has been in British Columbia in connection with instituting precautions looking towards the introduction of bubonic plague into Canada.

MR. R. B. FORBES, F.R.C.S., Stratford, Ont., has received the appointment of house surgeon in the West London (Eng.) Hospital. Mr. Forbes has had a very successful medical career, graduating from McGill University, taking the degree of M.R.C.P., L.R.C.S. in 1906, and the degree of F.R.C.S., London, in 1907.

ABOUT a dozen doctors from Stratford, Goderich, Clinton and other places, members of the Perth and Huron Medical Society, met at Clinton Wednesday afternoon, October 2. The meeting was an interesting one from a medical standpoint. Dr. Gunn presented a case, and Dr. Lorne Robertson, Stratford, and Dr. Macklin, Goderich, read papers.

Publishers' Department

OXOLINT is a new product which will be of great interest to our readers. By the Mudge process it is prepared from flax stock, and is said by surgeons of note to be a perfect absorbent linen. It is said to meet perfectly the requirements of medical and surgical practice, far surpassing absorbent cotton. It is manufactured by the Oxford Linen Mills, 212 Essex St., Boston. Canadian physicians visiting New York, may examine specimen products at 225 Fifth Avenue. A copy of a booklet, contrasting the old and the new method, may be secured through the Sterling Debenture Corporation, Brunswick Bldg., Madison Square, New York.

FOR NERVOUSNESS, sleeplessness and sexual excitement, characterized by erections or even chordee, various authorities vary in their recommendations. Ringer recommends the use of aconite and camphor. Bartholow and Phillips both advise the administration of lupulin. The value of Hyoscyamus has been appreciated by many medical men for a long time, and is quite valuable. Bromidia is to be highly recommended, since it consists of chloral, bromide, hyoscyamus and cannabis indica, and acts as a somnifacient, spinal sedative and hypnotic. The dose is a drachm to two drachms an hour before bed time.—*American Journal Dermatology.*

THE VALUE OF CODEINE.—*The Cleveland Medical Journal,* quoting from the *Denver Medical Times,* concerning Codeine, states that, according to Butler, "It is less depressing and more stimulating than morphine, does not constipate, cause headache or nausea, and rarely leads to the formation of a habit. Codeine seems to exert a special, selective, sedative power over the pneumogastric nerve, hence its value in irritative laryngeal, pharyngeal and phthisical coughs with scanty secretion. Like morphine, it has proved of value in checking the progress of saccharine diabetes, and it has been used for long periods, without the formation of the drug habit, inasmuch as when glycosuria was brought to a termination by dietary and other measures, the cessation of the use of Codeine was not followed by any special distress. The