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Original Articles

MALIGNANT DISEASE AFFECTING THE FUNDUS OF THE UTERUS.*

BY JAMES F. W. ROSS, M.D., TORONTO.
Associate Professor of Gynecology, University of Toronto.

When requested some time ago, by your President, to give a short paper for your consideration I decided that it would be interesting to discuss malignant disease affecting the fundus of the uterus, especially in connection with its early diagnosis. It is not my intention to take up the subject of malignant disease of the cervix uteri. I may say, in passing, that malignant disease of the cervix is readily recognized; it can be seen. The disease can be felt with the finger at the period of time when most of the cases present themselves to the physician for his opinion and advice. Unfortunately, a large proportion of those with which I meet are beyond help. The tissues about are already so much infiltrated that no operation will give a satisfactory result. Early diagnosis is to be hoped for and to be sought for, but, as yet, to be seldom obtained. The physician is not to blame and the patient herself can scarcely be blamed, because she has had but slight warning that there is anything amiss. But in those cases in which the malignant disease affects the fundus of the uterus there is, as a rule, ample warning and the attendant is certainly negligent in his duty if he is unable to diagnose the condition quite early.

I present for your consideration specimens showing malignant disease of the fundus in its earliest and its more advanced stages.

* Read at the meeting of the Toronto Medical Society, April, 1901.

Case No. 1.—Mrs. I., age fifty-three. Patient had passed the change of life and had seen nothing for several years. Hemorrhage occurred and it was found, on examination, that the blood was coming through a healthy cervix. No enlargement of the uterus could be made out. The fundus was freely movable. There was no disease to be found in the parametrium. An examination showed nothing except a normal condition. A curette was passed up into the interior of the uterus and a small portion of tissue removed. This was sent for microscopical examination and the report stated that it showed evidence of the presence of malignant growth. The patient was now prepared for hysterectomy. Before going on with the operation I dilated the cervix and passed my finger into the interior of the uterus. The finding of the microscopic report was corroborated by this examination and the malignant mass could be felt bulging into the uterine cavity. The uterus was removed per vaginam. Ligatures were used and two were placed on each broad ligament. The patient made an uninterrupted recovery.

Case No. 2.—Mrs. L., age fifty-two. In October, 1896, I removed both ovaries and tubes to produce atrophy of a fibroid tumor growing from the cervix uteri. The fibroid gradually reduced in size, degenerated into a cyst, and gave no further trouble. Four years passed by, the patient ceased being unwell in the interval. Hemorrhage began to show itself and the uterus was scraped to ascertain the presence or absence of any commencing malignant disease. A report was obtained from two pathologists and they were both of the opinion that the patient was suffering from malignant disease of the fundus uteri. The disease had all the characteristic appearance of malignant adenoma. I removed the uterus per vaginam, using silk ligatures to each broad ligament, two ligatures being placed on each side. The fibroid, that was at one time as large as a fist, has reduced down to the size of a walnut.

Case No. 3.—Mrs. S., age forty-seven. This patient was admitted into one of the hospitals, was curretted, and discharged as cured. Suffering from pelvic pains she felt anything but well, and decided to re-enter the hospital. This time she was placed in the medical wards. Her friends were anxious that I should see her. I found her suffering from indefinite pains and from a watery discharge, slightly streaked with blood, from the vagina. Her clothing was quite soiled by this discharge. In appearance the patient looked like a confirmed opium user and neurasthenic. Had it not been for the discharge per vaginam I should have considered the case as one of slight gravity. She was transferred from the medical to the surgical gynecological wards for further observation. An anesthetic was administered, cervix dilated, finger passed into the interior of the uterus and malignant disease of the fundus was found. It was quite unnecessary to examine the portions of uterine

tissue removed with the microscope as they were quite characteristic to the naked eye. Uterus was removed per vaginam; silk ligatures were used. Water was kept running over the wound during the performance of the operation, so that sponges were not required. The patient made an uninterrupted recovery.

Case No. 4.—Mrs. G., age fifty. Patient had suffered for some months with a discharge of blood from the uterus. Four years before I saw her the uterus was curretted by the family doctor. Hemorrhage then ceased and, within the past four or five months, a metrorrhagia came on and at times she almost lost her life as a consequence of the flooding. Nothing malignant was found when the interior of the uterus was examined four years before. A similar condition of the endometrium was supposed to exist on the second occasion. I decided to examine the interior of the uterus with my finger. When this was carried out a polypus was found and removed. Other rough nodules were to be felt on the endometrium near the fundus. A microscopical examination of the polypus removed showed that the case was one of malignant adenoma. The uterus was removed in the usual way; ligatures were placed on the broad ligaments. The patient made an uninterrupted recovery.

I might report other cases, but these four are sufficient to bring this subject fully before you.

The specimens presented for your consideration have been carefully preserved, owing to the fact that they demonstrate the different conditions met with. Let us now, for a moment, carefully examine the pathological specimens.

In the first case related the uterus is found to be normal in size, covered by healthy peritoneum, without any evidence of disease beyond the interior of the fundus. The cervix is normal in size and appearance. At one portion of the interior of the cavity of the body of the uterus a nodule is to be noticed slightly harder than the other contents of the cavity, but not as hard as the muscular structure of the organ itself. The remainder of the cavity of the fundus is filled by a soft structure, and it looks friable and loose on its surface, but firmly attached at its base. At another portion of the uterus, imbedded in the muscular wall, a firm nodule is present. This has not, however, extended to the peritoneal surface.

In examining the second specimen the position of the shrunken fibroid can be seen. It is found closely attached to the cervix uteri, towards its right side. The uterus is found to be normal in size, in fact, rather atrophied, as would be expected considering the age of the patient from whom it was removed. She had passed the menopause about four years. The peritoneal surface is intact and there is nothing in the outward appearance of the organ to indicate the gravity of the lesion really existing. On careful inspection of the endometrium the malignant growth can be noticed at the fundus, where it is found to exist in its very earliest infancy.

The inspection of the next specimen shows the disease further advanced. The uterine muscular tissue is hypertrophied and, as a consequence, the uterus is much enlarged. The whole interior of the cavity of the fundus is filled with the malignant mass. There is no evidence of any invasion of the peritoneal surface, but it is easily understood how, under such circumstances, the constitutional infection is greater than in patients in whom the disease has not progressed to such an advanced degree. This is the uterus that was curetted and the presence of malignant disease was overlooked, before I saw her. The presence of the watery discharge. and indefinite pains alone drew attention to the pelvic organs.

The next specimen shows, upon inspection, a healthy cervix. There is nothing in the cervix to indicate the presence of the disease above. The uterus is covered by a healthy peritoneum. The interior of the organ shows a nodule towards the right cornu about the size of a walnut. These nodules are irregular, lobed, but rounded. A polypus was present in this case but was removed from the specimen several months before the hysterectomy was performed.

Looking back over my experience with this disease I find that malignant adenoma, though removed early, is liable to recur within a short period of time. On two occasions I have removed the uterus presenting malignant adenomatous disease in its very earliest stages, from patients who have died from a recurrence of the disease within twelve and eighteen months respectively.

When the disease has extended beyond the peritoneal covering of the uterine fundus it is useless to operate. The only operation that can be considered, under any circumstances, is complete extirpation of the organ. In favorable cases this can always be carried out by the vaginal route.

When a patient, who has passed the menopause, has sudden uterine hemorrhage, the interior of the uterus should be explored by the finger. It is not sufficient to use a curette in many cases. It sometimes happens that the curette will remove sufficient tissue of the characteristic appearance to settle the diagnosis of the case, but in other cases the curette will fail to remove tissue that gives any such clue. The finger will readily detect the presence of commencing malignant disease of the fundus. The earlier the disease is recognized the better the result of the removal of the uterus ; a longer period will lapse before the disease recurs.

It must be remembered that in many cases there will be no uterine hemorrhage. A discharge, thin, watery, and irritating, will be complained of, and this discharge must not be mistaken for that accompanying senile vaginitis. These discharges become offensive after a time, but there may be no odor from them for a long period. When the discharges have become odorous it is often impossible to relieve the patient by surgical interference owing to the extensive ravages of the disease.

Indefinite shooting pains in the pelvis in a patient, past the menopause, must always arouse our suspicions. A careful examination should be made every six or eight weeks. Irritation and itching of the external genitals frequently accompanies malignant disease of the fundus. I look upon this irritation as the result of increased discharge.

Differential Diagnosis.

The differential diagnosis must be made between portions of retained placenta, sloughing submucous fibroids, hemorrhagic endometritis, deciduoma malignum, and malignant disease of the fundus uteri. The retained placenta can readily be made out by means of the finger. It may not, however, be as easy to differentiate between sloughing submucous fibroids and malignant disease of the fundus uteri. A microscopical examination of portions removed will be of very great assistance. I have met with several cases of sloughing submucous fibroids and have never had any difficulty in coming to a conclusion as to their nature after making a thorough examination of the interior of the uterus.

There should be no difficulty in diagnosing hemorrhagic endometritis. The endometrium feels velvety to the finger and the scrapings are characteristic of the disease. I rely very largely upon the appearance, under the microscope, of the portions scraped away.

Deciduoma malignum is a rare disease, but, when met with, its symptoms are rather classical. At first it is decided that the patient is pregnant. After a time hemorrhage sets in and it continues. The uterus enlarges and it is now difficult to diagnose between this condition and an ordinary mole. Metastases may occur and may obscure the diagnosis. Metastatic deposits frequently occur in the lungs, the patient becomes cachectic and the temperature becomes elevated and remains elevated, and death occurs in from six to eighteen months.

This disease is frequently mistaken for endometritis retained placenta, ordinary malignant disease of the uterus and placental polypus. The first symptom in each case is hemorrhage and, in a large number of the cases, it happens that the uterus has been emptied of a mole occurring as the result of the last impregnation.

Treatment.—What should the treatment of these cases be? In all cases in which the disease is confined to the fundus, the uterus should be removed without delay. If the disease has fixed the fundus no operation should be performed; the golden opportunity has passed. If nodules are to be found in either broad ligament it is useless to perform hysterectomy. The operation may be performed by means of the ligature or by using the clamps or angiotribe. I prefer the ligature; other operators prefer the clamps.

In performing vaginal hysterectomy I have a method of my

own. I use a water speculum and keep water running over the parts in order that I may do away with the nuisance of sponging. By this means the field of operation is kept clear so that the operator can see what he is doing. It is thus easy to dissect upon either side until the uterine arteries can be seen as curled vessels and ligated or secured. The outlines of the bladder can be readily made out as the blood is kept washed away from the raw surface and the exact position of the sound in the bladder can be seen through the tissues to assist in preventing perforation. When the operation is carefully performed and the bleeding thoroughly checked the mortality rate is low.

When considering the advisability of operation we have to consider, on the one hand, the risks to be run by the patient and, on the other, the fact that she is suffering from an incurable disease and that she has nothing but the grave staring her in the face. When dealing with an affection that of itself produces death, and considering the advisability of carrying out a somewhat hazardous surgical procedure we cannot afford to make the same allowance that we do when dealing with cases that may live for many years if left alone. On this account, I consider that partial operations, even though accompanied by a lower mortality rate, should give way to complete and more extensive procedures. Therefore, when a patient consults a surgeon for malignant disease of the fundus uteri, in its early stages, before the peritoneal covering is involved, before there are intra-peritoneal adhesions, and before any broad ligament nodules are to be made out, the only operation that should be considered is complete removal of the organ by abdominal or vaginal or abdomino-vaginal hysterectomy.

EXAMINATIONS FOR LIFE ASSURANCE.*

By W. H. Pepler, M.D., L.R.C.P., Lond.
Medical Examiner Mutual Life Assurance Company of Canada.

As medical adviser for life insurance, you are placed in a unique and often difficult position, for you have to pass between Charybdis and Scylla in trying to deal fairly and justly with both company and applicant; also while obtaining information from applicant you are his suspicious inquisitor; not *his* confidant, but the company's.

Insurance is based on the laws of average, not on isolated cases, and the low rate of mortality depends on the close reasoning, sound judgment and experience of the examiner. Life assurance

* Read before Undergraduates Society of Trinity Medical College.

is making rapid advances, and to-day in the United Kingdom, the liabilities of life insurance companies amount to £263,829,625; nearly half the entire population are insured. Business men look upon it as one of the best ways of investing their money. Medical men should all take out insurance when they are beginning their professional life, if possible, and I should advise the endowment plan, as in our profession the best work is done in early and middle life, having many years in which we will have to lay by the shovel and the hoe.

The examination forms have become very elaborate but very essential, for (1) they act as a guide; (2) they specify the points to which attention is especially called; (3) allow a proper estimate to be made of the proposer's health; (4) risks can be classified by them; (5) a useful indication for re-insuring; (6) a basis for statistics.

The expectancy table of life is what we base our reckoning on, and this expectancy at any age is the average after-lifetime of all persons at that age, and can be arrived at by deducting the age of the applicant from eighty, and taking two-thirds of the difference; thus, if forty is the age, twenty-seven is about the expectancy. In gathering statistics for life insurance we can get the after history of those. It is the duty of the examiner to promptly attend to all cases, to let no time elapse; as in many cases it is not the applicant who has sought the insurance, but the agent; and if any delay the applicant may cool off and the company lose the risk. Approach your applicant quietly and gently, as you would a child, whose confidence you wish to gain; try to put him in a good light, facing a window if possible; have a little chat with him for a minute or so, and during that time take soundings and note various points as to his general appearance, powers of resistance, etc. See if he looks like a man who takes care of himself. No third person should be present during the examination.

Heredity, as a rule, is not as fully considered as it should be. In noting the cause of death in family history do not use ambiguous terms, as accident, change of life, cold, dropsy, fever, debility—these convey very little information and require much tiresome explanation. Heredity as to duration of life I shall classify under three heads: (1) Where most reach adult life and die between sixty and seventy-two; (2) long-lived families; (3) short-lived families, where almost all die before sixty from a general break-down.

We find most applicants belong to class No. 1. No. 2 are very profitable risks, even if flaws in the applicant. No. 3 are very disastrous to the company. If applicant is young, inquire about grandparents, particularly as to their age either living or at death.

The hereditary influence of phthisis pulmonalis is a very

powerful element, greatest up to thirty, lessens from thirty to forty, and still less important from forty to fifty, but never ceases at any age. We often have cases after fifty if living is changed from good to bad. Heredity in chronic bronchitis and asthma and emphysema plays an important part, and if any such tendency in applicant refuse him.

Diabetes as to heredity.—Refuse applicant if under thirty, one parent and a sister or brother having died of diabetes; between thirty and forty a life might be taken with a large extra premium, and, later, a smaller one.

Arteritis is also often hereditary. Note if any relatives died of apoplexy or sudden deaths; if many deaths in family from any particular disease, traceable to either heart, arteries, nerves, kidney, alcohol, etc.; carefully note such tendency in applicant and base your report accordingly. The family history should be carefully collected by applicant beforehand, if possible. "We should be very careful whom we choose for our parents."

Influence of race on longevity at the age of twenty.—Americans and Canadians slightly better risks than British; then come the French, and lastly, and decidedly lower come the Germans. Negroes are bad risks from their tendency to tuberculosis.

Personal inquiry as to habits in the use of intoxicants, hours of work and taking of rest, tobacco, narcotics, employment—these will all influence you in your decision in summing up the case. The past history as to diseases, of course, should be carefully considered and weighed in the balance; personal examination as to nevi, warts, which often mean malignant growths in later life is important.

Average height to weight.—The heels of boots counterbalance the clothes. We allow a 15 per cent. average. An average table can be obtained in any work on insurance. A man five feet six inches should not weigh under 114 lbs., and not more than 174 lbs; sudden increase or loss of weight should be inquired into. If over weight find out where is the over development. The shoulders and chest should be large, abdomen moderate; limbs may be large and muscular; tissues firm, generally. Find out also habits as to exercise, food and stimulants. Of 587 overweights 74 deaths occurred, and only 68 were expected; excess not quite 10 per cent.

Note any deformities, blindness, deafness—these are prejudicial from their liability to accidents—find out their cause and the time that has elapsed since.

Spinal curvature.—I recently passed a severe case of lateral curvature of spine at the regular rate, the risk had had it for twenty years, and had been perfectly healthy ever since; and family history free from tubercle.

Note color of eyes, complexion, hair—the bright eye, long eyelash,

rosy complexion go with tuberculosis. The sluggish eye, muddy complexion with alcoholism, the puffy eye with kidney disease. Note pupils, if equal or sluggish to reaction, as from narcotics; note lips, if pallid or blue; skin, yellow or anemic. Note conformity of facial bones; high cheek bones often accompany tubercle. Is voice husky, high pitched or sharp, as it often is in tubercular laryngitis and aneurysms. Use laryngoscope in these cases. Temperature should always be taken, for in tubercular subjects this is often the red flag, as also in first stage of acute troubles. Watch for twitchings, either voluntary or involuntary. It would be as well to try the reflexes, as we so often have a hidden spinal or cerebral lesion. Examine mucous membranes for patches, syphilis or other diseases. Note breath, its odor, alcoholic or otherwise. Throat—generally only necessary to use the spatula; but the day is soon coming when the laryngoscope will be used in all cases.

Examination of chest must be without clothing of any kind; note shape, round or flat, fulness or otherwise of supra and infraclavicular spaces, the prominence of alæ of scapula. The amount of expansion is much a question of practice and knack. I find the average to be two and a half inches; some with large chest measurement can expand only one and a half inches, others with medium-sized chests often go seven and eight inches. See if both lungs do equal work. Take the number and character of respirations, often increased in number from nervousness; see if regular in rhythm.

Examination of special organs.—Lungs: Phthisis pulmonalis plays the most important part. Be careful of any risks who have a good growing ground for tubercle, such as an under-weight, narrow chested, dyspeptic-looking subject, with general poor vitality. Decline (1) all who have or might have had tuberculosis; (2) all with a family history of tuberculosis who might be suffering at the time, or have had, pleurisy, hemoptysis, chronic bronchitis, scrofula, curvature of spine, or any disease (suppurative) of bones or joints; (3) any person with family history of tuberculosis who has had much dyspepsia; (4) any person of tuberculous issue living under unfavorable hygienic conditions, or if the circumference of chest is small or weight below normal; (5) all under forty, if both parents were tubercular and if applicant is not of very strong constitution; (6) all who might be looked upon as candidates for tuberculosis, either from antecedents or constitution; (7) all issue of tuberculous parents, and who have lived, or are living, in contact with consumptives. Fistula in ano should be watched in this connection.

Heart.—The heart should be examined sitting, standing, lying, and after exercise. A slight attack of faintness during examination is not by any means a sign of heart trouble. Intermittency must be judged according to its cause; transient palpitation is of not much account. Epigastric pulsation is not very important.

Valvular diseases generally.—If applicant not over thirty-five, with entire absence in family and personal history of gout (kidney), alcohol and syphilis; compensation good with full regular and compressible pulse, and no hard manual or mental labor; most lesions could be passed with probably a slight extra premium. Valvular lesions, in private practice, seldom kill.

Special lesions—Aortic regurgitation and mitral stenosis are generally uninsurable. Mitral regurgitation is not by any means a bar to insurance, provided no cardiac symptoms and no evidence of changes in myocardium or chambers of heart, general nutrition being good, and habits regular. Look with suspicion on an irregular heart in those past middle life; look especially to walls of heart, as to hypertrophy and dilatation. A man with second aortic sound accentuated is overworking; postpone the risk and advise rest. I consider bradycardia more serious than tachycardia, as the latter is often due to nervousness. Tobacco heart is not generally a serious consideration and often a short postponement, with freedom from tobacco, makes risk good. In the heart of chorea the changes are generally structural, but may possibly disappear; however, always postpone. In a large abounding heart look out for kidney trouble. Angina pectoris and pseudo-angina are almost indistinguishable, and I would advise refusal. A congenital heart only insurable at a very early age.

Pericarditis.—After a regular attack with friction, effusion, etc., it may possibly end in a smooth surface and become a good risk; but lots of them end in adhesions and may interfere with heart's action, although you often have adhesion without functional disturbance, but these are dangerous and doubtful risks.

The pulse.—Low tension shows less vital resistance. The high tension pulse often points to kidney; a pulse from forty to sixty per minute a good working pulse. If below thirty at all times, you had better refuse. A pulse over eighty had better be postponed, and re-examined; look out for atheroma, as it often indicates syphilis, alcoholism or kidney trouble, and generally uninsurable.

Hemorrhoids go with blocking of portal system and constipation, and if very severe postpone and advise operation, with change of living, exercise, etc. Varicose veins not a bar unless severe; then postpone and advise operation. Hernia does not spoil a first-class risk, if truss is worn and is effectual.

The urinary and genital system.—See that the urine is passed by applicant, as there are numerous cases of fraud in this respect. Albuminuria, if permanent, refuse; if cyclic, use much care and repeated examinations; in absence of history of nephritis or renal changes it might be entertained. After great strain, physical or mental, it is less grave. Reject if albumin is present six months after an infectious disease. Take urine passed about 11 a.m., as more likely cyclic at that time. Cyclic albumin in those under

thirty may be admitted at higher rate for short period, if not more than 0.5 per cent.; but if it lasts five years do not renew policy. Remember albuminuria is always pathological—chills, emotions, over or bad feeding, and acute diseases the commonest causes. Albumin in middle life always dangerous.

Glycosuria, when temporary and controlled by diet, and family history being good, does not preclude. Middle-aged, fat diabetics may be taken with extra premiums. The microscope ought to be used in most cases when examining the urine.

Syphilis.—The laws are the same as to marriage; three years of proper and constant treatment and one year's freedom from symptoms I would admit on usual terms. Refuse (1) any person showing active or tertiary syphilis; (2) any person who had syphilis less than three years ago; (3) syphilitic persons who show signs of intemperance; (4) syphilitics suffering from malaria, as it is an aggravating factor; (5) refuse those who presented symptoms pointing to implications of nervous system during the early stages, such as transitory paralysis, diplopia, apoplectiform deafness. Fornier says: "Of seventy-nine cases of syphilitic tabes dorsalis, seventy-three were treated for less than a year; most cases met with between the sixth and twelfth year after infection." Syphilis with no treatment not accepted until fifteen years of freedom from signs.

Alcoholism.—Permanent reform is rare, therefore generally poor risks. The teetotal section shows decidedly better expectation of longevity than general section. In abstainers only forty-eight deaths out of each hundred expected is shown by statistics of the General and Temperance Insurance Company in fourteen years; if this continues abstainers should have a lower rate of premium; but be careful to find out how long applicant has been a total abstainer, as reformed drunkards are very bad risks. Statistics of Sceptre Life Assurance for thirteen years. Expected deaths of abstainers, 744; actual, 432, or 58.06 per cent.. Expected deaths of non-abstainers, 1399; actual, 1131, or 80.84 per cent. In liquor dealers, the actual deaths exceeded expectancy by 83 per cent. Causes of death of liquor dealers—urinary, very high; circulatory system, high; brain, high. This high mortality is due to late hours, bad atmosphere and over indulgence. They are bad risks.

Ear.—In suppurative middle ear look out for diseased bone, polypi, granulations and pain. If only perforation and discharge you might pass, guided by the position of the perforation—the higher, the worse the risk. Note acute character of discharge; social position and habits. If suppuration persists with caries, then refuse.

Neurasthenia.—Classes: (1) constitutional, including distinct nervous family history, these absolutely reject; (2) accidental or

acquired, which include (*a*) traumatic (*b*) symptomatic (hypochrondriac); (*c*) idiopathic or essential, brought on by excess of work—these adjourn or reject, according to family history, cause, general health, surroundings and occupation. Edema points to kidney, heart or vascular trouble, either remote or local; postpone and re-examine.

Hemophilia and scurvy.—Refuse temporarily.

Cancer.—Under forty, with cancer history, requires large additional premium or refusal.

Vaccination.—If not vaccinated should be at once.

Pregnancy.—Extra premiums are three times as large for first confinements. First confinement in women of thirty years and upwards, admittance should be delayed.

War risks.—Five per cent. per annum on all existing policies in localities of thirty degrees latitude, and an extra 5 per cent. on all south.

Endowment system good for those cases of early break-down in family history, or a consumptive strain in family history, or mitral disease with good compensation.

As to court evidence.—First get consent of the legal representative of the deceased and obtain your fee from the company calling you. If lawyer refuses, then decline to give evidence until the judge insists.

In conclusion, when rejecting an applicant, deal truthfully but gently with him; do not blurt out what can be explained in more tactful language.

SUGGESTIVE THERAPEUTICS.

By J. M. Jory, M.D., St. Catharines, Ont.

In the olden days men of physics and medicine were divided into classes, and adhered more strictly to their divisions than they do to-day; there were the Allopath, the Herb Doctor, the Homeopath, etc. To-day men are placed in certain classes but the conscientious physician is ever ready to accept that which is best for his patient, no matter whence it come. That in past years too many tinctures and extracts, powders and pills have been used, may be so; that now there is a tendency to lose faith in the drugs also may be a fact; but that drugs judiciously administered are of great value in very many cases no one will deny.

Electro-therapeutics already have been of much value, and there is yet room for investigation. Hydro-therapy had done much to relieve suffering humanity. Massage, dietetics, calisthenics and all the different kinds of therapies and treatments, including suggestive therapeutics, are of use and have their places.

In these days of hypnotism, mesmerism, telepathy, clairvoyancy, Christian Science, etc., with peoples of highly developed nervous systems, susceptible and imaginative, much may be accomplished by suggestive therapeutics. We believe that it is the suggestion and mental effect in the so-called Christian Science that enable people to get control of themselves and to know they have no actual disease. Every practitioner has a number of patients in whom there is "nothing specially" wrong. We all know the class, and yet they are "of all men the most miserable." Life is a burden to them and I fancy we often make it more burdensome by our dosing. If they become discouraged and leave us they may wander into hands of a Christian (?) Scientist. Probably the latter's mode of treatment is successful. He or she is lauded to the skies, and odium rests upon the practitioner or practitioners through whose hands they pass. Often in treating this class of patients we prescribe in a perfunctory sort of way, as much as to say: "Well, try this medicine and we'll see what it does for you." This does not tend to inspire faith in us; and faith is a great, powerful element in every human being—faith in something. I have heard it said: "If Dr. —— advised me to take a teaspoonful of Paris green I would do so." Even though faith be but the size of a grain of mustard seed it may remove mountains. We know not the limit of its power. If a patient have faith in his medical attendant he may give a bread pill, suggesting that it is a strong purgative, and free intestinal action may soon follow. A case that came under my notice some time ago was that of a woman who thought she had pneumonia. She had heard of a couple of fatal cases in the vicinity, which impressed her considerably. When I saw her she complained of shortness of breath, pain in the left lung, and numbness of the entire left side. The latter symptom was very prominent. There was complete hemi-anesthesia. As I examined her left chest (owing to her position she was unable to see me), I inquired if the pain in the lung were above or below the point of the stethoscope. She replied above, and yet she could not feel the prick of a pin anywhere on the left side. The lung was clear and I knew the condition to be hysterical. I informed her that I had no doubt whatever of her trouble and that I was confident I could help her. In order to increase her faith in me I told her there was always a sensitive spot on the calf of the leg. On the spot selected there was a small drop of blood which had exuded from a previous pin-prick which she had not felt. I applied a pin fairly vigorously which elicited no uncertain sound. I could not make her believe she had no disease, so left her some strych. nit. 1-60 gr., to take one every six hours. Told her at 9 a.m. next day the numbness would have left her head and face, and would be leaving her shoulder and arm. Saw her at 11 a.m. and it was so. Told her next day at same hour it would have left her arm, shoulder and side, and would

be down as far as the hip, and thus I worked it out at the great toe. She felt no more of it.

Another case; there was retention of urine following curettage of uterus. Not being attended by a trained nurse I had to visit and use catheter for three days. I became convinced that the woman had no valid reason to offer why she should not micturate. Even enema with free evacuation of bowels produced no action of bladder. Gave her two five-grain doses of boracic acid and informed her definitely that at 10 o'clock p.m. she would have to use the vessel. At the stroke of 10 o'clock she was quite successful in emptying the bladder.

Again, a case of heavy chill, teeth chattering—bed shaking—no evidence of fever, nor of absorption of anything septic, nothing which should produce a chill excepting, perhaps, a little domestic friction. Calomel triturates 1-10 gr., with suggestion, produced marked relief. The first relieved from chill and the second given in one hour, produced quiet, comfortable sleep.

A fourth case, which is most interesting—a woman at middle life, unmarried; has a remarkable variety of symptoms. She says her head is light, her bowels are about gone; her heart is bad; her stomach is cold; her knees are so weak, etc.

℞ Elix. lactopep..... ℥i.
Aqua.....ad ℥iv.

Sig.—Half teaspoonful after eating.

This will do almost anything for her that is suggested; but it will only do it for a few doses. Then it aggravates some of the existing troubles or induces others. Simple ointment applied to skin over cold stomach produces such a heat that it cannot be continued. The above mixture, given to strengthen the weak knees, does its duty, but besides that produces such a "boiling in the stomach." Definite suggestion works well for a time but her faith falters by the way and back she goes.

These cases are mentioned not because they are rare, but rather because they are so common. If by suggestive therapeutics, if by faith in us and what we give or do for them, we can relieve more speedily and more thoroughly, then are we a little nearer the object of our life's work. The fact is apparent that Christian (?) Scientists are increasing in number, that faith cures are more common and that the press the world over is giving more space to the discussion of this and kindred subjects. We gain nothing by standing aloof and pooh-poohing faith cures. Our desire is to cure. If there be some truth in faith-healing and Christian (?) Science let us accept it and use it, or any other means, if thereby we can the better help others and thus help ourselves.

Clinical Reports

CASES IN SKIN DISEASES.

By Graham Chambers, B.A., M.B., Toronto.

Lichen Planus.—Female domestic at St. Michael's Hospital; patient is deaf and dumb. Eruption began about the beginning of this year on the front of the forearms and slowly extended to the trunk and legs. The face and scalp have not been attacked, and as yet no lesions have appeared on the mucous membrane of her mouth. The primary lesions are always flat papules, which arise abruptly from the surface of the skin, and, as a rule, have a burnished appearance. This last character can be best seen when the papules are viewed obliquely. The lesions generally have a straight-lined polygonal contour. A few papules have a circular form, but these are usually larger than the polygonal-shaped lesions. Some of these appear somewhat umbilicated. When carefully examined with a lens the straight-lined margin of the papules can usually be shown to be the epidermic furrows which are normally found on the skin. The color of the lesions varies from white to violet. In addition to the discrete papules, small patches may be seen here and there over the body, but these are always formed by the coalescence of the primary lesions. The larger patches are covered with whitish scales. When the papules have disappeared pigmented spots frequently remain for some time. The patient suffered severely from itching and loss of sleep during the first month of the disease, but at the present time states that the rash does not give her any discomfort. The treatment consisted in the administration of a mixture of liquor arsenicalis and potassium bromide.

Scleroderma.—Case 1. William Davis, aged forty-nine, peddler; was admitted under my care to St. Michael's Hospital. His mother had died of old age and his father is still living and healthy. All his brothers and sisters are in good health. Patient was born in Poland and has travelled in England, Africa, Australia and Southern States. His business frequently compelled him to sleep out at nights, and he was exposed to cold and wet weather. When he was three years old he had cholera. When aged seven, an ulcer, one and a half inches in diameter, developed on posterior surface of left leg, about three inches above the heel. This persisted in spite of treatment, for seven years. It then healed, and from that date until he was thirty years of age he had good health. When thirty-two years old, and again two years later, he was attacked by rheumatism. He then had good health until he was forty years of age, when the first signs of the present disease showed themselves.

History of present disease.—Patient states that numbness and stiffness of the fingers were the first symptoms to appear. In two weeks the disease extended to lower half of forearms and then the legs and feet also became affected. The disease gradually extended until nearly every part of the surface of the body was attacked. The affected parts were stiff, hard and dry. The movements of the joints were interfered with and the stiffness of the muscles of the thorax caused some difficulty in breathing. The patient states the muscles of the jaws were so stiff that he was unable to masticate his food and had to be fed ; black colored spots appeared on the arm. The subjective symptoms at that time were numbness, coldness, shooting pains in the extremities, and insomnia. Patient was very nervous and had a poor appetite. About three years ago his eyesight became dull, and on account of this he entered Toronto General Hospital and was placed under the care of Dr. Burnham, who treated him with potassium iodide and pilocarpine. Considerable improvement appeared to result from this method of treatment.

Present condition.—The hardness of this skin has to a great extent disappeared except that on the hands. All the fingers were nearly fixed and somewhat deformed. Many of the natural lines are abolished. Patient is in a very poor state of health ; appetite is poor, and patient suffers from indigestion. The irides and conjunctivæ are inflamed.

Treatment.—Patient has had the advantage of many forms of treatment. While in New York he was successively under the care of Robinson, Bronson, and Fordyce. Hot baths, thyroid ext., electricity, massage, tonics, cod-liver oil, ichthyol, potassium iodide, pilocarpine, and many other drugs, have been tried. Some of these appeared to benefit the patient for a time. When he came under my care I gave him desiccated thyroids, and although he has appeared to improve, the stiffness and hardness of the hands still remain.

Scleroderma.—Case 2. M. M., aged thirty-five, female ; a patient of Dr. F. J. Guinane, admitted to St. Michael's Hospital on March 25th, 1901. Mother, one brother, and two sisters are healthy. Father died of apoplexy at the age of seventy-six. Patient had good health until present illness. There is no history of rheumatism. During last August patient was caught in rainstorm and got her clothing drenched, and although she did not feel any immediate ill effects from the exposure, still it was shortly after this that the first symptoms of her present illness appeared. The patient states that the first symptoms to appear were pains in arms and legs. She thought that they were due to rheumatism. These pains occurred two or three times a week, and did not last long. About two months later she noticed that the legs below the knees became tender to touch and the skin glossy and hard, and about the same time the thighs also became tender to touch. The disease

then extended to the arms. These parts became tender, hard and glossy, and the freckles which had been on her arm since she was a little girl disappeared from the diseased parts. The elbows and wrist became stiff, and she experienced considerable difficulty in using her fingers. Until a few weeks ago the disease continued to extend, indurated areas appearing on the neck, face, shoulders, and abdomen. At the present time she appears to be improving under the following treatment: Massage, electricity (constant current), and internal administration of theosinimin.

Case of Tinea Barbæ, Contracted from Cattle.—S. S., farmer; a patient of Dr. J. J. Cassidy, Moorefield, Ont. Patient gave the following interesting history of his case: He noticed, last fall, that fifteen to twenty of his cattle had scaly patches on various parts of their bodies. As soon as he began to stable them for the winter he obtained a "dip" from a druggist, and in a few weeks effected a cure. About the beginning of the present year the patient noticed a scaly patch on his face. This soon became indurated. The disease quickly extended until nearly every part of the face, covered with beard, was a mass of nodules and pustules. The hairs lost their lustre, and were easily extracted. An examination of the hairs showed the presence of large-spored trichophyton. The patient was treated as follows: All the hairs on the affected parts were epilated, and an ointment containing naphthol and ammoniated mercury applied twice daily. Dr. Cassidy informed me that the patient completely recovered in three weeks.

Case of Tinea Circinata, due to a Fungus Similar to Microsporon Audouini, and of Probable Animal Origin.—M. D., professional nurse, consulted me on May 2nd on account of rash on her face and neck. The eruption consisted of a number of circular patches about three-quarters to an inch in diameter, situated side by side. The borders of the patches were inflamed and crusted, while the centres showed a tendency to clear up. The arrangement of the patches side by side, and seven in number, produced a rather unusual appearance. A microscopical examination of the scales from one of the patches revealed the presence of a fungus which very closely resembled microsporon Audouini. The spores were not arranged in chains, and long filaments of mycelium, as occur in large-spored ringworm, could not be made out. The fungus consisted of spores and short rods, which were arranged, for the most part, in the form of clusters. The rods had lengths equal to about two or three diameters of the spores, and many of them appeared as if about to divide into spores. On inquiring as to source of infection, patient thought that she had contracted the disease from a little girl whom she had been recently nursing at Colborne, Ont. The child was under treatment for typhoid fever, but had ringworm on her face as well. She was supposed to have

been infected by a calf, which had scaly patches on its head. Unfortunately no microscopical examination of the scales and hairs from the patches on the animal's head was made.

Case of Tinea Barbæ, Contracted from Cattle.—(Notes supplied by Dr. M. Crawford.) Mr. L., rancher, Dakota, thirty-five years of age; lived some thirty miles from town. His cattle were suffering from ringworm, and he was applying a lotion prescribed by a veterinary surgeon. His neck became sore, but he allowed it to run about ten days, when he came to town and consulted me. The lesions—pustules, nodules—were situated on both sides of the neck. The superficial cervical glands were somewhat enlarged and later one on each side suppurated. Itching was intense, so that sedatives were necessary to secure sleep. On examination of the hairs from the lesions, the large-spored trichophyton was found, verifying diagnosis.

Treatment.—Applied mercurial ointments with moist dressing of bichloride of mercury from time to time, and epilation of hair from lesions.

FURTHER EXPERIENCE WITH THIOCOL.

Dr. J. W. Frieser, of Vienna (*Therap. Monatschrift*, Dec., 1900), who about a year ago published a report (*Therap. Monatschrift*, Dec., 1899) on the use of thiocol in pulmonary tuberculosis, etc., has had further experience in the use of this drug, which he details in a second report. From the numerous cases which the author treated with thiocol during the past year, he takes fifteen and gives their history in brief, without, however, omitting any essential detail. The results were excellent in all of these cases. The author used thiocol successfully in cases of tuberculosis, bronchitis, broncho-pneumonia, pleurisy, etc. He summarized his experience as follows: Thiocol is a remedy which deserves special consideration from physicians in the treatment of pulmonary tuberculosis, and of catarrhal and chronic affections of the pulmonary tract in general. It affects favorably the local process, not only in incipient phthisis, but even in the far advanced stages; it increases the strength, decidedly improves the appetite, as well as the digestion and the general nutrition; an improvement in the general condition of the patient and a constant increase in weight is the result. The cough and night-sweats are also influenced in a most favorable manner. Some patients took the thiocol uninterruptedly for months without any unpleasant by-effects ever having manifested themselves. Most of the time it was administered in a 10 per cent. aqueous solution with syrup of orange peel as the corrigent. Considering all these excellent properties thiocol deserves to take a high place in the therapeutics of tuberculosis.

Reports of Societies

TORONTO CLINICAL SOCIETY.

Stated meeting, April 3rd, 1901.

The President, Dr. W. H. B. Aikins, in the chair.

Notice of Motion.—Dr. Meyers—To amend Section 2, Article 9 of the Constitution, that the nomination of officers shall be held at the April meeting of each year.

PAPILLOMA OF LARYNX.

Dr. G. Boyd read clinical notes of this case, occurring in a child six and one-half years of age. First came under his notice in November, 1898, with loss of voice. Measles at four years and history of several attacks of croup. In spring, after measles, became hoarse; since that time voice gradually lost. Physical examination showed respiration, etc., normal. Papillomatous patches on both cords; tonsils hypertrophied. Three weeks after operation symptoms of whooping cough set in; membrane appeared and antitoxin and calomel fumigations employed. Intubation performed, tube for a four-year-old child being used. The tube was expelled in a few days, but as there was no dyspnea present it was not replaced. Two days after a severe laryngeal spasm occurred and the tube was reinserted. Post-mortem examination showed usual signs of asphyxia.

Drs. Ryerson and Anderson discussed the case.

MULTIPLE NEURITIS.

Dr. D. C. Meyers exhibited patient and described the conditions present in this case. The man, during the latter part of January, was exposed to a severe cold, and following that paralysis set in in both hands and feet, beginning simultaneously in all four extremities. Dr. Meyers had been unable to trace the cause to any other source than a severe cold.

Drs. Anderson and Rudolf discussed the case, the latter stating he had seen the patient in the hospital and thought he had had from him a history of using white arsenic in connection with his work.

INTERNAL HYDROCEPHALUS.

Dr. H. C. Parsons described this case, which had occurred in a child of twelve years. At the age of seven the child was quite well, going to school and quite bright. A full description of the case has already been reported.

Stated meeting, May 1st, 1901.

The President, Dr. W. H. B. Aikins, in the chair.
Visitors present: Drs. D. M. Anderson and Howland.

TEMPORO-SPHENOIDAL ABSCESS; OPERATION, RECOVERY—EXHIBITION OF PATIENT.

Dr. Herbert A. Bruce presented this patient and recited history of the condition. It occurred in a young man of twenty-four years. When he was a small boy, about five or six years of age, he had ear trouble, otitis media in the right ear, and was treated in Toronto by two or three ear specialists for a period of five or six months. He was taken home then apparently cured, continuing to have a little boracic acid dusted into his ear, and the discharge ceased in a few months. Up to the 1st of March of this present year had no trouble, apparently, at all, except occasionally a little discharge at times when he got a cold; but it was nothing to speak of at any time—only a few drops, and then it would cease. He was on the ice playing a wind instrument, a trombone, in the band of a country town, and the next day he was taken seriously ill. He said he felt as though he had blown a hole through his ear. His temperature was 101°, and pulse increased to 100. Headache, pain in the side of the head, and sickness of the stomach were present. The local doctor was called in and prescribed for him, and he lay in bed for two weeks. He had very few symptoms when seen by Dr. Bruce. He was lying in bed quite rational, with a temperature of 97.8° and a pulse rate of 66, with pain in the side of his head and sickness at times. The history was that he was sick every day three or four times without any apparent cause, which had no relationship with ingestion of food. He had not been out of bed then for two weeks, and inquiry about dizziness or giddiness showed that none had been present. Dr. Bruce got him up to walk a little through the room, when he felt a little light headed, but not more than one would expect after lying in bed that length of time, so that was not looked upon as a symptom of importance. He had much exaggerated knee-jerks and ankle clonus on both sides, particularly well marked on the right side. Drowsiness was another condition present. He slept a great deal, and seemed drowsy and willing to go to sleep almost any time. He took nourishment fairly well. These were the only symptoms present. There were no eye symptoms. On examination of the ear Dr. Bruce found a slight discharge at the consultation in the country, very slight, with perforation of the drum. Over the mastoid there was a slight amount of swelling. Dr. Bruce came to the conclusion that there was certainly mastoid disease, and probably also cerebral abscess. He advised his removal to Toronto General Hospital, where he was taken immediately on the advice, and after two days in bed he was operated on. The condition found was

briefly as follows: An incision was made in the usual position down over the mastoid from the base to the tip, one-half inch behind the ear, and the antrum was opened. Pus was found here, and then on passing a probe down into the cells, these were found filled with cholesteatomatous material. A portion of the squamous bone was then chiselled away, thus exposing the temporo-sphenoidal lobe of the brain. A grooved trocar was passed in, and pus was seen oozing along the groove. A considerable quantity of pus was then evacuated, between three and four ounces, and there was a cavity as large as a tangarine orange. The ossicles were then removed from the ear and a portion of the posterior wall of the meatus removed. A drainage tube was placed in the cavity and dressings applied, the whole wound being left open. This operation was performed on the 14th of March last, about seven weeks ago, and the result is very satisfactory. The cavity drained nicely, and Dr. Bruce thinks it entirely filled in; but a little opening remains, and syringing is still done through the opening and out at the external auditory meatus. During the first week after the operation there was considerable delirium, the patient being noisy and restless, but that disappeared, and he made a satisfactory recovery. One peculiar feature of the pus was the extreme offensiveness of the odor. The roof of the middle ear had been completely destroyed.

Dr. Hamilton asked Dr. Bruce the condition of the reflexes, which were much increased before the operation. Dr. Bruce then examined these and found them still slightly exaggerated. Ankle clonus was also still slightly present.

Dr. Grasett thought Dr. Bruce ought to present the case again in the fall, when discussion could then take place.

Dr. Orr thought that chronic suppuration had been going on in the middle ear for many years, and that it was extraordinary that there should be such extensive lesion of the bone with so few symptoms.

Dr. Ross referred to the case of a boy who was shot in the temporo-sphenoidal region. A probe demonstrated that the bullet had gone through the bone. He was perfectly conscious; no symptoms at all, until gradually and slowly he began to get weaker and weaker, until he finally died, and on post-mortem examination one-half of the brain was a great amount of pus.

The Fellows coinciding, Dr. Bruce agreed to the suggestion of Dr. Grassett that he would give a more extended history of the case early in the fall.

TUMOR OF THIGH—CLINICAL NOTES. DUODENAL ULCER—SPECIMENS.

Dr. F. LeM. Grassett reported these cases and presented the specimens.

The second was a case of ulcer of the duodenum with rupture

into the peritoneal cavity, and death following somewhere within forty-eight hours. It occurred in a domestic servant. The case was first seen by Dr. A. A. Small, and indicated that there was some trouble in the neighborhood of the appendix. There was dulness in the right flank, and the diagnosis was confirmed a few hours later by Dr. Nevitt. The woman was rapidly approaching a moribund condition, and if something were not done immediately death would intervene. Dr. Grassett then operated and found everything in the right region normal. There was, however, a collection of fluid like thin, green mucilage, the like of which Dr. Grassett had never seen before. He considered there must be a rupture somewhere; and if he had prolonged the incision upwards he thinks he would have found the rupture without any difficulty; but the anesthetist said the patient was collapsing, so Dr. Gassett desisted. The patient died one to one and a half hours afterwards. It was found on post-mortem that rupture had taken place in the duodenum from an old ulcer, probably the day before. Everything she had been taking in the way of food went into the stomach and then into the peritoneal cavity. By external palpation nothing could be felt, she was in such a tympanic state.

The tumor of the thigh was a fatty tumor. The specimen shows that it is broken down, forming a large cyst in the centre and a number of smaller cysts. It produced a large tumor in the back of a woman's thigh, a little above the popliteal region. It had existed there for eight years. Six months before she was seen by Dr. Grassett a doctor attended her in confinement, and during the confinement he noticed this tumor. Six months after this the tumor had grown enormously, and there was great pain in the sciatic nerve, and the woman was rapidly becoming a cripple. Dr. Grassett then operated, and had no trouble in enucleating it. A large part of the tumor had lifted up the sciatic nerve, and it took considerable time separating the nerve and tumor. The wound healed by first intention from end to end. Gradually power came back into the limb and the woman got perfectly well. She sat up in the hospital and got an attack of grippe, followed by trouble in the middle ear; from this she recovered: examination of the tumor done by Dr. Anderson and pronounced a lipoma. An interesting feature of the case was the manner in which the tumor was hugged by the sciatic nerve.

Dr. A. A. Small, enlarging on the case of duodenal ulcer, said the patient, a very healthy looking young girl of seventeen years, came to him complaining of nausea, and only nausea, for which he prescribed a mild stomachic. He was called to see her early the following morning, when he found her complaining of very severe abdominal pain, which pain was confined to the right inguinal region. She was sent at once to the hospital, and as it

was thought that it might be coprostasis, a high enema was given with very slight result. Section was then advised, and the results found as given by Dr. Grassett.

Dr. George A. Bingham spoke in reference to the lipomatous mass. There is danger in connection with these tumors, and mentioned a case of a woman of sixty years, who had for twenty years a small mass situated over the anterior crural nerve. Ulceration occurred from irritation of underclothing, and there was general breaking down of the whole mass. The temperature rose to 101° or 102°, and there was a slight cardiac murmur also prior to operation. The growth was removed, and for some time after the operation this cardiac murmur persisted. It was probably due to septic endocarditis as a result of absorption, owing to broken-down tissue, from a simple fatty tumor. This gradually got well, and the patient left the hospital recovered.

Dr. Ross referred to a case of duodenal ulcer occurring in his practice. Patient was taken suddenly with pain, with severe hemorrhage from the stomach and died. Post-mortem showed old duodenal ulcer, which had suddenly perforated into a vessel, resulting in death. Also spoke of a case in consultation, a man who for years had very severe hemorrhage from the intestine at long intervals. This case was jocularly referred to as "onionitis," from pieces of green onion being found in stomach when operated on. From this the man made a good recovery, but some months after came back to the hospital. He died, and on post-mortem found old ulcer.

OPERATIONS FOR DEFORMITIES—WITH PHOTOGRAPHS.

Dr. George A. Bingham presented photographs and recited the history of this case. A cripple, a young lad of fourteen years, although he looked seventeen, came to the Children's Hospital, having heard of the wonderful surgical operations done at this institution. From his head to his knees his physical condition was normal, but from his knees down he was not so. This lad, with a dog, and a sleigh to which he harnessed the dog, drove down in winter-time to the Children's Hospital, not having other means of getting there, and being bound to get there somehow. The right leg below the knee was rudimentary, eight inches in length. There was but one bone in the leg—the tibia. There were only four metatarsal bones and four toes. The foot was turned looking directly upward in the direction of the knee. The toes were also webbed. Dr. Bingham amputated at once and obtained an excellent stump. The bones of the left leg were twisted inward. The internal malleolus was lower than the external; as a matter of fact he walked on the internal malleolus. The metatarsal bones were turned inward toward the toe. This leg was perfectly useless, and the problem was what to do with it. Dr. Bingham chiselled the

bones and broke them down in order to bring the foot back into proper relation with the leg. There was great difficulty in getting the bones to co-apt properly.

Dr. Meyer's motion to elucidate the meaning of Section 2, Article 9 of the Constitution, fixing the April meeting of each year for the nomination of officers was carried.

Election of officers resulted as follows: President, Dr. J. F. W. Ross; Vice-President, Dr. E. E. King; Treasurer, Dr. W. H. Pepler; Recording Secretary, Dr. George Elliott; Corresponding Secretary, Dr. A. A. Small; Executive Committee—Drs. H. J. Hamilton, H. B. Anderson, W. B. Thistle, H. A. Bruce, and George A. Bingham.

Dr. Pepler, as Treasurer, was authorized to remit $25.00 to Dr. Conerty, of Smith's Falls, and also to open a subscription list towards a fund for Dr. Conerty from members of the Clinical Society.

GEORGE ELLIOTT,
Recording Secretary.

A QUIET EFFUSION INTO THE KNEE-JOINT OCCURRING IN WOMEN AND YOUNG GIRLS.

Dr. W. H. Bennett (*London Lancet*) in *N.Y. Med. Jour.* calls attention to a condition of quiet, passive effusion into the knee-joint occurring in women and young girls, which is always associciated with menstrual irregularity or uterine trouble. It rarely occurs in any other joint than in the knee, and the joints of the opposite sides are usually involved at the same time, but the effusion is, as a rule, much more ar :d on one side than on the other. There is rarely any pain unless some injury has been received. It occurs either at the time of puberty or at the climacteric. Although the joint may contain considerable fluid, it is never tense, except after superadded injury. The common cause of the discovery of the condition is an injury, commonly very slight. Any error in diagnosis can usually be avoided by noting the character of the swelling, the existence of effusion on both sid· (that on the uninjured side being painless and without heat), and the coincidence of marked menstrual or uterine trouble. The primary treatment should be directed to the correction of the faulty uterine functions, with moderate exercise and massage, combined with the healthiest of outdoor lives. Treatment by splints and absolute rest should be vigorously avoided. In the absence of acute symptoms arising from injury, the condition of the knees need lead to no restriction in the exercise of an ordinary person. The author has seen some twenty cases of this affection; in no case did recovery occur while the uterine or catamenial irregularities continued, and in every case their correction was followed by prompt improvement in the condition of the knee.—*Post-Graduate.*

Special Selections

NINE QUESTIONS ON SYPHILIS, WITH ANSWERS FROM A NUMBER OF AUTHORITIES.*

By B. B. Foster, M.D., of Portland.

First Question.—What per cent. of our population have syphilis?

1. This varies according to the size of the communities. It is relatively rare in the country and small towns, the proportion increasing *pari passu* with increase in population and the consequent increase of vice. I believe that in our large cities fully ten per cent. of the population have syphilis; probably more than that have been syphilized at some time or other. G. F. Lydston.

2. One-fifteenth of one per cent. Ramon Guiteras.

3. L. B. Bang says: I do not know, and I have always been doubtful as to the accuracy of statistics which authors have presented in regard to this question.

4. I do not know, and doubt whether anybody can answer that question with any claim for accuracy. I believe, however, that a larger number of people have syphilis than is generally assumed. H. G. Klotz.

5. Eugene Fuller sends the following answer:

The disease is much more frequent than is commonly supposed; any attempt to state the exact percentage of the population affected in the absence of data would, of course, be pure guess-work.

6. It is estimated by competent authorities that there are between six and seven million people in the United States suffering from some form of syphilis. Joseph M. Mathews.

7. From Gardiner W. Allen I have the following:

I have never looked into the question, and do not know whether there are reliable statistics on this subject.

8. This is all guess-work. I should guess ten per cent. S. C. Gordon.

9. In New York State I should say a fraction of one per cent., although it is impossible to get accurate data. It is certainly a much smaller per cent. than many have claimed. G. H. Fox.

10. I have no means of judging. A. T. Cabot.

11. Possibly ten per cent. of the men whom in our practice we could classify in a way as "men of the world," "men about town," etc. Impossible to summarize the statistics among women or poor people. R. Greene.

* Paper read at the Forty-fourth Stated Meeting of the Maine Academy of Medicine and Science, held February 11th, 1901.

Second Question.—When you are satisfied that a person has syphilis, do you advise specific treatment previous to the appearance of secondary symptoms?

1. Yes; they do not do so well in the long run, but I wish to forestall disfigurement, detection, and possible maligancy of the attack. I also like to protect innocent persons, so far as may be, by getting the lesions out of the way (or preventing them) as soon as possible. G. F. L.

2. Yes; as soon as I feel sure, and I can generally tell when I see the venereal sore—that is, in 85 per cent. of cases. R. G.

3. L. B. Bangs says:

Certainly, as soon as a reasonably satisfactory diagnosis is made as to the initial lesion, I begin the treatment.

4. Decidedly "No." The only exception being cases in which the location or the extent of the primary lesion involve danger to some organ or to the general health, or any part constantly liable to cause infection of the surrounding people—for instance, extra-genital lesions, as eylid, lip, etc. Under such circumstances I give small doses of mercury or iodide until the danger is averted, and then stop to await the appearance of the secondary symptoms. Over and over again I observe that the larger number of the irregular troublesome cases have been treated before the appearrance of secondary symptoms. H. G. KLOTZ.

5. Eugene Fuller says: Theoretically, the earlier treatment is commenced the better. The practical objections against beginning treatment before secondary symptoms are that by so doing (1) a certain percentage of people are treated for syphilis who never contracted the disease. (2) The patient later on, not being perhaps convinced that he ever had the disease, neglects his treatment, or comes to mistrust the diagnosis or honesty of his doctor. No patient should be started on treatment until he is convinced that he has the disease.

6. As a rule, I would not so advise. J. M. MATHEWS.

7. Decidedly not. I can imagine that there might be very rare exceptions to the rule, dependent on individual and peculiar circumstances, but I believe that it is of great importance that the rule should be strictly followed. A diagnosis based on the initial lesion alone can rarely be absolutely certain. G. W. ALLEN.

8. In my opinion the earlier the better. S. C. GORDON.

9. Yes; but I am rarely sure of the diagnosis until the appearance of the secondaries. A. T. CABOT.

10. Yes, if the patient is also satisfied. R. GREENE.

11. No; because the little time lost is of no consequence, and the patient is then convinced that he has syphilis, and much more likely to continue treatment. Early treatment postpones and modifies the symptoms to such an extent that the recognition of the disease becomes difficult, and an undesirable uncertainty often

results. Even an expert cannot always be perfectly satisfied that a local sore is syphilitic, and early mercurial treatment of a chancroid causes many a patient to go through life in constant dread of a disease which he has never contracted. G. H. FOX.

Third Question.—How do you treat the local sore or lesion?

1. Avoid caustics; avoid greasy applications; keep it clean and dry, and protected from friction. The lotio nigra or flava, simple calomel powder, aristol, suboxide of bismuth, europhen, are all good. Of course I refer to typic induration and exulceration. Complicating chancroid is another matter. I sometimes excise the primary lesion. G. F. LYDSTON.

2. If ulcerating, I cauterize with one per cent. of nitrate of silver, and then use a wet dressing of black wash, instructing the patients to wash lesion and put on fresh cotton night and morning, and to pour black wash on cotton every time they pass water, or often enough to keep the cotton wet. If no ulceration, I do not cauterize—simple black wash. If lotio nigra does not work well, use crystal or a powder composed of acid. boric., bismuth, calomel, equal parts. For chancres of meatus, use absorbent cotton plugs soaked with black wash. R. G.

3. By the direct application of some form of hydrargyrum. L. B. BANGS.

4. I avoid cauterization as much as possible, as well as any other irritation; sometimes rest or suspension of the penis by means of a T-bandage afford great relief. Usually ointments (aristol, white precipitates, etc.) or washes, lotions of sulphate of copper are applied. Do not allow a crust to form over any sore or spot not covered by epidermis. Excision may be done if circumstances are favorable, but not with view to preventing secondary symptoms. H. G. KLOTZ.

5. As I would any other sore or lesion. J. M. M.

6. Where the sore is confined to the prepuce and it can be easily removed, in my experience, excision has been beneficial. I am sure it has a good mental effect, which is an important item in treating syphilis. It also limits the glandular infection. If it cannot be removed readily, antiseptic dressing with some aseptic, absorbent powder—simply cleanliness and dry dressings afterward. S. C. G.

7. By an antiseptic lotion and calomel powder in most cases. When ulceration is present iodoform is a remedy for which there is no substitute of equal value. G. H. F.

8. By simple non-mercurial and non-irritating applications. Ordinary cleanliness is sufficient in most cases. G. W. A.

9. Never cauterize a hard sore. Treat it expectantly till the general treatment is inaugurated or by the local application of mercurials. E. F.

10. With a dilute unguent. hydrarg. nitratis. A. T. C.

11. Ordinarily with rather mild applications, washes of bichloride, applications of mercurial plaster, aristol, "iodoformogen."

R. GREENE.

Fourth Question.—In your opinion is syphilis curable?

1. Yes; from 80 to 90 per cent. recover; cases that do not recover are sufferers, not from active syphilis, but its sequelæ.

G. F. L.

2. Yes; in 95 per cent. of cases who take the treatment and keep themselves under observation as long as desired. R. G.

3. Yes. A. T. C.

4. Never promise a patient, unless the prescribed treatment is followed, that late manifestations cannot in after life develop; they are, however, very unusual in those who have been properly and thoroughly treated early in the disease. E. F.

5. Probably a large portion of cases recover entirely, but we have no test by which we can say in regard to any particular case that he has eliminated all traces of the virus, and is as free from the disease as before he first contracted it. G. W. A.

6. Certainly!!! When a man inherits a good constitution, and does not dissipate in any way, syphilis will run its course, even without treatment, as measles with a child. Valuable as mercury and the iodides undoubtedly are in the treatment of syphilis, it is the "*vis medicatrix naturae*" which is the prime factor in effecting a cure.

G. H. F.

7. It depends entirely upon circumstances, and it would do much harm to so proclaim. There is much individuality about such cases—some can be cured, some not. For the sake of posterity it would be a better plan to say that syphilis *cannot* be cured.

J. M. M.

8. Certainly. L. B. B.

9. I would not say syphilis is curable, but that it has, under ordinary conditions and favorable circumstances, the tendency to become extinct in the system, *i.e.*, self-limited to a certain extent. While this may take place even without any treatment, the usual treatment apparently greatly favors and supports this tendency to voluntary elimination, besides having strong influence on the symptoms of the disease itself. H. G. K.

10. I have no reasonable doubt about it. I am sure I have seen many cases absolutely cured—cases where I have had an opportunity to watch them for twenty years or more, and where they have had children who were perfectly healthy. S. C. G.

11. In some cases yes, *i.e.*, patients will live perhaps longer than if they had never had it on account of better care—show no evidence of relapses. Those cases inflicted by syphilis to the deeper tissues of the body, like nerves, etc., cannot be cured any more than a scar can. Some evidence of reinfection of syphilis would show occasional positive cure. DR. GREENE.

Fifth Question.—Would you advise against marriage in all cases where syphilis had existed? If not, how soon after the attack, in your opinion, is it safe to marry?

1. Not at all, but in a certain number of cases showing decided malignancy, complications with other diseases or impaired health conditions, marriage seems not advisable. The character of disease, etc., would greatly count in determining the period which ought to elapse between infections and marriage. I should consider three years (two years treatment and one constant observation) the lowest time for waiting. H. G. K.

2. (*a*) No; I would not. Such advice would be an unnecessary burden for the individual.

(*b*) (This part of your question is not clear.) In my opinion, it is not safe for the patient to marry until at least two years have elapsed since the disappearance of the last symptom, no matter what it may have been. L. B. B.

3. With my pronounced views on the subject I would advise against marriage in all cases where syphilis had existed, taking for granted that the diagnosis was correct. J. M. M.

4. No! From three to five years. If the attack is mild, and the patient remaining under careful observation and treatment, and particularly if the circumstances are urgent, marriages may be permitted in two years, although in such cases pregnancy should be avoided for a year or more. G. H. FOX.

5. No. In a case that has done well and has been under treatment, thoroughly carried out, for at least two years, beginning with the appearance of secondary symptoms I think it is safe to allow marriage two or three years after leaving off treatment.

G. W. ALLEN.

6. Certainly not. If thoroughly treated, one can safely marry five years after inoculation. E. F.

7. I would not advise against marriage in a majority of cases; of course there may be modifying circumstances, but in a man previously healthy and no unusual development from the disease, if the patient has followed directions, I would allow marriage in from two to four years. S. C. G.

8. If three years have elapsed, during which treatment has been thorough and no lesions have been observed for eighteen months, the patient may marry. He should, however, continue treatment for another year. *I never tell the patient that marriage is free from risk at any period.* I tell him the chances and let him assume the responsibility. This rule should be adopted by the profession. Syphilis is tricky, and the patient is often trickier. G. F. L.

9. No. Three or four years after, if thorough treatment was kept up for at least two years. A. T. C.

10. Not until two years have elapsed, and not then unless no symptoms had existed for two years. A man should never im-

pregnate a woman until he has been under treatment for two years. R. G.

11. No. Ordinarily, if case has been under observation, two years without any evidence of return. R. GREENE.

Sixth Question.—Do you believe one attack of syphilis immunes from others?

1. I like an attack of variola, I believe it does so in the great majority of cases. G. H. F.

2. I am not convinced that it does. J. M. M.

3. Not absolutely. I reported to the American Medical Association a few cases of unmistakable reinfection. L. B. B.

4. This seems to be the rule, notwithstanding a limited number of undoubted cases of reinfection. Personally, I have not observed an indisputable case of reinfection. H. G. K.

5. Instances in which a reinoculation of syphilis has occurred are of such extreme rarity that it can be stated as a rule that one who has had the disease is in the future immune. E. F.

6. Yes; in almost all cases. There are cases on record of reinfection, but they are exceedingly rare. G. W. A.

7. No; they may have it again, usually not before eight or nine years, although sometimes in five years.

8. I have seen no reason to suppose otherwise. A. T. C.

9. With very rare exceptions, yes. I also believe this immunity to be hereditarily transmitted to a certain degree. What has caused the gradual diminution of the severity of syphilis under treatment? That has not improved much for centuries. Why not reason this out along evolutionary lines like other problems? G. F. L.

10. As a mere matter of opinion, yes. I have never seen any case where one has had a second attack, neither do I know of a case where a syphilitic has been exposed. S. C. G.

11. Ordinarily, yes. R. GREENE.

Seventh Question.—Must a parent or parents that have had syphilis and been properly treated, transmit the disease to their offspring?

1. (This question is a trifle ambiguous.) It all depends on which parent has the disease, and at what period it has arrived. Many of my syphilitic male patients procreate healthy children. No system of treatment will protect the fetus in a woman in active syphilis. Fetal syphilis may be modified, but not prevented in such cases. If the woman acquires syphilis after the seventh month the child usually escapes. (Colles' law.) Much of so-called hereditary syphilis is not syphilis, but perversion of nutrition in every phase, which is the result of syphilis in the parent. The syphilis does damage to the parent, which is transmitted to the child as a faulty constitution or faulty development, which may give rise to various phases of pathologic change which I call "attenuated syphilis," yet are not syphilitic in the true sense of the term. G. F. L.

2. Not necessarily—usually not. If he or she transmits the disease, I should say the treatment had not been sufficiently thorough. A. T. C.

3. Not if they have been cured. Some patients are never cured. They always have the recurrence of some manifestation. R. G.

4. No. I believe that children who are perfectly healthy and remain so are constantly being born of parents with a history of syphilis, sometimes comparatively recent. G. W. A.

5. No. E. F.

6. No; and in a minor degree the father than the mother. However, no rule holds good on this question, and you will meet with great surprises in both directions, sometimes to find a healthy child when you would expect a miscarriage, and, on the other hand, traces of syphilis where the time elapsed would have warranted a healthy offspring. H. G. K.

7. Yes; in many instances and in many ways. J. M. M.

8. Not necessarily. L. B. B.

9. I am sure in many cases to the contrary. In my opinion it is only a question of proper treatment a sufficient length of time. S. C. G.

10. Not necessarily. G. H. F.

11. No. GREENE.

SYPHILIS AND MARRIAGE.

(*White and Martin.*)

The prevalence of acquired syphilis, the frequency with which it is transmitted, the severity of its lesions, and its crippling, deforming, and often fatal effects when it is inherited, make questions pertaining to the marriage of syphilitics of cardinal importance. Opinions upon this subject should be clear and decided.

From what has already been said, it is obvious:

1. That syphilis is most apt to be inherited from parents who at the time of conception are in the first year of the disease. The aptitude is greatest when both parents are syphilitic, is slightly less when the mother alone is affected, and is diminished more than half when the father alone is affected.

2. That the tendency towards heredity becomes rapidly less from the first to the third year, and after the fourth year is rarely manifested.

3. That time, in conjunction with vigorous continued specific treatment, so affects the tendency to heredity that after the fourth year it is practically brought to the vanishing point.

4. That time and vigorous treatment combined cannot always prevent the transmission of syphilis by heredity. The instances in which such transmission has occurred after four years, in spite of active treatment, are, however, so few that they properly can be rejected in considering syphilis and marriage.

The logical deduction from the foregoing summary is that men who have had syphilis which has been treated carefully for four years, can marry and will have healthy children. When the woman is syphilitic, or both the man and woman have contracted syphilis, it would be safer to avoid conception till after a long period.

Eighth Question.—Does inherited syphilis immune from the primary disease?

1. I have no personal experience in reference to this question. H. G. K.

2. No; unless perhaps in instances where the child is born with active evidences. E. F.

3. I think it does. G. W. A.

4. I do not know. R. G.

5. I don't know. A. T. C.

6. Yes. Inherited syphilis (not the results of syphilis, but syphilis *per se*) bears the same relation to immunity that the acquired form does. G. F. L.

7. To a less degree than the acquired form. G. H. F.

8. In my experience it does not. J. M. M.

9. It does, excepting in rare cases, where reinfection is possible. L. B. B.

10. I should doubt very much if it does. S. C. G.

Ninth Question.—What plan of treatment do you advise?

1. I prefer in most cases, particularly in severe cases, to begin treatment with the inunction of ung. hydrarg., keeping it up until the roseola has disappeared. Of internal remedies, it seems to me that the protoiodide of mercury works best as a rule, 1–3 or 1–4 gr. three or four times or more daily. If not well borne, I either combine with a very small dose of opium, or substitute the biniodide in 1-2 gr. doses. I have used the bichloride, but do not like it as well. Mercury with chalk and the mass hydrarg. work very well in some cases, especially during exacerbations. I generally give mercury constantly for two years or more, and the iodide of potassium intermittently, and wind up with two or three months of it at the end of treatment. G. W. ALLEN.

2. Full mercurial medication for the first year, lighter for the second year, and longer if relapsive evidences develop. The iodides are often of greatest importance in the dissipation of later evidences. EUGENE FULLER.

3. After waiting for the eruption of secondary symptoms as already stated, I favor a treatment continued for about two years from the time of infection, and to watch the patient for another year. In the presence of mild or usual symptoms, I begin with a mild internal treatment, preferably corrosive sublimate in solution alone, or in combination with iodide of sodium, particularly in throat affections. Occasionally I use pills of the protoiodide or tannate of mercury, but I find them invariably more liable to cause

pains in the stomach, disturbance of bowel movements and salivations, than the solution. This treatment is continued for several months, and renewed after six to eight weeks—even when no symptoms of syphilis appear, gradually diminishing the periods of taking the medicine and increasing the intermissions of treatment. Whenever the symptoms present are not sufficiently affected by the internal treatment, or new and more severe symptoms make their appearance, I usually resort to the treatment by intramuscular injections of soluble salts, usually the salicylate of mercury, and in by far the greater number of cases with the happiest results. I do not use inunctions frequently, not because I do not believe in their effectiveness, but because it is not easy for most patients to use them in a thorough manner. In the so-called tertiary lesions, I do not rely on the iodides alone, but use mercury alone or in combination with iodides, either in the shape of the so-called mixed treatment, or more often by the injections of salicylate of mercury, or even of calomel. General care of the whole body, keeping the functions of all the important organs in the best possible condition, and avoiding all excesses in eating, drinking with pleasure, are very important. I do not find the reasonable use of beer, wine and tobacco so dangerous as is often claimed. However, in affections of the tongue, lips and throat, tobacco ought to be entirely stopped. HERMAN G. KLOTZ.

4. The natural history of the disease indicates very decidedly one very important method of treatment. The skin eliminates or attempts to eliminate the poison, therefore, I believe that the hot baths are among the most successful of all means. It should commence early in the disease and be followed systematically for two or three years. Potassium iodide acts in a similar manner, and therefore should be the second remedy. Mercury used moderately, the third. In my opinion, too much has been used and is yet, to the neglect of the other remedies already mentioned. Tonics, like reduced iron and strychnia or nux vom., should be administered early—especially if anemia is marked and appetite fails.

S. C. GORDON.

5. Hydrargyrum by the mouth, or by inunction, or hypodermically in alternation, or according to the activity of the symptoms. (Permit me again to refer you to my article in the *International Clinics*.) L. B. BANGS.

6. First, mercury; then alternating mercury and iodide of potash. In troublesome cases, combinations of both together.

A. T. CABOT.

7. No answer from J. M. Mathews.

8. Mercury in courses of three months each, alternating with mixed treatment and the iodides, and occasionally with K. Clo., a very valuable adjuvant, by the way. I sometimes give two or three weeks of inunctions to begin with. If I require quick action of

hydrargyrum, I give inunctions. In very stubborn cases, calomel injections have rendered me yeoman service.

G. FRANK LYDSTON.

9. A general tonic and hygienic treatment of the patient is too often neglected. A sole and blind reliance upon mercury and the iodide of potash is a most frequent mistake, if not a crime. I have seen many a patient who has suffered far more from a so-called "vigorous treatment" than from the disease itself.

G. H. FOX.

10. Protoiodide or tannate of mercury for two years, if the stomach can tolerate it in sufficient quantities to do good. Patients can take from 1-5 grs. of the former a day and more of the latter. If they cannot take 1½ grs. a day, it does them no good. Ordinarily a patient can take 2 grs. of protoiodide or 3 grs. of tannate a day. If internal remedies are not helping the patient, I believe in inunctions of ung. hydrargyrum six days a week, using each time a paper containing forty or more grains. If any symptoms appear during the first two years, resuming treatment, I use mixed treatment, and if very severe, I use in addition a certain amount of K. I. In tertiary trouble I use mixed treatment, reinforced by K. I. and mercury usually; if externally, in the form of zinc, ammoniated mercury ointment alone or mixed with equal parts of zinc ointment. For mouth wash I use bichloride in peppermint water 1-1000.

R. G.

RETROSPECTS AND PROSPECTS IN GENITO-URINARY SURGERY.*

BY REGINALD HARRISON, F.R.C.S. (ENG.), LONDON;
Late Hunterian Professor of Pathology and Surgery of the Royal College of Surgeons, England.

Although I have but two or three days in your great city, my friends, Professor Dennis and Professor Alexander, have afforded me the privilege of addressing you. I must disclaim at once any intention of giving you anything that is either original or novel. I shall talk of retrospects and prospects in genito-urinary surgery. The end of an old century, the beginning of a new one very naturally makes us look before and behind us. We pick out the landmarks of the past and are tempted to peer into the future. To you, just entering on the practice of medicine, the review of some of the achievements of the past may seem like ancient history. The discoveries of times that are no more may well furnish texts, however, for the illumination of the future.

*Abstract of an address delivered at the Cornell Medical College, New York City.

It would be false modesty in me if, in reviewing genito-urinary surgery, I should attempt to pass unmentioned my own contributions to the science as it has grown in the last half-century. You will pardon me, then, if I sometimes seem too personal in recalling the advances that have been made.

LITHOLAPAXY.

The most prominent feature in the progress of genito-urinary surgery during the last century was undoubtedly the development by Bigelow of a method of crushing calculi within the bladder and then the added invention which enabled him to wash out the débris of the crushed stone at a single sitting. It was my privilege to see Professor Bigelow at some of his earliest work on this subject and to hear his anticipation of what might be expected from this invention when it was perfected. May I add that all of these anticipations have been realized. Litholapaxy has taken a deserved place as one of the great surgical measures that saves mankind suffering and reduces mortality.

I had the privilege of demonstrating in England Professor Bigelow's method with instruments furnished me by himself. I have seen his method for treatment of vesical calculus replace all others. I had occasion the other day shortly before my voyage to America to look over the old apparatus which he sent me from America. It is, in all essential features, the apparatus in use all over the world at the present moment for the accomplishment of litholapaxy. The invention came from your great compatriot's brain in all its perfection, and needed no after improvement to make it completely successful. Very seldom is it the lot of an individual thus to perfect his work before giving it to the world. It is a sure sign of the genius of the man.

OTIS' URETHROMETRY.

Bigelow's work in litholapaxy was undoubtedly influenced by the patient investigations of another distinguished American genito-urinary surgeon. When I had the pleasure of meeting him, in 1878, Professor Bigelow mentioned to me Dr. Otis' investigation as to the size of the urethra and the amount of distention the healthy urethra would permit of without suffering injury. This very practical work of Otis' was almost a necessary preliminary to Bigelow's success. When I saw Bigelow's perfected instrument afterward, I remembered his mention of Otis' work and realized how much he owed to the distinguished New Yorker.

ETIOLOGY OF VESICAL CALCULUS.

Bigelow's invention has tended also to throw light on the etiology of vesical calculus. Especially the etiological influence of enlarged prostate in the formation of stone became evident as the

result of his methods of treating calculus. This influence of the prostate in the production of calculus has been a favorite subject of study on my own part.

It is not generally known that one of the most important contributions to the etiology of stone in the bladder was made as long ago as 1851 by Rainey. His paper was concerned with the investigation of molecular coalescence. He showed that stones could be artificially produced when the solution of certain salts dissolved in urine was disturbed by the presence of unfavorable factors. This chemical side of the origin of stone in the bladder has never been given the attentive investigation it deserves.

It has been a great pleasure to me to be conducted through this magnificent building by my friends among the faculty. I have seen laboratories and class-rooms and anatomical rooms fitted out in a style that is worthy of this great city and of the new century that is beginning. I have especially admired the magnificent equipment of your laboratory. I cannot think of any subject that I could suggest that would be more suitable for your investigation in these laboratories and that would tempt more to research than the etiology of vesical calculus. No subject is more fascinating or more important and the mere repetition of Rainey's experiments would undoubtedly throw light on this interesting subject. It seems too bad that this patient investigation with its suggestive results should so far have proved profitless. Let us hope that the new century and American enterprise will make that use of them they deserve.

PROSTATIC HYPERTROPHY.

In 1893, Professor J. William White, of Philadelphia, announced a new method for the treatment of prostatic hypertrophy. On theoretic grounds he suspected a close relationship between the testicle and the prostate. He demonstrated experimentally on dogs that the removal of the testicle led to a decrease in size even of the normal prostate. He argued that the excision of testicles in the human being would probably lead to a reduction in the size of enlarged prostate. The method was tried on several patients and the surmise of Dr. White proved to be not without some foundation. Other investigators found that the exsection of a portion of the vas deferens had the same effect on the prostate as the excision of the testicle.

This method of treating prostatic hypertrophy has given rise to a good deal of controversy. Undoubtedly the method of treatment, whether by removal of the testicles or vasectomy, has given a certain measure of successful results. Those results are so variable, however, as to leave the subject almost more obscure than before. In certain cases the measure of relief afforded is very striking. In others practically no good is accomplished. The

whole subject requires reinvestigation, and will well repay any work that may be done on it.

Meantime these seven or eight years during which Professor White's work has been the subject of controversy have not been wasted. We are beginning to recognize now better than ever that under the term, enlarged prostate, or hypertrophy of the prostate, there are included not one but many pathological conditions. To talk of enlargement of the prostate simply without any further definition of the term is now almost as crude and unscientific as if a surgeon were to talk of enlargement of the breast without defining the different forms, of enlargement of the tonsils without explanatory differentiation. Our success in the treatment of prostatic hypertrophy depends on our ability to differentiate the various forms of the disease which occur. We need to determine precisely the character of the enlargement, and for this the only sure means is ocular inspection. A case that illustrates this very well was under my care within a month before I sailed from England. The patient suffered less than two years ago from a stone in the bladder which was removed by litholapaxy. Another calculus formed before the year was out and a second recurrence of the stone took place before the expiration of two years. With a cystoscope I found that there existed a pouch in the enlarged prostate. A tongue of prostatic tissue extended backward into the bladder forming a sort of lid for a box within the folds of the prostate and it was in this that the stones had formed. Besides the stone which had escaped into the bladder and which had been detected by the sound, two smaller ones were in process of formation within the prostatic pouch. I made a median incision and twisted off the tongue of prostatic tissue and the man made a good recovery. Two weeks after the operation he was practically well.

Recently I have described three forms of prostatic hypertrophy. These three are so characteristically distinct from each other that it is very unlikely that they will admit of uniformity of treatment, or that any one method of dealing with them will bring the relief of symptoms in all cases. Since landing in New York I have seen Dr. Alexander's specimens and these have modified my opinion as to the forms of prostatic hypertrophy which exist. Dr. Alexander's specimens certainly extend our information as to prostatic condition beyond what it was before. I am free to confess that they were for me a suggestive chapter in the pathology of the prostate. I have not been wedded to my own divisions in prostatic pathology and the modification of my views since seeing the specimens here forms a good illustration of the fact that we must not be ready to formulate cast-iron distinctions that will admit of no modification. I must take this occasion to express how much genito-urinary surgeons owe to Dr. Alexander and how much we expect from his future work.

The first form of prostatic hypertrophy and one that is of a great deal of interest is the simple enlarged prostate which bulges upward and backward into the bladder. This form of prostatic hypertrophy is more generally cured than any other by castration, vasectomy, or by the Bottini operation. What Bottini's operation really accomplishes in these cases is an obliteration of the upper projecting portion of the enlarged prostate which because of its projection in the trigone is interfering with urination.

The second variety of prostate is the one that I have already described in speaking of the relapse of stones in the bladder. In these a tongue of prostatic tissue or a median lobe of the prostate is the active agent that interferes with the emptying of the bladder. For these cases castration or vasectomy as a rule does absolutely no good. The median tongue of tissue must be removed.

The third variety of prostatic hypertrophy is that in which there occur in the midst of the enlarged prostate hard glandular growths—adenomata they really are. For this form of prostatic hypertrophy castration and vasectomy are always failures and Bottini's operation will invariably be done without success. I shall never forget one of my first experiences with this form of enlargement of the prostate. The case was one in which for the removal of a large stone in the bladder, a suprapubic lithotomy was done. The stone was removed without any difficulty and, in passing my fingers around the base of the bladder in order to be sure that no small calculi were left, I shelled out one of these adenomata. It came away without any bleeding and required very little effort for its removal. No other method of treatment would have been successful, however, in relieving the symptoms of enlarged prostates or in preventing recurrence of the stone.

What is needed at the present moment, then, is not further discussion of the merits of castration and vasectomy, nor of the limits of utility of Bottini's operation, but a precise diagnosis of the form of prostatic hypertrophy which really exists in individual cases. In prostatic surgery as in every other branch of surgery that has developed during the past century, what is needed is more accurate diagnosis with adaptation of the treatment to the specific affection which exists and not the application of general methods to a supposedly general condition which has no existence in individual cases.

Surgery of Kidney.

The surgery of the kidney even in its present stage may be regarded as one of the most important advances of the century that is just passed. What has been done for renal stone, growths, distentions with pus and urine, abnormal mobility and other painful affections of this part is sufficient to indicate this. Nor is it at all likely that we have reached limits in the surgery of the

kidney which cannot be extended much further with great advantage. The interesting question for us just now, however, is, What is there in the future of the surgery of the kidney? Is there, for instance, anything that can be done by surgical means for the relief of albuminuria, or for the prevention of the development of degenerative conditions. There is no doubt that albumin has been found for long periods in the urine in connection with stone or abscess of the kidney and that after the surgical treatment of these conditions the albumin has disappeared and the patient has completely recovered.

A very interesting subject that I discussed in a paper that appeared some years ago in the *Lancet* seems worthy of consideration here. I allude to the effects of tension arising out of excessive excretory efforts on the part of the kidneys and resulting in congestion and inflammation which in some instances are probably more disastrous and far reaching in their local consequences than the severe surgical conditions of the kidney already mentioned.

There is no more delicate organ in the body than the kidney. There is no doubt that the delicate, complicated, secretory structure suffers severely from congestion. When the congestion is intense, lasting harm may be done. In several cases I have had the opportunity to see congested kidneys in the very acme of their congested state. They are not only of a deep color that is almost black, but the capsule of the kidney is tense and shining, because so overstretched. If such a kidney is punctured during an exploratory operation upon the kidneys the blood is found to be present in it under great pressure, so that it gushes forth.

There is no doubt that this pressure, as in the testicle, may work serious and lasting harm. It is not improbable that under circumstances like these, lesions are produced which lead to the formation of connective tissue and prove the foundation of the hypertrophic and atrophic condition of subsequent chronic nephritis. Renal glaucoma is the name that to me seems most suggestive for this condition.

I had occasion to say some years ago that if certain organs of the body occupied other positions than those where Nature has placed them, a variety of morbid conditions to which they are respectively liable would receive somewhat different treatment from that which has hitherto been adopted. Of the complex organs of the body the eye furnishes us with the best example of what surgery is able to accomplish in removing obstacles and impediments to vision and in combating the disastrous effects of intraocular tension and the degenerations arising therefrom.

Modern antiseptic surgery, however, has brought even the internal organs of the body within the range of the surgeon's skill without imposing any very great risk on the patient. For the condition of congestive tension in the kidney, an antiseptic explora-

tion with puncture of the capsule might easily be done without great danger. This operation would perhaps serve as a prophylactic against the development of kidney disease later in life. I have had some personal experience with cases of this kind that have proved very encouraging. Others have taken up the subject in a way to make me think that this idea may be developed successfully. At the next session of the British Medical Association there are two questions that I have proposed to set down for discussion.

First.—To what extent may kidney tension, as in inflammatory conditions and congested states, be responsible for the serious damage in these organs that often follows. Is this excessive tension the etiological factor in chronic degeneration, or chronic Bright's disease? In a word does the expression renal glaucoma convey an idea that is important in kidney pathology?

Second.—When is it expedient and justifiable to relieve this tension by exploratory laparotomy and puncture of the capsule of the kidney?

The kidney and its functions remain as yet a great mystery. The urine is an extremely complicated solution and its suppression may cause the most serious symptoms. Re-absorption of its constituents may readily give rise, as every genito-urinary surgeon knows, to septic conditions. The irritation of a simple bougie, or of a sound, or the wound produced by urethrotomy may easily prove the point of serious infection when urine is passing over it. Long ago under Lord Lister's influence I suggested the use of boracic acid as a prophylactic for these septic accidents. It has proved of great service to the genito-urinary surgeon, but there still remains a large field for investigation as to the ways and methods of making the urine aseptic.

The understanding of urinary tuberculosis is a chapter and a very important one that is just opening up. Janet and Guyon and Albarran have been doing good work in this specialty and the obscurities of pathology and of clinical observation are clearing up.

At the present time good men are at work all over the world in the specialty of genito-urinary surgery. It is no wonder that we have advanced. Practice of the specialty has become a most honorable profession. Great advances can be looked for in the new century that is opening up and especially in this new country where you have the enterprise, the equipment, and the opportunity for the work.—*New York Medical News.*

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EDITORS:
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ASSOCIATE EDITOR:
GEORGE ELLIOTT, M.D.

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VACCINATION.

Small-pox for well nigh a generation has been so rare a disease in Ontario that the public have regarded the possibility of exposure to contagion so lightly as to have almost forgotten the necessity of any precautions other than the prompt isolation of such few cases as have occurred. Medical men, likewise, many of whom have practised for years without ever seeing a case, have been lulled into a false sense of security and have neglected to urge upon their patients the necessity of vaccination. In addition to this we have had our share of anti-vaccination doctrine preached into the ears of a people much less tolerant of any inconvenience or discomfort than their fathers, and more alive to the possibilities of infections of various kinds being introduced with the vaccine virus. There is no doubt that, whether the fault lie with the public or with the profession, only a small proportion of the children born in Ontario in the last fifteen or twenty years have been vaccinated. Revaccination in adults is rare and only called for by patients who have had suddenly and forcibly brought home to them the necessity of precaution by some lesson such as that taught by the most unfortunate case of Dr. Little. That vaccination is protective against small-pox is admitted and recognized by nearly all the people of this Province. Public opinion, once alive to the subject, would support stringent measures for insuring proper and thorough vaccination of the community, in spite of any opposition raised by faddists.

Small-pox has been very prevalent during the past winter, and has unfortunately spread over a wide extent of territory. While there will likely be some abatement of the disease during the

warm months we may look for a recrudescence in the fall. We consider the conditions as alarming.

Small-pox is very prevalent in the United States, and will, no doubt, be introduced still further here by the large number of visitors crossing the line during the coming summer. It is also, according to the press despatches, very prevalent among incoming immigrants at New York, especially those coming from Northern Italy, many of whom find their way into Canada, and likely, on account of the activity in railroad building in our north country, will do so in larger numbers than ever this year. We believe that the circumstances warrant a general revaccination of the whole population of the Province. The public are sufficiently alive to the danger to support compulsory vaccination. If the necessity exists, and the public will support drastic measures, we think that the Provincial Board of Health should take steps at once to enact such laws as would compel every one, *nolens volens*, to submit to vaccination unless successfully vaccinated within seven years.

THE HORSE VS. THE AUTOMOBILE.

The advent of the motor carriage is stated by some to herald the disappearance of the horse; but of what use would a motor carriage have been in a case reported a few days since (and right here in Ontario, too), where a patient suffering from puerperal sepsis, having refused medical aid, and supported in her refusal by her husband and friends, yielded only when so low that she felt she was dying? Even then, infirm in their faith, her friends looked for guidance. The old horse was hitched up—if he took the road towards the doctor's this gentleman was to be brought in. If the steed started in the opposite direction it was all off. Unfortunately for the patient the noble beast turned his tail, and not his head, in the direction of the doctor's abode and forthwith the expedition was abandoned. The woman died, and now the coroner is investigating.

One swallow does not make a summer, and, consequently, we cannot argue from this single experiment that a horse is absolutely useless under such circumstances. He may have been an old horse who never had a doctor in his life and wished to show his independence of the fraternity by having nothing to do with it at a critical moment, or, again, he may have known of another doctor living, perhaps, miles in the direction upon which he started out whom he considered to be better on sepsis than the one towards whom he would have been blindly driven had he not the opportunity of using his own good sense and free will. Be this as it may we may at least all agree that he was little better, under the

circumstances, than an automobile, because if the husband, coming out of the lane, left the automobile to itself to determine the direction in which it would proceed, it would certainly run straight across the road and into the opposite fence. This would afford no information whatever. If, on the other hand, nervous lest he might knock down the fence and be sued for damages, he gave the lever a yank, the direction would be determined by him and not by the automobile, and so he would be back to first principles and have shouldered upon himself the responsibility for calling in medical aid. All circumstances considered, we believe that in such terrible emergencies it is hard to improve upon the old stand-by, the yellow-backed almanac.

SOCIETY NOTICES.

THE Ontario Medical Association will meet in Toronto on the 19th and 20th of June.

THE Canadian Medical Association will meet in Winnipeg on the 28th, 29th, 30th and 31st of August.

THE American Pediatric Society will meet at Niagara Falls, N.Y., on the 28th of May.

THE American Medical Association will meet in St. Paul, on the 4th, 5th, 6th and 7th of June.

THE American Climatological Association, Niagara Falls, N.Y., May 30th.

THE American Orthopedic Association at Niagara Falls, N.Y., June 18th, 19th and 20th.

THE International Association of Railway Surgeons at Milwaukee on June 10th, 11th and 12th.

THE British Medical Association at Cheltenham, July 30th to August 2nd, inclusive.

Editorial Notes.

AMERICAN MEDICAL ASSOCIATION—THE ST. PAUL MEETING AND YELLOWSTONE PARK.—Arrangements have been completed for an excursion of the members of the American Medical Association to Yellowstone Park. The Committee of Arrangements has finally succeeded in persuading the officials to open up the park a week earlier than usual in order to accommodate the association. A special train will be run from St. Paul to the

Yellowstone Park, and the railroad officials have promised to do everything in their power to make it satisfactory to all concerned. The rates will be very low, but how low cannot at this time be definitely stated. Those who attended the meeting in 1882 will remember with much pleasure a similar excursion that was run at that time, and these will not need to be informed that the one now proposed will be full of enjoyment. Further announcements will be made later. The Yellowstone National Park contains more natural wonders than are to be found anywhere else in the world, and this will be a rare opportunity for our Eastern friends to see what this portion of the great West possesses.

AMERICAN ACADEMY OF MEDICINE.—The twenty-sixth annual meeting of the American Academy of Medicine will be held at the Hotel Aberdeen, St. Paul, Minn., on Saturday, June 1st, 1901, at 11 a.m. (Executive session; the open session beginning at 12 o'clock), and continuing through Monday, June 3rd. The principal features of the meeting will be a symposium on "Institutionalism," and another on "Reciprocity in Medical Licensure." Series of valuable papers on both topics have been promised, as well as interesting papers on some other subjects. The President's address (Dr. S. D. Risley, of Philadelphia), will be delivered on Saturday evening, June 1st, and the annual social session held on Monday evening, June 3rd. Members of the profession are always welcomed to the open sessions of the academy. The Secretary (Dr. Charles McIntire, Easton, Pa.), will be pleased to send the programme (when issued) and blank applications for fellowship, etc., when requested to do so.

News Items.

LOOK out for more small-pox from the Pan-American.

DR. R. A. REEVE has been reappointed dean of the medical faculty of Toronto University.

DR. D. M. ANDERSON, late of the *Empress of Japan*, is visiting his brother, Dr. H. B. Anderson, Toronto.

THE new Victoria Asylum for Women at Cobourg will be open for the reception of patients by Sept. 1st.

ON April 19th, H.M.S. *Condor* put into the Williamhead Quarantine Station with several cases of "yellow jack" on board.

DR. H. H. CHOWN, Winnipeg, on the evening of the 30th April, tendered the matron and nurses of the General Hospital a ball and supper.

WINNIPEG General Hospital has appointed permanent lady night superintendent.

SMALL-POX on the Indian Reserve along the Grand River, below Brantford, Ontario, is well in check.

DR. W. T. GRENFELL, of the Labrador mission-field, was in Toronto recently, lecturing on the mission and its work to the fisher-folk of that country.

DR. SPARLING, Winnipeg, has been appointed to a lucrative position in Omaha; and Dr. J. Hislop, of the Winnipeg General Hospital will take over his practice.

DR. LEONARD VAUX, Ottawa, who is surgeon to the Canadian Contingent of the South African Constabulary reports the deaths of four Canadians on the voyage out to the Cape.

THERE is an old saying "pay up, or shut up," but now this has no application to the 700 doctors whose names have been erased from the Register of the Ontario Medical Council

DRS. JAMES STEWART, Blackader and Adami (Montreal) attended the meeting of the Association of American Physicians at Washington. Dr. Stewart was elected Vice-President.

DR. ROBERT BELL, B.Sc., LL.D., F.R.S., who is acting director of the Geological Survey of Canada, has had the degree of Doctor of Science conferred on him by McGill University.

SIR WILLIAM HINGSTON, on the 8th of May will have completed his fortieth year's connection with the Hotel Dieu Hospital, Montreal. The sisters of the institution tendered him a *dejeuner* on that occasion.

MR. WM. PATTERSON, the Queen's medical student who was arrested last February, having the dead body of a woman in his possession, has been found guilty of having committed an offence against the criminal laws.

DR. MCNICHOL, who has been appointed superintendent of the Victoria Asylum for Women at Cobourg, Ont., has retired from private practice and is familiarizing himself with his duties in the different asylums of the province.

AT a meeting of the physicians of the counties of Ottawa and Pontiac, held at Dr. Eli. Paquet's, Hull, Que., it was resolved that the Bill of Dr. Roddick, now before Parliament, receive the approbation of all physicians of the two counties.

PROF. SHUTTLEWORTH reports the quality of Toronto drinking-water to be good. The number of colonies of bacteria is 1,040, as against 2,373, the average for the past six years.

A DAILY paper announces that a woman near Ottawa, while dressing one of her children's vaccinated arms scratched her nose on which was a pimple. The self-conducted operation is said to have been successful.

WHILE the Medical Council has a club in pickle for recalcitrant doctors who refuse to pay "two bucks," what about the waste of gilt high up on the corner of Richmond and Yonge, only a stone's throw from the lion's den?

DR. HARRIET COCKBURN, Toronto, has been appointed assistant physician to the new Victoria Asylum for Women at Cobourg, Ont., the first instance of a lady physician being appointed to a similar position in Canada.

THE Minister of Agriculture has a Bill before Parliament seeking to amend two sections of the Contagious Diseases (animal) Act which will provide for the sale of meat of an infected animal, provided such meat is not in itself affected.

DR. BRYCE states that during the outbreak of small-pox at Toronto Junction last year that all who had been vaccinated escaped, with but one exception; while none of those who were attacked by small-pox had been vaccinated, but one person.

THE Samaritan Hospital, Montreal, recently held its annual meeting, when the annual report was read by Dr. Lapthorn Smith, who is surgeon-in-chief and superintendent of this hospital. During the past year there were 110 patients in the institution with 142 operations and only five deaths, three of which followed operations. This gives a death rate of a little over two per cent. Only women of irreproachable character requiring treatment peculiar to their sex, are admitted to this hospital.

The local branch of the Victorian Order of Nurses held its annual meeting in Toronto on the afternoon of April 27th. Lady Minto was present and delivered an address. Dr. Jas. Thorburn presided. Thirty-eight more Toronto physicians used these nurses than in the previous year; 249 patients were under their charge during the year and there were sixteen deaths. The Dominion Government has given $6,000 towards the establishment of cottage hospitals in the Territories, Sir William Macdonald $3,000 and some $4,000 more has been received by contributions.

DR. PATTERSON, Winnipeg, acting under instructions from the Central Government is inspecting the Indian Reserves inquiring into the prevalance of small-pox there.

THE month of April was a busy one at the Montreal General Hospital; 210 patients were admitted, 190 discharged and 23 died, the greater number of deaths occurring within three days of admission. In the out-door dispensary department there were 3,136 consultations. During the month nine nurses graduated after examination.

DR. ANDREW HALLIDAY, Shubenacadie, N.S., one of the bright medical men of that province, has been studying during the past winter in the Pathologic and Public Health Laboratories of the Western Infirmary and the University of Glasgow, where after examination, he has been awarded first-class honors, with first place in the sanitary division of the class of pathology and bacteriology. He also received a diploma in State medicine.

THE ladies of Carberry, Manitoba, proposed to build a hospital all by themselves without any assistance from people of the male persuasion. The professional and business men of that thriving city of the plains object, and there are chances of being "blood on the moon" in Carberry. The town council has refused to vote any money for such purpose, and the adjoining township of Cypress, although they voted the ladies $500, built a good-sized fence around their proposition in the shape of certain conditions, that the ladies of Carberry flung it back in their faces with disgust. "Have a hospital, we shall!" they say. There will be much hair-pulling in Carberry the coming summer.

Obituaries

DR. CHARLES WILLIAM COVERNTON, TORONTO.

Dr. C. W. Covernton died recently at his late residence, Huron Street, this city, at the advanced age of 88 years. He was born in England in 1813, and was a graduate of the London College of Surgeons, and also of the University of St. Andrew's, Scotland. He came to Canada in 1836, and for many years practised in Norfolk County, and was at one time President of the Ontario College of Physicians and Surgeons. He also held the position of chairman of the Provincial Board of Health for a number of years.

DR. J. ARCHER WATSON, TORONTO.

By an unfortunate accident Dr. J. Archer Watson, of this city, was instantly killed on the morning of the 11th of April. Dr. Watson was graduated from Trinity Medical College with the class of '85, and had been in active practice in this city since that time. Some ten or twelve years ago he served for a period on the anatomy staff of his *alma mater*. He was forty-five years of age and unmarried.

DR. THOMAS HENRY LITTLE, TORONTO.

Dr. T. H. Little died on the morning of the 25th of April from hemorrhagic small-pox, contracted while attending one of his patients. He was a graduate of the Toronto School of Medicine, and had been in active practice in Toronto for twelve years. The statement that he had never been vaccinated has been denied by his friends. A widow survives him.

DR. THOMAS RITCHIE ALMON, HALIFAX, N.S.

Dr. T. R. Almon died in the city of Halifax, on the 25th of April. He was the second son of the late Senator Almon whose death was recorded in these columns only a few months ago. Like his father, Dr. Almon was one of the foremost physicians of Nova Scotia. He was a graduate of King's College and also of the College of Physicians and Surgeons, New York. Up to two years ago he was on the staff of the Victoria General Hospital, Halifax, but was forced to resign owing to ill health.

DR. WILLIAM R. WARNER, PHILADELPHIA.

William R. Warner, M.D., senior member of the well-known house of W. R. Warner & Co., died April 3rd from apoplexy, at his home in Philadelphia.

Abstracts

MODERN PATHOLOGY OF PUERPERAL SEPSIS.

A. Bass (*Centralblatt fur die Grenzgebiete der Medizin und Chirurgie*) comes to the following conclusions: 1. The uterine cavity of healthy pregnant and parturient women that have not been meddled with is free from pathogenic organisms; this is likewise true in most cases of healthy women during the puerperium. 2. The question as to whether the vagina of the healthy pregnant, parturient and puerpurant women that have neither been examined nor douched, is or is not free from pathogenic organisms cannot as yet be positively answered, notwithstanding that a series of observations seems to indicate the affirmative. 3. Autoinfection can only be considered when every probability of an external infection has been excluded; even then autoinfection contrary to Ahlfeld, is very rare. 4. The following bacteria have been shown to be the cause of puerperal sepsis: Streptococcus pyogenes, Staphylococcus pyogenes aureus and albus, Bacillus coli communis, pneumococcus, typhus, and diphtheria bacilli, and various obligate anaerobes, especially the Bacillus aerogenes capsulatus and the Vibrion septique. 5. The portal of infection is generally the endometrium (the placental area) where the bacteria not only directly enter, but may also gain access by means of their own surface growth. 6. The infection occurs either by the lymph- or blood-channels, rarely by both simultaneously. 7. A certain clinical differentiation in regard to the various forms of bacteria cannot yet be given; nevertheless the anaerobic infections are milder. 8. The blood-examination, with the exception of an eventual bacteremia and the findings of Kaminer (still requiring more substantiation), offers nothing characteristic for the puerperal sepsis. 9. Antibodies are probably not formed in the blood in this condition; at least this has not been proved.—*Philadelphia Medical Journal.*

THE PATHOLOGY OF RHEUMATIC FEVER.

Drs. F. J. Poynton and Alex. Paine (*London Practitioner*) isolated in twelve successive cases of rheumatic fever a diplococcus which on intravenous inoculation into rabbits produced the clinical appearances of rheumatic fever. The micro-organisms were isolated from the blood, urine and tonsils of the living subject suffering from rheumatic fever, and also from the pericardial exudation and cardiac valves after death. They were also demonstrated in the visceral and parietal pericardium, cardiac valves, the pleura and pericardial exudations, the tonsils and rheumatic nodules. In rabbits they produced, on intravenous injection, polyarthritis, valvulitis, pericarditis, pleurisy, pneumonia, chorea and nodules. The lesions were

non-suppurative. The cocci also produced coagulation necrosis in the kidneys and liver.

The diplococcus was demonstrated in the following tissues of the rabbit: The cardiac valves, pericardium, joint, pericardial and pleural exudations, kidneys, liver, connective tissues, cerebro-spinal fluid, lungs and urine. The organisms circulate in the blood stream both in man and rabbits during an attack of pericarditis. The disease produced in rabbits tends to recovery, unless the dosage is very large, and when fatal is so by reason of the thoracic inflammations produced. The heart is dilated, and fatty changes occur in the myocardium. The pyrexia is moderate, and the clinical symptoms are remarkably constant when the organism is passed from animal to animal.

The organism itself is minute, each individual element of the diplococcus measuring five micro-millimeters in diameter. In the author's experience it thrives best when grown anaerobically in a slightly acid medium, and the medium they used for isolation was a mixture of milk and bouillon, acidified with lactic acid, in which the organism grows in streptococcal chains. It also grows aerobically upon blood agar in a staphylococcal arrangement, but upon agar-agar it rapidly loses both its virulence and characteristic appearance.

Inoculations were undertaken, and the lesions that were produced resulted not from one series of inoculation only, but from several. The incubated pericardial exudation produced one series of experimental results, and the others were obtained from cultures from the pericardial fluid, from the urine and from the tonsils. The most important fact deducible from this investigation is *that this diplococcus which they have isolated is claimed by them to be a cause of rheumatic fever.* As yet the authors are not in the position to state that this coccus is the only cause, but they believe that it will eventually prove to be the actual cause of all cases of rheumatic fever which conform to the usual type of the disease.—*Post-Graduate.*

LOCALIZATION OF A BULLET WOUND OF THE SPINAL CORD.

A woman who was shot in the back (Pershing, *Phil. Med. Jour.*), the ball entering at the level of the eleventh rib, presented the following condition on examination: Complete absence of voluntary motion in the lower extremities and lack of faradic irritability; the muscles were flabby and somewhat wasted. Reflexes in the lower extremities were lost, except the anal and perineal, which were quite lively. All sensibility was lost up to a definite line crossing the external genitals, the front of each thigh, the buttocks and the sacrum, this line corresponding to the line separating the sensory areas of the first and second lumbar segments of the cord. There was much pain in the thighs and buttocks. Control of the

bladder and rectum was lost. The limit of the sensory loss showed the upper limit of the lesion to be at the junction of the first and second lumbar segments, a part of the cord which is enclosed by the eleventh dorsal vertebra. The retention of the perineal and anal reflexes showed that the lowest sacral segments were not involved, but the fact that all the reflexes in the legs were lost would show that the greater portion of the lumbar enlargement, including at least the lower four lumbar and first sacral segments, were severely injured. On removal of the spine and laminal of the eleventh dorsal vertebra, the ball was found and removed. Aside from lessening of the pain there was no improvement in the patient's condition, and death resulted three weeks later.—*Medical Fortnightly.*

SAUSAGE POISONING (BOTULISM.)

Lauk (in the *Munchener Medicinische Wochenschrift* of September 25th, 1900), says that this form of poisoning is due to a special bacillus which produces a specific toxin. The poison may be developed in ham or bacon but is by far most frequent in liver or sausage. The striking characteristic in this form of intoxication is that the symptoms are slow to appear, twelve or thirty-six hours often elapsing from the time the tainted food is eaten. The first to show themselves are a general malaise, with pain in the epigastrium, nausea, or actual vomiting. Later there is a sense of suffocation and great prostration. All the secretions are diminished, and the skin and mucous membranes are very dry. Ulcerated patches appear in the mouth and larynx, and certain cerebral nerves are generally paralyzed. Ptosis is common, the pupils being commonly dilated and reacting slowly to light. Difficulty in swallowing may be so marked as to necessitate the employment of the stomach-tube. The spinal nerves with the central nervous system commonly escape. There is no temperature in the absence of complications. If death occurs, it is commonly eight or ten days after the poisoning, and is usually due to respiratory paralysis, or to some complication, such as pneumonia or possibly asthenia from inanition.—*Medicine.*

THE SURGICAL TREATMENT OF GASTRIC ULCER AND ITS SEQUELÆ.

W. Körte (*Deutsche med. Wochenschrift*) reports on thirty-eight cases of operation for benign diseases of the pylorus and its neighborhood, including thirty-two cases of stenosis following or accompanied by ulceration. In numerous instances the thickening was massive, simulating a malignant new growth, and while in most cases the hydrochloric acid was increased it was absent or diminished in seven of the number. The chief indications for operation

were stenosis and secondary dilatation, though sixteen cases of perforation, and one of dangerous hemorrhage, are included in the list. Resection, gastro-enterostomy, pyloroplasty, and gastrotomy were tried, the conclusion being that gastro-enterostomy is the most generally useful procedure. Direct suture was done, the Murphy button being dispensed with. Resection is a suitable treatment for many cases, and is especially indicated when carcinoma is suspected, but it demands favorable conditions with absence of adhesions and greatly taxes the recuperative powers of the patient. The deaths reported were due in two cases to collapse, in two more to secondary bleeding from the ulcer, and in one each to pneumonia, pericarditis, and suppuration.—*Medical Record.*

CARDIAC CIRRHOSIS OF THE LIVER.

Dr. Piery (*Arch. Gen. de Med.*) in *London Practitioner* concludes that cardiac cirrhosis is not the result, pure and simple, of venous engorgement; this is supported by careful clinical and microscopical observations. Venous stasis, however, is a disposing factor, inasmuch as it renders the liver a favorable soil for the true causes of cirrhosis. Thus alcohol and poisons produced by intestinal auto-intoxication are important factors in the production of hepatic cirrhosis, while infections such as tuberculosis and acute rheumatism have the same effect. In nine cases where there had been prolonged chronic venous congestion of the liver, microscopic examination failed to show any trace of proliferation of connective tissue in the liver. Parmentier's experimental results obtained by producing tricuspid regurgitation in dogs were confirmatory. In fifteen cases of cardiac cirrhosis the causes of change were alcoholism (in seven), with (in five) or without arterio-sclerosis, tubercular (in three) and acute articular rheumatism (in two).—*Post-Graduate.*

NOTES ON THE TREATMENT OF DISEASES OF THE NERVOUS SYSTEM.

J. J. Graham Brown (*The Scottish Medical and Surgical Journal*) gives a detailed lecture on the treatment of paralysis resulting from lesion of the upper motor neuron. In cases of apoplexy he says that if the diagnosis is certain and if there are signs of a continuing hemorrhage, and if the site of the lesion is the usual one, it may be advisable to compress the carotid artery in order to diminish the rate of the circulation, and so allow of clotting and the arrest of hemorrhage. It may even be well to ligature that vessel in special cases. The quickest and most effectual way of reducing the intracranial tension is by blood-letting. But a clear and certain diagnosis of cerebral hemorrhage must be made, for in the case of embolism or thrombosis venesection would be very harmful. The cases in

which it is likely to do good are those in which the face is darkly flushed, the pulse slow and full, and the coma deep and of long duration.—*Medical Record.*

A CASE OF ERYTHEMA MULTIFORME, CLOSELY RESEMBLING SMALL-POX.

Norman Walker (*The Scottish Medical and Surgical Journal*) reports a case during a small-pox "scare." The eruption on the face, neck, and back did not resemble small-pox, but on the hands the likeness was marked. The history of the case was altogether against such a diagnosis. The patient had been vaccinated two weeks before and a large scab testified to the efficacy of the inoculation. She had had no rigor, no dorsal pain, nor sickness, and the temperature was subnormal. After consideration and consultation with the health authorities, the diagnosis of small-pox was negatived, and the after-history of the case showed that the physicians were correct.—*Medical Record.*

Physicians' Library.

Progressive Medicine. Vol. I., 1901. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital, etc. Assisted by H. R. M. LANDIS, M.D., Assistant Physician to the Out-patient Medical Department of Jefferson Medical College Hospital. Philadelphia and New York: Lea Brothers & Co. 1901.

This is the first volume of the series for 1901. It contains the following articles: Surgery of the Head, Neck and Chest, by J. Chalmers DaCosta, M.D.; Infectious Diseases, including Acute Rheumatism, Croupous Pneumonia and Influenza, by Frederick A. Packard, M.D.; the Diseases of Children, by Floyd M. Crandall, M.D.; Pathology, by Ludvig Hektoen, M.D.; Laryngology and Rhinology, by A. Logan Turner, M.D. (Edin.); Otology, by Robert L. Randolph, M.D. From a perusal of the foregoing list it is quite apparent this book covers a wide field of medicine and surgery. Dr. Hektoen's article on the latest developments in pathology is an excellent one. The subjects of Cytotoxins and Antitoxins are discussed, and much new matter concerning the pathology of infectious and pathogenic micro-organisms has been added. The sections on Infectious Diseases are very instructive. Dr. Clement Dukes' idea of dividing the cases which are now

classed under rubella into two divisions: rubella and "fourth disease," is fully explained, and the distinguishing characteristics between rubella, scarlatina, and the "fourth disease," are tabulated. We heartily recommend this series of books to all physicians and surgeons who strive to keep posted in the advancement of medical science.

A Practical Treatise of Materia Medica and Therapeutics, with Special Reference to the Clinical Application of Drugs. (Student's Edition.) By JOHN V. SHOEMAKER, M.D., LL.D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia. Fifth edition. Philadelphia: F. A. Davis Company. 1900.

The third and fourth editions of this work were much larger volumes, as they contained the subject matter of this edition, as well as a description of remedial measures other than drugs. It was thought by many teachers that it was too large for a student's use, so Dr. Shoemaker determined to issue the treatise in two volumes, one a student's edition on the materia medica and therapeutics of drugs and preparations which are official in the B. P. and U. S. P.; the other a physician's edition on such remedies as electrotherapy, massage, rest, cure, climato-therapy, diet in disease, etc. We think that this departure is a good one, as the previous editions were too large for a student's use. The present edition makes an excellent text-book for students, and should also be of great value to practitioners. The author has been very careful to make the work as complete as possible, by revising many of the sections and introducing the results of the latest researches in materia medica and therapeutics. The book should continue to be popular with the medical profession.

An American Text-Book of Physiology. By HENRY P. BOWDITCH, M.D., JOHN G. CURTIS, M.D., HENRY H. DONALDSON, PH.D., W. H. HOWELL, PH.D., M.D., FREDERIC S. LEE, PH.D., WARREN P. LOMBARD, M.D., GRAHAM LUSK, PH.D., F.R.S. (EDIN.), W. T. PORTER, M.D., EDWARD T. REICHERT, M.D., and HENRY S. EWALL, PH.D, M.D. Edited by W. H. HOWELL, PH.D., M.D., Professor of Physiology in the Johns Hopkins University, Baltimore, Md. Second edition. Revised. Vol. I. Philadelphia: W. B. Saunders & Co. 1900. Toronto, Ont.: J. A. Carveth & Co., Canadian agents. Price, $3.00.

This well-known work, which appeared in the previous edition in one book, will in this edition be divided into two volumes.

The general plan of the work has remained the same, and all the articles have been thoroughly revised. Volume I contains the following articles: Blood, Lymph, Secretion, Digestion, Movements by the Alimentary Canal, Bladder and Ureter, by the Editor; Circulation, by John G. Curtis and W. T. Porter; Respiration and Animal Heat, by Edward T. Reichert; Chemistry of the Animal, by Graham Lusk. All these writers are so favorably known to the medical profession that their names alone are a sufficient guarantee for the contents of the work. On looking over the book we were pleased to note that a short section on Physical Chemistry had been added to this edition. This, no doubt, will prove of great value to medical students.

Annual and Analytical Cyclopedia of Practical Medicine. By CHARLES E. DE M. SAJOUS, M.D., and One Hundred Associate Editors, assisted by Corresponding Editors, Collaborators and Correspondents. Illustrated with chromo-lithographs engravings and maps. Vol. IV. Philadelphia, New York, Chicago: The F. A. Davis Company, Publishers. 1899.

The high standard of the previous volumes is maintained in this, the fourth one, and the book will, no doubt, be well received by the medical profession. The great majority of the articles are excellent. Some of the most important of them are as follows: Diarrheal Diseases of Infants, by Professor Blackadar, of Montreal; Malaria, by Professor J. C. Wilson and Dr. Thomas Ashton; Locomotor Ataxia, by Dr. W. B. Prichard; Intubation, by Professor Waxham, Chicago; Diseases of the Liver, by Professor McPhedron, Toronto; Meningitis, by Dr. Charles M. Hay, Philadelphia; Leprosy, by the Editor. We are very pleased to note that two of the most important subjects were assigned to Canadian writers, who, we have no doubt, have done their work with great satisfaction to Dr. Sajous.

The Medical News Pocket Formulary. New (3rd) Edition. Containing 1,700 prescriptions representing the latest and most approved methods of administering remedial agents. By E. QUIN THORNTON, M.D., Demonstrator of Therapeutics, Pharmacy and Materia Medica in the Jefferson Medical College, Philadelphia. New (3rd) edition, carefully revised to date of issue. In one wallet-shaped volume, strongly bound in leather, with pocket and pencil. Price, $1.50, net. Philadelphia and New York: Lea Brothers & Co. 1901.

Books of this description have a legitimate field of usefulness. The best informed practitioner may at times forget an appropriate

drug or a happy combination. The treatment of disease will often be more successful if the physician has at hand the collective experience of the leaders in the profession. The "Medical News Pocket Formulary" is one of the best and most trustworthy of its class, and gives under each prescription full directions for use, and clear indications for the special phase of the disease to which the remedy is peculiarly adapted. Great care has been used to exhibit every drug with due regard to palatability and pharmaceutical elegance. The prescriptions, of which there are over seventeen hundred, are arranged alphabetically under the various diseases.

A Text-Book of the Practice of Medicine. By JAS. M. ANDERS, M.D., PH.D., LL.D., Professor of the Practice of Medicine and Clinical Medicine in the Medico-Chirurgical College, Philadelphia, and Attending Physician to the Medico-Chirurgical and Samaritan Hospitals, Philadelphia, etc. Fourth edition. Philadelphia and London: W. B. Saunders & Co. Toronto: J. A. Carveth & Co., Canadian agents.

The appearance of a fourth edition within one year after the publication of the third is the best proof of the continued appreciation of this most excellent text-book of medicine. The short period of time intervening between the two editions has not allowed the introduction of much new matter. Such additions as have been made are principally advances in therapeutics and in the diagnosis and treatment of diseases of the digestive system. Part of the subject matter has been rearranged and some rewritten. The whole work is complete without being too bulky.

International Clinics. A Quarterly of Clinical Lectures and especially Prepared Articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Eye, Ear, Nose, and Throat, and other Topics of Interest to Students and Practitioners. By leading members of the medical profession throughout the world. Edited by HENRY W. CATTELL, A.M., M.D., Philadelphia, U.S.A., with the collaboration of JOHN B. MURPHY, M.D., ALEXANDER D. BLACKADER, M.D.; H. C. WOOD, M.D., of Philadelphia; T. M. ROTCH, M.D., of Boston; E. LANDOLT, M.D., of Paris; THOMAS G. MORTON, M.D., CHARLES H. REED, M.D., of Philadelphia; J. W. BALLANTYNE, M.D., of Edinburgh; and JOHN HAROLD, M.D., of London. With regular correspondents in Montreal, London, Paris, Leipsic and Vienna. Vol. IV. Tenth series, 1901. Philadelphia: J. B. Lippincott Company. 1901.

This work is so well known and has been so favorably received that it seems almost unnecessary to recommend it to the medical

profession. The idea of presenting medical literature in the form of clinical lectures is a good one, and such reading is always agreeable to busy practitioners. The volume before us contains, amongst others, the following interesting papers: Use of Digitalis in Heart Disease, by A. Potain; Massage in Raynaud's Disease, by Douglas Graham; Mosquitoes and the Prophylaxis of Malaria, by B. Grassi; Symposium of Genito-Urinary Diseases, by Alexander Renault, James Peder (sen.), Felix Guyon, A. H. Ohmann-Dumesnil, and A. Fournier; Progressive Muscular Atrophy, by Jean Charcot; the Rôle of the Blastomycetes or Ferments in the Etiology of Cancer, by Demetrius Roncoli.

Manual of the Diseases of the Eye. For Students and General Practitioners. With 243 original illustrations, including 12 colored plates. By CHARLES H. MAY, M.D., Chief of Clinic and Instructor in Ophthalmology, Eye Department of College of Physicians and Surgeons, Columbia University. New York: William Wood & Co. 1900.

This book is intended as a concise and practical manual of the diseases of the eye for students and practitioners. The author says enough to make the work clear on the principles of ophthalmology. Considerable space is given to the description of common diseases which the general practitioner is frequently called upon to treat. Rare diseases are dismissed with a few lines. The author has the faculty of presenting the subject in a clear and concise form. This characteristic will, no doubt, make the work a favorite with students in medicine.

Infant Feeding in Health and Disease. A Modern Book on all Methods of Feeding. For Students, Practitioners and Nurses. By LOUIS FISCHER, M.D., Professor of Diseases of Children in the New York School of Clinical Medicine, etc. Containing 52 illustrations, with 16 charts and tables, mostly original. Philadelphia and Chicago: F. A. Davis Company, Publishers. 1901. Price, $1.50.

The author has had a long experience in some of the largest clinics in diseases of children in this country. He has also had the advantage of studying abroad under Professor Adolf Baginsky, in Berlin, and is, therefore, in a position to give sound advice on the difficult subject of infant feeding. Dr. Fischer believes that to understand the differences between the various forms of infant feeding it is necessary to study the scientific details, as well as the

results of experience. He has, therefore, devoted considerable space to the anatomy and physiology of the infantile stomach, bacteria of the intestines, constituents of milk, stomach capacity, etc. The section on infant foods is particularly interesting. Several of the artificial foods, such as Nestlé's, Mellin's, Horlick's and Wampole's, are discussed and compared with woman's milk.

Reprints Received

"A Scientific Basis for Medicine." By E. C. HEBBARD, M.D., Boston, Mass.

"Progressive Pernicious Anemia." By ALFRED STENGEL, M.D., Philadelphia.

"The Hospitals Commission." Speech by Mr. BURDETT-COUTTS, M.P.

"A Review of the History of Cardiac Pathology." By ALFRED STENGEL, M.D.

"Some Notes on the Treatment of Rheumatism." By ALFRED STENGEL, M.D.

"Fatty Degeneration of the Heart." By THOS. E. SATTERTHWAITE, M.D., New York.

"Remarks on the Surgery of the Nineteenth Century." By HAL C. WYMAN, M.S., M.D.

"Causes and Recent Treatment of Neurasthenia." By JOHN D. QUACKENBOS, A.M., M.D.

"Aneurism of the Arch of Aorta, with Rupture into the Superior Vena Cava." By ALFRED STENGEL, M.D.

"A Compendium of Recent Literature on Various Lesions of the Genito-Urinary Tract and Methods of Treatment."

"Two Hundred and Thirty-seven Consecutive Abdominal Sections." By CHARLES GILBERT DAVIS, M.D., Chicago.

"Diseases of the Blood in their Relation to Surgery, and their Treatment." By GEORGE C. VAN SCHAICK, M.D., New York.