INDEX, 1895.

VOL. I.

ORIGINAL COMMUNICATIONS.

CLINICAL NOTES.

SOCIETY REPORTS.

EDITORIALS.

BOOK NOTICES.

VOL. II.

ORIGINAL COMMUNICATIONS.

CLINICAL NOTES.

TRANSLATIONS.

PROGRESS OF MEDICAL SCIENCE.

EDITORIALS.

CORRESPONDENCE.

BOOK NOTICES.

PERSONALS.

MISCELLANEOUS.

OBITUARY.

THE

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Original Communications.

Recent Electro-Therapeusis of Goitre, with Improvements in Apparatus.

BY DR. CHARLES R. DICKSON, TORONTO,

Electro-Therapist to Toronto General Hospital, Hospital for Sick Children, St. John's Hospital and St. Michael's Hospital.

[Abstract of paper read before annual meeting of American Electro-Therapeutic Association, in New York, September, 1894.]

ABOUT five years ago I formed the opinion that for the treatment of goitre we had at our disposal an agent which, properly and rationally employed by competent operators, should prove safer, more efficacious and acceptable than any other in a majority of the various forms of this trouble. Electricity had been on trial with very varying results, but it seemed to me that the discrepancies were attributable to the apparatus employed or to the operator, and that we did not fully appreciate its value.

The literature on the subject was conflicting, misleading and most disappointing. Electricity was discredited, and other methods advocated fraught with gravest menace to the patient's future health, usefulness and happiness, in the event of recovery, from the immediate results of the procedures, and recent literature shows little improvement.

Here, surely, was a promising field for research, and I determined upon a careful investigation.

The immediate vicinity of Toronto is not goitrous, yet as a recognized medical and surgical centre it draws many cases from an extensive territory around, and in the great majority of these cases the best-known therapeutic measures adopted by the general profession have already been resorted to. My connection with Toronto hospitals places me in a most favorable situation with regard to the supply and character of this clinical material, and a number of our prominent practitioners have very kindly referred to me their private as well as their hospital patients, thus testifying to the unsatisfactory state of the therapeusis of the thyroid as well as to the success of my labors. This is most gratifying to me, and greatly to the credit of my professional brethren, well illustrating their broad and progressive spirit in contrast to the opposition to methods electrical manifested in other quarters. Improved apparatus and methods have retrieved past failures, and rendered possible results hitherto unattainable.

The discussions elicited by my former papers disclosed a decided variance of opinion as to the value and range of applicability of electrical treatment, and demonstrated the need and incalculable usefulness of our Association. I have again to report progress and state the deductions from a year's further experience. My aim has been to shorten the period of treatment, while extending the interval between *séances*, to improve technique and to discriminate the treatment most appropriate to each case.

The percutaneous method, using strong currents by means of flexible clay electrodes, has received considerable attention. I have found it very tedious, and have come to the conclusion that its chief utility lies in combating the hyperæmic condition, in reducing simple hypertrophy, in stimulating liquefaction and absorption of recent fibroid growth, and lessening the œdema of older cases preparatory to more active measures. It may also be employed where puncture would not be well borne, and occasionally to alternate with puncture treatments.

Thyroid hyperæmia occurring at the menstrual period or during pregnancy, and disappearing at their termination, does not call for interference unless there be accession of size at each period or gravid state. Galvanization of the sympathetic should then be resorted to, with occasional clay pad percutaneous treatment if necessary. This remark also applies to goitrous cases of amenorrhœa, whether primitive or secondary.

In the slighter forms of hyperplasia, the clay electrode treatment is indicated, the positive electrode at the back and the negative over the goitre, starting with 20m.a. to 30m.a. The patient will, after a few

sittings, gradually tolerate 100m.a. to 150m.a. for ten or twelve minutes two or three times a week.

In vascular forms, by diminishing excessive blood-supply and stimulating absorption, we induce a process of partial atrophy. The negative electrode, a large clay pad, is placed at the shoulders, while the active surface of the positive (a properly insulated platinum needle) is introduced within the capsule of the gland alongside a tenotomy knife. Of course, a local anæsthetic is first used. From 50m.a. to 150m.a. should be employed for eight to ten minutes every ten or twelve days.

In distinctly fibroid forms, the nutritive process may be lessened by the positive puncture, with occasional resort to the negative needle to hasten absorption. In some advanced fibroid cases where, owing to the small proportion of healthy tissue left the process of absorption and atrophy was slow, I have hastened matters by the formation of a central cavity or artificial cyst. This I have done by large negative needles, treating it as an ordinary cyst and maintaining drainage. It requires specially careful manipulation. In very large fibroids, I frequently discard the clay pad and use instead a second needle in another portion of the growth.

Thin-walled unilocular cysts are the most amenable to treatment. The positive pad is placed at the shoulders, while the negative electrode is an insulated canula, through which the cyst is aspirated and a solution of chloride of sodium introduced. From 50m.a. to 100m.a. is employed for ten minutes, the cyst again emptied and firm pressure maintained by broad adhesive straps. A single treatment may suffice, but frequently in the thick-walled and multilocular varieties drainage must also be kept up to permit escape of the fluid effused subsequent to the operation. The aim is thus to obliterate the sac by exciting adhesive inflammation of its walls.

Thick-walled fibro-cysts are often very rebellious. Following the above treatment, I have introduced a solution of zinc sulphate through a tube which carries a positive platinum wire, and employed 50m.a. to 75m.a. for ten or twelve minutes. I have also used a zinc positive electrode.

When the contents of a cyst are not sufficiently fluid to pass through the canula, some of the saline solution should be forced in, and currents of 50m.a. to 100m.a., or if the patient will tolerate it, and it is necessary, 150m.a. to 200m.a. employed. This will liquefy the contents, which may be withdrawn immediately or at the following *séance* eight or ten days later.

Puncture of the thyroid, apart from electrical treatment, is not

devoid of danger. Considerable dexterity is required, and a slight error may prove disastrous. When in addition to this we consider the power of the agent employed, it will easily be understood that great care is requisite both during and subsequent to the operation. Cleanliness and strict antisepsis are imperative. Drainage should not be unnecessarily prolonged.

With regard to exophthalmic goitre, I have nothing novel to offer. I meet very few genuine cases, and think that the Fellows fully appreciate the value of galvanization of the sympathetic and other electrical methods.

I have modified the canula and attachment of the Potain aspirator by enlarging the lumen to permit the easy passage of No. 3 drainage tubing. I have had the tube of the canula constructed of platinum. It may thus be used with the positive pole; and I have added a second stop-cock, which renders it independent of the reservoir.

As the use of chemical solutions corrodes metal parts, I employ for injection a second bottle, with tubes of glass leading to and from it. I have also furnished it with a third tube to facilitate the introduction of the solution. Provision is also made for emptying the sac after treatment without polluting the contents of reservoir.

The possession and care of the necessary apparatus, and the ability to employ it skilfully, minute acquaintance with fundamental laws, and a proper estimation of the power of this agent, are only a few of the factors which militate against the electrical treatment of goitre by the general practitioner, and he will be wise if he resist the temptation to use it.

Finally, the keynote of success is discrimination.

Treatment of Colles' Fracture.*

BY W. BRITTON, M.D., TORONTO.

PROBABLY this injury, more frequently than any other, is the bone of contention in vexatious litigation, and unscientific treatment has far less to do with it than a too sanguine prognosis.

The community at large is not slow to force upon our daily attention the obligations devolving upon us; but the first law of nature, that of self-protection, is quite as applicable to the medical profession as to the rest of mankind, and he deserves just a little touch of legal scorching who, when about to be burdened with a case of Colles' fracture, omits provision for future contingencies by neglecting to state in the presence of a witness the most disastrous outlook warranted by the circumstances.

So vividly has this been impressed upon my mind that some time ago, when summoned to a case of the kind, and finding on my arrival that the patient and her spouse belonged to that irresponsible caste which rakes up the majority of malpractice suits, before even asking for a shingle I draw up in "whereas" and "wherefore" form a stringent document holding me harmless financially in case of an imperfect result. To this formulated profession of absolute confidence in my skill and integrity were appended their signatures. The case followed the usual course satisfactorily—nothing of consequence transpired until some weeks afterwards when, having rendered a modest bill for attendance, I received from the husband a gentle intimation, in language outside the vocabulary of modern drawing-rooms, that the fingers were imperfect in their movements and were doomed to grow worse instead of better. It is needless to add that I awaited in vain a gratuity, while I fondly treasured the little scrap of paper securely locked away as a souvenir of my narrow escape from the clutches of judge and jury.

This subject has been worn almost threadbare in the text-books; therefore I dare lay claim to no special originality, and can only hope to emphasize the salient points in dealing more especially with the difficulties that so frequently occur.

The trio "reposition, rest and rigidity of fragments," which has become classical as the abbreviated indications in the treatment of fractures generally, deserves, in relation to Colles', the addition of another member—prevention of anchylosis.

* Read at the meeting of the Toronto Clinical Society, December 12th, 1894.

Analysis of the causes of deformity is necessary in order to arrive at a scientific method of correction.

The hand is abducted not only by the supinator longus and extensor proprius pollicis, but also, owing to the fact that, excepting in young subjects where the epiphysis is often separated, a certain degree of radial shortening ordinarily occurs through impaction.

The continuance of that force, which drives the inferior fragment upwards and backwards and lacerates the triangular cartilage, drives the ulnar portion of the carpus away from the ulna, whose styloid process finds its way forwards and inwards amongst the meshes of the annular ligament.

This is easily accounted for: the fibro-cartilage, the direct bond between radius and ulna, is already severed, and both anterior and posterior radio-ulnar ligaments passing downwards and inwards do not offer the same opposition to separation of the bones as though they were transverse; therefore the ulna has nothing to encounter in the way of luxation excepting the superficial structures.

In a recent instance with which I met there existed an additional deformity. The patient was a child and the radius was fractured at the epiphyseal line; therefore the opposing surfaces, being comparatively smooth, considerable flat pressure was required over the muscles to prevent the upper fragment from approaching the ulna. This tendency is caused in part no doubt by the pronator quadratus, but chiefly by the elastic stringency of the surrounding fasciæ.

Considering the difficulties attending perfect reduction, I do not think that any but the most simple cases should be attempted without an anæsthetic, and under its influence, while extreme adduction with extension are made, the most delicate manipulation should be observed in order that the operator may fairly conclude that the fragments are so accurately adjusted as to bring compact tissue in contact with its kind, otherwise it will enhance the difficulty of obviating radial shortening and consequent deflection of the hand to that side.

Subsequent circumduction of the hand with firm pressure will often restore the ulna to its proper position; but, should the dislocation be extreme and irreducible, although I cannot speak from experience, I imagine it an open question as to whether or not subcutaneous section of the offending fibres of the annular ligament would be less objectionable than a badly-deformed wrist.

A thousand and one splints have been devised and christened. I am well aware that in offering suggestions I run the gauntlet of being set down as another crank; and, in the way of excuse, express the conviction that the plan of treatment meets as far as possible every

indication in a simple manner, while at the same time I hold myself open for criticism and possibly for conversion.

At the first visit I am contented with placing and retaining the limb in an easy position, deferring perfect reduction for the short time required in the preparation of a permanent splint.

On a strip of pasteboard I secure the radial and ulnar outlines of the sound forearm and adducted hand, which, reversed, is the pattern for a pistol-splint made of a thin, flat board and extending from the elbow as far as the metacarpo-phalangeal joints. With a large flattish gouge, a few seconds suffice for the formation of a concavity for the base of the thumb. A convex piece of wood to fill the palm and elevate the knuckles to an easy position, together with a strip of galvanized iron one and a half inches by three or four, completes the anterior splint.

Each end of this strip is doubled in the form of a hem to increase its strength. It is then nailed to the ulnar edge, its distal extremity just below the position of the styloid process and its anterior edge flush with the upper surface, which leaves about an inch and a quarter in width projecting.

If the contrivance possesses any special virtue it consists largely in the use of this small piece of metal; but why?

Even after complete reduction of the ulna there often exists a tendency to more or less displacement inwards, with a corresponding carrying of the carpus and attached fragment of the radius outwards. This disposition is largely augmented by effusion into the membrana sacciformis, which is naturally opposed by pressure; therefore, a prime object is to maintain the ulnar extremity as closely as possible in contact with the sigmoid cavity of the radius.

In using the ordinary pistol-splint the arm and hand may be represented as a lever—the fulcrum, the radial side of the second metacarpal bone; the power, the fixed splint above near the elbow, and the weight, the pressure exerted outwards anywhere around the inner side of the wrist, wherever the bandage happens to be the tightest, and which may occur over the carpus instead of the ulna.

The very opposite is that which must be accomplished if the radius and ulna are ever to be brought into contact; and, by introducing the strip of iron well padded, the force is concentrated and limited to the very part desired—the lower ulnar extremity—while the counter-pressure forces the carpus inwards.

A flat posterior splint extending to the carpus, with the routine arrangement of padding and bandage, completes the dressing.

It cannot be called complicated or troublesome in construction, for

it may be made in almost as little time as I have taken up in the description; and, so far as my experience goes, it fulfils every requirement.

No amount of care will prevent some stiffness of the wrist and fingers; but, as the extensor tendons are much nearer the radius than the flexors, and, therefore, in the region of provisional callus, I am fully persuaded that rigidity is due more to the former than the latter, and that passive movements of the fingers are often deferred too long. I do not hesitate to employ them as early as at the end of the first week; and, should fibrinous effusion take place into the tendinous sheaths, it is well that motion should anticipate its organization.

It is to be taken for granted that the wrist is to remain at rest until fair union is secured, and that more or less permanent anchylosis is to be looked for should there be cleavage into the radio-carpal articulation.

The splint which I present for ocular demonstration was hurriedly made this evening, and, therefore, will not strike one as the work of a Phidias; but it will answer the purpose as well as though it were shining with polish to suit the æsthetic tendency of those who are able and willing to pay for the artistic.

Clinical Notes.

A Case of Infantile Spinal Paralysis, with Severe Resulting Deformities.

BY W. W. BREMNER, M.D., TORONTO,
Late Assistant Surgeon, New York Hospital for Ruptured and Crippled, etc.

J. M——, age 25 years, suffered from myelitis of the anterior horns when he was five years old. He was very kindly referred to me in the autumn of 1894 by Dr. Geikie. There was very severe talipes equino-varus of the right foot and about three inches of knock-knee of the same limb (that is to say, there was an interval of three inches between the internal malleoli when the internal condyles touched each other). This state of affairs is seen in Photos 1 and 2. Every muscle on the front of the leg and foot seemed to have been permanently paralyzed, although it is quite possible that some of them, especially the short dorsal muscles of the foot, may not have been involved originally, but had just suffered atrophy from disease, as three weeks after the foot was rectified he was able to flex and extend some of the toes. The inversion and flexion of the foot were so great that he walked on the ends of the tibia and outer side of the

cuboid. Large bursæ had developed over these bones, which are well shown in Photo 1 before operation and in Photo 2 after operation. The planter, muscles and fasciæ were also greatly contracted, so much

PHOTO 1.

PHOTO 2.

so that the great toe was brought within four to five inches of the heel. See Photo 1. The man had suffered very much and very frequently from severe pain in the bursæ on which he walked; but being of a very determined disposition, he had persisted in going about and had often worked at heavy laboring, at one time acting for a considerable period as a driver to a coal dealer and having to carry the heavy coal bags in which coal is frequently delivered in this city. The affected limb was 1½ inches shorter than its fellow and considerably atrophied, as can be seen in Photo 2.

With the assistance of Dr. A. J. Geikie, the correction was made on September 15, 1894. Every precaution was taken to prevent sepsis, the limb having been scrubbed and shaved the previous night, and wrapped in absorbent cotton, saturated in a carbolic acid solution 1 in 20. An open incision two inches long was made over the posterior tibial artery, midway between the internal malleolus and the tendo-Achilles. Through this the tibialis posticus and long flexor tendons were divided, the tibialis anticus and plantar fascia were cut subcutaneously and an attempt made with a powerful wrench to bring the foot into position, but the resistance of the short plantar muscles and of the deeper ligaments was so great that it was found necessary to cut every tendon on the plantar surface near its insertion, and many of the deep ligaments were also incised. This was all done subcutaneously with a very small, blunt-pointed tenotome, great care being taken to avoid the plantar arch, which, fortunately, we succeeded in doing. Before these short muscles were cut, it was very interesting to see how the toes were contracted like hen's claws as the wrench

was applied. After all these structures were divided, the tendo-Achilles was cut and the foot brought into a position of over-correction by means of the wrench. Very considerable force was necessary to do this. Iodoform gauze was applied to each puncture, the incision closed and a plaster of Paris dressing applied.

The result forty days after operation is seen in Photo 2. The sole of the foot is flat on the ground. The toes are straight and freely movable, and the range of motion in the medio-tarsal and ankle joints is very nearly normal. The bursæ on which the patient walked now adorn the dorsum of the foot, but, as their usefulness is ended, they will gradually disappear. There is little doubt the patient will have a very useful foot. A light ankle brace, fitted with a check action joint, will be worn for a little time to prevent recurrence.

The knock-knee was corrected on Nov. 9, 1894, by cutting through the femur subcutaneously just above the joint. There was no rise of temperature after the operation, nor any symptom to cause anxiety.

In treating these cases of infantile paralysis in their early stages, it is important to remember that deformity can usually be prevented by suitable orthopedic treatment. There is no doubt that all the very terrible deformity of this patient could have been prevented by suitable massage, passive motion and electricity, combined with a very simple walking brace with an elastic band to supply the place of the deficient peroneal and extensor muscles. The knock-knee I consider to be a secondary result of the neglected foot, an attempt by Nature to correct the centre of gravity.

A Peculiar Fracture of the Clavicle.*

BY DR. J. J. CASSIDY, TORONTO,
Consulting Surgeon, Toronto General Hospital.

LAST October 23rd, 10 p.m., Mr. B——, aged 17 years, presented himself at my office with a fracture of the right clavicle. The accident had been caused by direct violence during a game of foot-ball, in which he was one of the participants. The game was played at night, the field being lit up by the electric light. The bone was broken into three fragments—an acromial and a sternal piece, each of about equal length, and a central piece an inch in length. This central piece had been wrenched from its bed, and could be felt beneath the skin like a sharp fragment presenting in a vertical direction. No efforts that I could make, assisted by Dr. W. H. B. Aikins, who kindly responded to my call for counsel and assistance,

* Read at meeting of Toronto Clinical Society.

succeeded in restoring the fragment to its proper position. The advisability of operating immediately and removing the fragment was naturally discussed. Finally we decided to treat the fracture in the usual way for twelve or fourteen days, until union would take place, and then to trim or remove the central piece. The principal reason for this course of action was that the fragment was large, and if removed by immediate operation the gap between the acromial and sternal ends of the clavicle would cause considerable shortening of the bone and deformity of the shoulder. The fracture was therefore dressed with figure-of-eight bandage to the shoulders, the right arm being placed in a sling and the patient sent to bed.

November 2nd.—This bandage was removed, and the blade of the right scapula was fixed to the back of the thorax with a pad and adhesive straps, which encircled the chest from the spine to the sternum, the arm being sometimes placed in a sling or occasionally extended by the side. This was done to avoid the irksomeness of constantly having the forearm lying on the chest, while the patient was in bed. I also tried to relieve the tension of the skin over the fragment by using strapping in such a way as to cause wrinkles over the front of the fragment. My efforts to prevent perforation of the skin were in vain, and November 6th, fourteen days after the accident, the point of the fragment appeared through the skin.

November 10th.—Assisted by Dr. H. H. Oldright, who chloroformed the patient, and by Dr. Aikins, I cut down on the injured clavicle and exposed the fragment. At first it seemed that, owing to its firm attachment to the other pieces of the bone, I would be obliged to smooth the surface of the fragment, and leave whatever was sound bone in its unnatural position. By manipulation, however, the fragment became loosened, and I finally drew it out, exposing an opening which extended to the posterior surface of the bone. The fragment, which I now exhibit, was about 1⅛ inches in length, and appeared to belong to the anterior surface of the bone, but did not include its whole thickness. It was denuded of periosteum. It had become united by callus at one spot to the sternal fragment.

The subsequent treatment, which was uneventful, consisted in keeping the wound clean, dressing it with rubber tissue and Gamgee tissue, the whole retained by strapping. The wound was quite healed December 6th when he returned to his work. The callus thrown out was considerable, the clavicle at the seat of fracture measuring about 1½ inches in width, the opposite bone being about ¾ inch in diameter.

Society Reports.

TORONTO CLINICAL SOCIETY.*

(NOVEMBER MEETING.)

Pathological Specimens.

Colloid Cystoma.—Dr. J. A. TEMPLE, in presenting a large colloid cystoma, said—The patient, since confinement, had been tapped three times; the fluid accumulated very rapidly indeed. The last tapping was done on Saturday week. I operated on her yesterday, assisted by Dr. Macdonald. On opening her, we found a large quantity of ascitic fluid and a large ovarian tumor. The first appearance made us think it was a malignant growth, but I have had it examined by Dr. Anderson and he pronounced it of benign origin. She is progressing favorably to-night. The main object I had in showing it was because of its peculiar appearance. It will no doubt not be new to men of large experience, but perhaps it may be to some of the others. It is very soft; breaks down very easily. The great distinguishing character, and what makes it unique, is that there was not a single proliferation. These colloid cysts are rapid in their growth. The reason that I operated was because the woman was in such a terrible condition. She measured fifty-four inches around the abdomen. She had been tapped only ten days ago and had all the fluid taken out then. She had been tapped seven times in four weeks. On visiting the woman to-night, I found the temperature normal, the pulse ninety, and doing remarkably well. There was nothing to account for the ascites, except the peritonitis, which was caused, I think, by the rapid growth of the tumor.

Meningitis —Dr. SHEARD—A boy, nineteen, perfectly well until two weeks ago, was then taken with a tendency to sleeping, drowsiness and muttering of a low kind. He was in the hospital under my care for ten days. During his wakefulness, he would snatch at imaginary objects; would look at a distant point, and would make a snatch at it. He was also inclined to get up, and opposed any efforts to soothe him or confine him to bed. He had no distinct convulsive seizure, although the nurse reports that he had slight convulsive attacks. He had spasmodic contraction of the right cervical muscles. The head was drawn over to the right shoulder. This was a pretty constant symptom. It seemed to me that he had some congestion of

* Reported by Dr. J. N. E. Brown.

the right hand and forearm, and also slightly above the elbow, as was shown when the nail was drawn over, a feature which is noticed in basal meningitis. He had no ptosis. But he had a tendency to divergent strabismus. The eyes were drawn outwards, and held in that condition, until attempting to talk with him, when he would then move his eyes and look at you ; but I do not think he could see or understand, because he did not appear to notice a light or any object put before his eyes. The pupils showed no change. They were not sluggish. There was marked retention of urine and feces as well.

Kyphosis.—Dr. SHEARD—The patient, from whom this specimen was taken, eight years ago met with an accident, receiving a severe blow in the lower dorsal region. After this he suffered a good deal of pain and tenderness, even after getting up. This persisted for several years, when an abscess developed, which presented itself at the iliac crest in the lumbar region, and was opened up by Dr. Bryans, and a small amount of pus escaped. After a week it healed up kindly, and the symptoms practically disappeared. His occupation was a sailor, and he worked a couple of years when he began to develop a kyphosis. This was accompanied by a small amount of tenderness and pains He was placed in the House of Providence. On the 4th of November he began to have acute symptoms, marked by weaknes. in the legs, which soon became paralyzed in feeling, but he could move them and there was no increase of reflexes. He had also a marked tendency to semi-coma, and died comatose on the 12th of November, after four days' sickness. He had strabismus and ptosis, the lid covering the upper half of the cornea. In both of these cases there was general tuberculosis. In case number one the diagnosis was meningitis. Adhesions were found in the pons, and the upper medella was thickly coated with lymph and congested. Examining the sylvian fissure and the sylvian artery, a quantity of lymph will be seen deposited there. Looking very carefully at the meningeal membrane, you can scarcely see the tubercle.

In connection with number two, I have one or two very interesting specimens. First, the kyphosis. You will see a softened condition of the vertebral body. It is perfectly carious, and can be easily broken down, and there are adhesions between the spinal meninges and vertebræ, and also inflammatory deposits. The most interesting thing was the caseous condition of the prostate. It shows a central caseous condition, which is very rare in it. The lungs of that patient showed cavities in the apex of the left lung. Then the brain shows basilar changes. The deposit of lymph unites the convolutions all through, especially in the sylvian fissure separating the tempero-

sphenoidal and frontal lobes. The lymph is unbroken, and shows the old adhesions in that way. In reply to question, Dr. Sheard said the age of the first patient was nineteen, that of the second, thirty-eight. There was no traumatism in the first case.

Fatty Tumor.—Dr. ALBERT A. MACDONALD—The peculiarity of this specimen is more in its situation than anything else. It was situated in the perinæum, about an inch in front of the anus and about an inch to the right of the medial line. It had the appearance of a hernia, and the history of the case rather led one to suppose that it might be a perineal hernia. The patient was a male, aged 32 or 33, in good health and an active man. He said that after a strain from lifting a roll of carpets he felt this protrusion, and that he had felt it ever since. He was in the habit of riding a bicycle, which interfered with the lump. When he presented himself to me, I discovered a pedunculated tumor, which was already in the position I have described, and on pressing it I was able to press it upwards, and seemed to reduce what might readily be considered a hernia, and at the same time it had not the feeling of a hernial sac; it seemed thicker and harder. It felt as though it could easily be reduced. For that reason I was led to believe it to be such possibly, though I was not sufficiently clear on the subject to give a positive diagnosis. I reserved that until after it was cut out. Drs. Temple and Baines assisted me to remove it. I cut down on the tumor, which was much larger than it is now, and removing it we found it to be a fatty tumor, and, fortunately for the patient, not a hernia.

Dr. CASSIDY—Had it a pedicle?

Dr. MACDONALD—Yes. I mentioned that it was distinctly pedunculated.

Dr. MACFARLANE—This is an interesting case—its situation, and the fact that it was taken for a hernia. I think it is very unusual. I never saw a hernia in the position this is described to have been in, and I would like to ask Dr. Macdonald if he got any of the symptoms usually accompanying hernia—any impulse on coughing, and the mode of growth of the tumor; in what way did he come to the conclusion that it was a hernia? We could easily understand, if the growth appeared in the neighborhood that was liable to rupture, how a mistake of that kind could occur; but in the location this tumor appears to have been, I would like to learn the peculiar symptoms that led him to have drawn the conclusion that it was hernia or like a hernia. Dr. Sheard asked if the doctor thought that riding on the bicycle had anything to do with it. Friction will cause a fatty tumor. They appear in the line of the braces, in the

line of the waist-band. That continued pressure, combined with the friction, would produce the origination of a fatty tissue growth, and taking this rather peculiar seat for a tumor, together with the habit of bicycle-riding, surgery may develop a new field.

Dr. ALLEN BAINES—One thing struck us all which was not mentioned—the skin over the tumor had become thinned and the covering of the tumor beneath seemed very much like mucous membrane. It felt like gut. It was very easily replaced. The doctor asked me to see this case with him and give him assistance. We supposed that it might be perineal hernia. As perineal hernia was a condition I had never seen, I fortified myself by reading up the subject, and found that perineal hernias are not very uncommon. They do occur frequently in this region.

Dr. TEMPLE said—When I saw this case with Dr. M——, I could verify what Dr. Baines says. There was the history of the sudden appearance and it had a most peculiar feel which simulated the feel of omentum. On manipulating it and squeezing it you could force it away out of sight, and then one could feel nothing but a loose bag. One might easily make a mistake in diagnosis.

Dr. MACDONALD—Regarding Dr. MacFarlane's remarks, I did not say that I had made a diagnosis of perineal hernia ; I distinctly stated that I was unable to make an accurate diagnosis, and Drs. Temple and Baines have both given you the reasons why we could not. The fact of its coming on suddenly rather led me to the idea that it might be hernia. Then it was somewhat constricted at the base. It was in the region where we know perineal hernia may come down, passing through between the levator ani muscles, it was reduced by pressing it up into the cellular tissue ; and I could not tell but what it might have been forced back into the abdominal cavity. The question of obturator hernia was also one that occurred to me, but that was easily disposed of ; I had examined per rectum. I may say that before the operation the idea of hernia had almost disappeared from my mind. Then with regard to the question Dr Sheard has raised as to bicycle-riding and as to whether that had anything to do with the causation of the tumor—I am not prepared to answer that question ; it was in the situation likely to be pressed on by the seat of the bicycle, provided that the front part of the seat was a little wide and tilted upward. That would be more the case if the seat were high and the handles were low, as in the custom of those who imitate fast riders. I have not come across any other injuries or growths that might be said to be caused by riding. Whilst our minds are directed to this subject I may say that I believe on the whole that bicycle-riding is healthful,

though like any other form of exercise harm may be produced on the heart-muscle and may produce strain or rupture. Like other forms of exercise carried on injudiciously, it may cause disease.

Gastric Ulcer, with Perforation and Operation.—Dr. A. B. ATHERTON—Synopsis. Patient, servant girl, aged 20, suffered from dyspeptic symptoms, vomiting being one of the principal symptoms. Could not eat meat without pain; lost flesh. After dinner, on September 19th, four hours later, she complained of severe pain in the epigastrium and also in the right shoulder, accompanied by vomiting of a thin serous fluid. When seen in an hour, Dr. A—— found her lying on the back, with the knees straight, hands clammy, temperature 99.4, respiration 28, breathing thoracic, upper abdomen tender and the wall tense and hard. Morphine was administered until the next day, when the operation was done. Incision in the medial line above the umbilicus. A few ounces of turbid serum escaped. Traction on the stomach walls caused the adhesions to give way. Ulcer was found on the anterior surface near the pylorus. Approximation of the edges was made by two fine silk sutures, and outside of these five or six sutures (Lembert's) several times they cut through. Abdominal cavity wiped out and closed up without drainage. There was some vomiting after the operation. Patient made a good recovery.

Dr. TEMPLE said that he was much interested in the history of the case. He said Dr. Atherton deserved great credit for his success in the case and his good diagnosis. He (Dr. Temple) had never seen the operation performed. Dr. Davison asked if there was any theory to account for the pain in the shoulder. He had two or three cases of gall-stones in which the patient had very severe pains in the shoulders, accompanied with cramps and vomiting. She required two grains of morphine to keep her quiet.

Dr. CASSIDY—Is there any rule with regard to the incision in these cases? Some advocate the incision in the side. Mr. Callahan advocates the incision to be L shaped. Some advocate the central incision. The L shape can be made from this by making an incision to the right. In regard to the diagnosis, these ulcers are found most in maid-servants and middle-aged men. Why are maid-servants more exposed to this than young ladies? I have often thought of this, and can give no satisfactory reason for it. Why is it not found in other walks of life? As regards the operation, is there no means to tell whether the ulcer is anteriorly or posteriorly situated, near the pyloric or cardiac orifices? Is there anything to show except the shock and localized pain after previous dyspeptic symptoms (and

sometimes they have none at all). Regard to the suturing, Dr. Atherton used silk. Did he pare the edges of the wound, or did he stitch the wound as he got it?

Dr. POWELL—It seems to me that it is worth while considering, where the ulcer is large, the advisability of forming an anastomosis between the stomach and the small intestine by means of the button or plate, rather than trusting to union taking place through the use of the Lembert's sutures. I simply throw out the suggestion. It seems to me that a puckering string would bring the parts together, and if there were any circumferential thickness or hardness in these cases there would not be that approximation that would ensure safety to the patient.

Dr. MACDONALD—Dr. Atherton said he did not consider that there was any escape of the fluid from the stomach, or but little, and he did not wash out. I suppose if there had been much escape, it would have been wise to have washed out. If you make the diagnosis and decide to operate, the choice of operation can only be that of stitching up. If the stomach be dilated, I suppose it may be overlapped; they are taking reefs in stomachs now.

Dr. ATHERTON—As to Dr. Davison's question regarding the pain in the left shoulder, I leave it to the anatomists; I suppose it is due to reflex action. I cannot give any other explanation. Regarding Dr. Cassidy's question as to the incision, it was in the median line. I made it here for one or two reasons. One is that the incision here holds more satisfactorily, and you are less likely to have a hernia follow afterwards. Another reason is that many of these cases of perforation can be reached more easily from the incision in this place. If the ulcer is near the cardiac region you can make a cross cut through the rectus and integument and get at it in that way. Many recommend the incision to the left side a little, near the median line. But personally I think the median line is very satisfactory. If the point could not have been got at without a cross incision, I would not have hesitated to have made it. As Dr. Cassidy says, undoubtedly in female servants we are most likely to find this condition rather than in young women in other walks of life. Many of these have more or less anæmia. This girl had somewhat of that aspect. It was markedly present in a young woman I had with gastric ulcer two years ago, and who died from perforation. Then I decided never to have another pass through my hand in that way—where they have anæmia and gastric ulcer. Men beyond middle age are apt to have it. I have seen two or three in men. With regard to re-vivifying the edges, I did not find it necessary. They healed perfectly well without it.

Regarding Dr. Powell's suggestion of making an anastamosis with the intestine, I cannot see how that would better matters. I think you would be more apt to have a bad result than if you turned the ulcerated surfaces inside and covered with peritoneum. I do not think the suggestion has been carried out. Another thing recommended is: If you can get at the perforation, to suture, pass the drainage tube into the stomach and pack around with iodoform gauze and drain off externally the contents of the stomach. I did not wash out the abdominal cavity, because there seemed to be but little escape of the contents. I sponged it slightly around the parts where there seemed to be a turbid serous fluid. That seemed sufficient. I think this procedure is wiser in these cases, because if one attempts to wash out there is danger of spreading infection from one or two pockets to the entire peritoneum.

Editorials.

The Canadian Medical Review.

NEARLY all those who are interested in the promotion of the REVIEW a short time ago were associated with another periodical. We shall endeavor to make the REVIEW a first-class medical journal. Original articles shall be selected with care, and we shall carefully sift the best medical literature for our readers.

Medical Ethics.

ON December 13th, at the meeting of the Toronto Medical Society, reference was made to the fact that some members of the Society had been made unduly prominent in the public press in connection with their cases. Whilst it is true that medical men, as a rule, are more thin-skinned in this respect than are either clergymen or lawyers, we must not forget that the doings of those in the professions last-named are more of a public nature, and so are, in the natural course, more open to comment by the press. Though medical men cannot control the papers, and though the names of medical men may be dragged into print without their knowledge and consent, and even to their detriment, we believe that much can be done to discourage such actions, and that by keeping the harrowing details of operations to ourselves we will do much to uphold the honor and dignity of a profession which holds a good position in every civilized country.

Antitoxin Diphtheriæ.

So far as this new remedy has been tried there is some good grounds for regarding it as of substantial use. Judging by the reports of cases so treated, about ninety per cent. has recovered. By the very best care without the antitoxin the results are about seventy per cent. of recoveries. Under five years the mortality is over forty per cent.

A pure diphtheria bacillus culture is obtained. This is injected into the animal that is to yield the serum. Very small doses are injected at first, and gradually increased until the most powerful doses are administered. It requires considerable time to reach the point of immunity. The animals generally selected are sheep, goats, dogs, cows and horses.

After immunity in the animal has been reached, the serum of the blood is taken as the antitoxin, to control and counteract the diphtheria

toxines. In a cool place this serum is supposed to keep for two or three months.

One of the features of this treatment is that paralysis appears to be less frequent than after the usual methods. It seems to control the toxines of the disease and lessen the tendency to paralysis. It does not appear to have much influence in controlling the membrane or the bacillus. Its power seems to be directed against the toxines of the disease.

Before definite conclusions can be drawn from its use, a large number of cases must be treated. Medical men will be glad to hear further from such men as Aronson, Behring, Roux, Yersin, and others. So far it appears that the remedy has come to stay.

The Patrons and Public Appreciation of Our Profession.

In these days when rampant Radicalism and class prejudice threaten to overthrow the safeguards which have been thrown about our profession, and free trade in medicine is held up to the public as the ideal condition, when columns of vituperative misstatement of fact are taken as the very Gospel, when to be a member of the profession is to be at a political disadvantage, it is gratifying to observe in the *Illustrated London News*, of November 10th, a double-page portrait-group of the leaders of the profession in England. The accompanying letterpress is sympathetic and appreciative: "There is no profession," says the *News*, "requiring a higher degree of intellectual culture and proficiency in special studies not within the comprehension of ordinary laymen, the practical utility and even necessity of which, for the social welfare and for the preservation of families and of individuals, will be universally admitted. Modern physicians have found means to preserve for many years the lives of invalids who would, in former generations, have died early." And much more in a similar strain. It is passing strange that the *News* considers that there are medical subjects "not within the comprehension of ordinary laymen," while the *Farmers' Sun* "knows it all!" The editor of the *London News* must be a very "ordinary layman." He should come out here to get pointers. We may be pardoned if we remark that we do not know how to run a farm, not having been brought up to the business. But it strikes us as singular that those who presumably do have also to wrestle with mortgages first; second, and chattel in abundance. It appears to us, and we desire to express ourselves

humbly, that it might be well for the farmers to devote a little of their great and versatile ability to the study of agriculture, and to the commonplace but somewhat necessary art of making ends meet, before they attempt to practise medicine and to reconstruct everything in sight.

Diphtheria.

THIS is not a modern disease. It was known to the ancients. Its study, however, dates back to Bretonneau. He gave the first account of the disease that really separated it from other conditions.

As to the origin of diphtheria there is now no doubt. The Klebs-Loeffler bacilli are the *fons et origo malorum* of this dread disease.

Is the disease local or constitutional? All good pathological teaching at the present goes to prove that it is a local disease. The germs attack some broken cutaneous or mucous surface, and there multiply and manufacture their deadly toxines.

Then, again, there is some dispute as to the existence of a membraneous croup that is not diphtheria. That there is a laryngitis that is not diphtheritic there can be no two opinions, but that there is a membraneous croup without the specific bacilli is still a contested point.

The poison is a toxine of great virulency, and possesses extremely depressing powers on the living tissues of the body. This toxine enters the system at the seat of infection. On nerve-matter its action is specially potent.

The question of immunity is now to the front. The work of Behring, Aronson and others have given the profession the antitoxin. By such efforts the time may not be far distant when perfect immunity may be produced through these culture methods. Hydrophobia, tetanus and anthrax are good examples of the work so far done.

This whole problem is in its infancy. Much may yet be expected. As our knowledge of the life-habits of the bacilli increases, and further experiments are made with culture preparations, the laws that govern immunity will no doubt be discovered.

It is clear from the local origin of the disease that its local treatment ought to be most painstaking and thorough. To destroy the bacilli is to lessen the toxines and improve the chance for recovery.

Electricity.

Few remedial agents are attracting more attention or being investigated more thoroughly and scientifically at the present time than is electricity.

Long shrouded in mystery, it has been left in the hands of the charlatan and the unskilful, but it is gradually emerging from its hazy surroundings, and is being accorded its rightful place among rational modern methods of combating disease.

It occupies the entire attention of a vigorous young society—The American Electro-Therapeutic Association — most enthusiastically devoted to its interests, and composed of the engineer and expert, who study its laws and not its action upon inert matter; of the physicist and biologist, who follow up these results in their laboratories and investigate its effects on living tissue, and, finally, of the physician and surgeon, who put to a practical use the deductions of their co-laborers in this most interesting field, and determine the palliative or curative properties of the agent.

Our own city is to be congratulated in that it has not been backward in according to electricity the dignity of a special department in all the public hospitals, thus openly acknowledging its value, and electricity plays no unimportant part in many of the smaller institutions of Toronto.

Perhaps in no field has it made its presence felt more than in gynæcology; here it has joined hands with conservative surgery in sparing from mutilation many a suffering female. It has been grossly misunderstood and misapplied, consequently its failures have been as marked as its successes; but to-day its position is more secure than ever, even though its range has been narrowed beyond what was anticipated for the measure when first it claimed the attention of the gynæcologist.

In surgery it is often an alternative to more severe proceeding, and has the advantage that, properly used, it does not prejudice the case for future more radical interference where necessary. In the field of medicine it plays an essential *rôle*, and here its range of applicability is very wide.

Recognizing the value of electricity in these and other fields, more definite allusion to which is not possible here, we hope to place before our readers from time to time short articles on electricity of interest to the general practitioner by acknowledged authorities.

QUININE AS AN OXYTOCIC. — Dr. E. A. Edlen (writing in *New York Medical Journal*, November 24th) claims that quinine is a good oxytocic. He states that, in uterine inertia, ergot often fails to stimulate contractions. In one case where the pains were poor he had given ergot without results. He then gave eight grains of quinine. In half an hour the pains began in an active manner. He regards quinine as much safer and surer than ergot.

COD LIVER OIL.—Dr. E. F. Billings, of Boston (*St. Louis Medical and Surgical Journal*, November), directs attention to some of the uses of cod liver oil. 1. In wasting diseases it holds a well-merited reputation. Great care must be taken, however, to secure its digestion. The writer is not in favor of the extracts of cod liver oil. 2. In some forms of neuralgia cod liver oil is of the greatest value. When all other remedies have failed, some brilliant triumphs have been obtained by this remedy. When given with extract of wild cherry, extract of malt and syrup of hypophosphites, very excellent toning effects are obtained.

CONGENITAL ANNULAR STENOSIS OF VAGINA.—Dr. H. N. Vineberg, of New York (*Medical Record*, November 17th), describes a new method of operating on these constricting rings. Instead of making incisions in them and then keeping up dilatation, he incises the mucous member along the entire length of the constricting band. He then dissects out the band. The mucous membrane is carefully replaced and sutured. No dilatation is necessary in this operation. As soon as the mucous membrane has united the result is complete. By this operation, all the constricting tissue is removed. There is much less irritation in this method than that by forced dilatation. When the incision has healed, no rigidity or constriction remains.

TRICHINOSIS.—Dr. Frank J. Thornbury, of Buffalo (*Cincinnati Lancet-Clinic*, October 13th), reports on five hundred cases of trichinosis in swine. Of these cases, the parasite was found in four hundred; in the loin in two hundred and ninety, in the neck in one hundred and seventy. All three parts were affected in two hundred of the cases; two parts in one hundred and thirty-six cases; and one part in one hundred and sixty-four cases. The diaphragm, therefore, appears to be the favorite point of attack. The trichinæ bore into the muscles in the region of the digestive canal. When the hog was extensively infected they were found in the hams, shoulders, sides and

almost every part of the body. In twenty human cases, the trichinæ were found in the muscles of the extremities, the diaphragm, intercostals, abdominal muscles, etc. In some cases the trichinæ were calcified, in others alive and active.

Hypertrophic and Atrophic Rhinitis.—Dr. Albert Pick, of Boston (*New York Medical Journal*, November 17th, 1894) states as follows: In hypertrophic the first thing to attend to is that of thoroughly cleansing the nasal cavity. When this has been thoroughly done, some application like Sieler's tablets may be employed. The hypertrophied tissue may be removed by chromic, nitric, glacial acetic acids, or the cautery. Bony spurs may be removed by the saw. Deviated septum must be straightened by same method. Vegetations removed as you would polypi. Good constitutional treatment is needed in most cases to restore the due balance of health. In atrophic cases atomizers are of great value. They throw in the solution in such a manner as to have a stimulating effect on the mucous membrane. The Sieler's tablets, or sod. bi-carb., gr. xx; listerine, ℥ss., aquæ ad. ℥ii. are good sprays. Tincture iodine and glycerine, equal parts, applied on the cotton-tipped probe, do good; when treatment is continued the outlook is good.

Cholæmia.—Dr. J. H. Clayton, of Birmingham (*Birm. Med. Rev.*, October), divides cholæmic conditions into two groups: The first, where the elements of the bile are circulating through the body in the blood, and the second, where they pass through the vessels into the tissues. This latter form is jaundice or icterus. The writer claims that these two conditions should be carefully distinguished. In many cases there are changes in the liver, and the bile is found in the blood and urine, and no jaundice present. On the other hand, all the conditions may exist for some time, and the bile be found in the blood prior to the appearance of jaundice. The cholæmia, in other words, precedes the jaundice for a time. In many of these cases, with muscular weakness and molaise, a saline laxative affords great relief. In some cases this cholæmia is caused by close business application or mental application during the week, then taking some brisk exercise on Saturday. This throws a large amount of bile into the blood, and causes much distress on Sunday. Brisk salines on Saturday corrects these cases. Thus the keynote to the treatment of these cases is purgation, so as to evacuate the intestinal canal and prevent the absorption into the blood of the bile lying in the canal.

The liver is torpid during the week, and the active exercise of Saturday causes a free excretion of bile, hence the utility of the purgative. The best are mercurials and salines.

Guaiacol Externally in Tuberculosis.—Dr. J. Solis-Cohen, of Philadelphia (*Medical News*, November 24, 1894), states that he has had great benefit from the external employment of guaiacol in the elevated temperature of tuberculosis. At first he used as much as ℥40, but found this too depressing. Doses varying from ℥10 to ℥25 are usually sufficient. He selects that portion of the surface over the seat of disease, washes it off well with soap and water, and then dries thoroughly. The guaiacol is painted on with a brush until it is all absorbed, the part is then wiped with the hand and covered with cotton wool and oiled silk or paraffin paper. Sometimes the temperature will drop three or four degrees in a short time. When the temperature falls much below normal, the patient feels uncomfortable and chilly. This is readily corrected by a warm drink and a warm bag to the body. The results are best when the application is accompanied by free perspiration. In one case the temperature was maintained at normal for six weeks. Free perspiration is favored by giving the patient some hot milk, or a warm drink, and applying warm bags to the sides. In no other way can the temperature in these cases be reduced so readily and with such good results to the patient. The applications can be repeated as the temperature rises. After an application of ℥20 the temperature usually remains normal for two days to nearly a week. The reduction is usually accompanied by a feeling of comfort.

[We have used guaiacol in cases of typhoid fever, but discontinued its use owing to the great depression following. The effect appeared to be transient; temperature was only lowered for a few hours.]

The Hygiene of the Eyes.—Dr. L. W. Fox, of Philadelphia (*Diet. and Hyg. Gazette*, November), remarks as follows: "A woman with leucorrhœa should be ordered an antiseptic injection before confinement, and the child's eyes should be treated with nitrate of silver, gr. 1 to the ounce. During the first six months of the child's life, its health should be well looked after. It should be much in the air. Its eyes must be guarded against sudden bright lights and objects. Children should not be allowed to do much with printed books till they are ten. Kindergarten work up to this age is far better for them in more ways than one, but specially with regard to their eyes. Myopia is one of the direct results of school life and

education. Savages are all far-sighted. As people begin constantly to look at near and small objects, near-sightedness is produced. This is greatly obviated by not allowing the child the use of books too young; and, when reading is allowed, only for a limited period each day. Hyperopia, or far-sightedness, is the natural condition of the eye. Savages are all far-sighted. When a person with this condition is put into an office, and begins close work on books, eye-strain soon follows. Headaches, pain about the eyes, a languid feeling, are prominent symptoms. Suitable glasses must be obtained in these cases, though the person be quite young. Adults employed much at reading, etching, engraving, book-keeping, type-writing, etc., should take special care over their eyes. The nature of their occupation is sedentary. There is usually insufficient daylight in most offices. This is supplanted by artificial light. A pure white light is not good. In many cases a reflector is used. This focuses the light on the white paper, whence it is reflected into the eye. This causes contraction of the iris and constant eye-strain. The reflector should be removed from the light, and a shade worn over the eyes. Gas light diffuses round a room better than electric light. Reading in railway and street cars is hard on the eyes. Owing to the swaying motion, the paper is held too close to the eyes; this keeps up much eye-strain. When book-keepers are adding up columns of figures, they should place behind the sheet a tin plate colored green, blue or black; this color penetrates the white paper, and they are then working on a neutral tint: when this cannot be done, glasses of some tint, such as the arundel. Blank walls should be decorated with scenery paper, or pictures on which the eyes will rest when raised from the white paper of a ledger.

Book Notices.

Essentials of Diseases of the Skin. Including Syphilodemata arranged in the form of questions and answers, prepared especially for students of medicine. By Henry W. Stelwagon, M.D., Ph.D., Clinical Professor of Dermatology in the Jefferson Medical College. Third edition, revised and enlarged, with seventy-one letter-press cuts and fifteen half-tone illustrations. Philadelphia: W. B. Saunders, 925 Walnut Street. 1894.

The very flattering reception given to the first edition of this compend when it appeared three years ago, was the best indication of its worth. That a third edition has been called for so soon, shows that it is still popular, and rightly so, with both students and practitioners.

Diagnosis and Differential Diagnosis and Treatment of Diseases of the Eye. By Dr. A. E. ADAMS. New York: G. P. Putnam's Sons. 1894.

This little book gives the diagnosis and treatment of eye diseases in a clear and concise manner, and should be of use to students and general practitioners as a work of ready reference. The design of the book is novel.

Difficult Labor: A Guide to its Management for Students and Practitioners. By G. ERNEST HERMAN, M.B., Lond., F.R.C.P., Senior Obstetric Physician to the London Hospital; Physician to the General Lying-in Hospital; President of the Obstetrical Society of London; Examiner in Midwifery to the Royal College of Surgeons; Late Physician to the Royal Maternity Charity. Crown octavo, 442 pages, 162 illustrations, muslin, price $2.25. New York: Wm. Wood & Co.

This is a work which, to the busy practitioner, commends itself at once. The arrangement is good, and the matter, though somewhat arbitrary, is excellent and very correct. Page after page is not consumed in the recitals of the history of operations and statistics. The author has plunged into his subject apparently with the determination of assisting his readers and giving them the advantage of his vast experience in as brief but comprehensive a manner as is possible.

The book is a handy size, well printed and profusely illustrated with easily understood cuts. We believe that the active physician will find it indispensable, and we can recommend him to purchase it, as he will get more than the value of his money in return.

Practical Uranalysis and Urinary Diagnosis. A Manual for the use of Physicians, Surgeons and Students. By CHARLES W. PURDY, M.D., Queen's University; F.R.C.P.S., Kingston; Professor of Urology and Urinary Diagnosis at the Chicago Post-Graduate Medical School. Author of "Bright's Disease and Allied Affections of the Kidneys"; also of "Diabetes: Its Causes, Symptoms and Treatment." With numerous illustrations, including photo-engravings and colored plates. In one crown octavo volume, 360 pages, in extra cloth, $2.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

Dr. Purdy had a good reputation before this work appeared. It was therefore with considerable expectation that the volume before us was opened. This expectation has not been disappointed.

The first part of the work deals with the analysis of the urine. The subject is handled in a very clear and full manner. In this day of accurate diagnosis and life insurance work, we hardly see how any physician should not have such a work of reference.

The second part deals with urinary diagnosis. There is much valuable matter in a condensed form in this section. The work is well illustrated. Both publishers and author are to be congratulated upon their work. We can cordially recommend the book.

The Popular Science Monthly. New York: D. Appleton & Co., 72 Fifth Ave.; Toronto Agency: N. G. Morang, 63 Yonge Street.

This valuable journal maintains its well-earned position as the best popular scientific periodical published in the English language. The December number is replete with interesting papers contributed by scholarly and well-known writers.

Psychopathia Sexualis, with Especial Reference to Contrary Sexual Instinct. A Medico-Legal Study. By Dr. R. von Krafft-Ebing, Professor of Psychiatry and Neurology, University of Vienna. Authorized translation of the seventh, enlarged and revised, German edition. By Charles Gilbert Chaddock, M.D., Professor of Nervous and Mental Diseases, Marion-Sims College of Medicine, St. Louis; Fellow of the Chicago Academy of Medicine; Corresponding Member of the Detroit Academy of Medicine; Associate Member of the American Medico-Psychological Association, etc. In one royal octavo volume, 436 pages, extra cloth, $3.00 net; sheep, $4.00 net. Sold only by subscription. Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street.

Whether this work will become an authority in the study of perverted instinct or not, remains to be seen. It contains in its 436 pages an unvarnished recital of the depths of human depravity, such as can best be familiar to the alienist. To the general practitioner it discloses material for sad reflection.

The work has been sold extensively throughout the country; fortunately, for the most part, to physicians. It is not easy for the general practitioner to review this book. We would almost be disposed to think it should be confined to the library of the alienist.

Professor Zakharin has been presented by the Czar with a valuable snuff box bearing a portrait of the late Czar Alexander III.

The promised "Life of Sir Andrew Clark" is being prepared by Canon MacColl, with the co-operation of Dr. W. H. Allchin. An introduction will be contributed by Mr. Gladstone. The book, which will be published by Messrs. Longmans, is not expected to be ready for some time yet.

Correspondence.

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

Reflections.

The Expression "Doc."....The Drug Store "Doctor"....Patent Medicines....Wealthy Physicians....Tariff of Fees.

To the Editor CANADIAN MEDICAL REVIEW.

SIR,—The expression "Doc." is becoming more and more common in this Province, and no medical gentleman of any pretensions or worth, who has respect for the exalted title of "Doctor," which he during the best few years of life worked zealously to obtain, can otherwise regard himself than humiliated when addressed as "Doc." "Doc." is by the rough element of every country town or village applied to such who obtain a certificate as V.S., or to some sport about town. It is really an expression that should be stamped out by every physician.

It has been my sad experience to have lived in places wherein the really licensed M.D. has secured his stronghold in a drug store. His position is such that he dispenses his drugs, advice and skill at rates which his fellow-practitioners, relying on their practices, cannot adopt and keep their families. As a rule, no greater stumbling-blocks as regards adherence to the Divisional Tariff of Fees exist greater than these "condition powders" doctors. He reads but little medicine, frequently criticises your prescriptions, and, among several faults, is doing quietly a lot of good work for the patent medicine man, and frequently that same man is the doctor himself.

So much has been written about patent medicines condemnatory of their sanction by medical men, that I will state that it is my opinion that in recommending or prescribing such preparations as "seng," "H.V.C.," "broncholine" and the hundred or more of such preparations, we are to a great extent but endorsing patent medicines; yes, encouraging a company probably composed of really qualified M.D.'s, who, not wishing to undergo the toils of professional life, probably rich or backed up in the enterprise by a few rich loafer-companions, push a medicine or preparation before our notice, and being recommended as specifics by many who like to see their "names in print" —by J. Smith, M.D., Alligator Creek, Florida, to W. H. Brown, M.D., Hudson Bay P.O., Manitoba; or by Peter Physic, M.D., Sc.B., Orange Grove, Cal., or some Blue Nose M.D., of Blue Nose P.O.,

Halifax, N.S.—it is no wonder that some of us older ones should be tempted to play the fool and buy a ticket.

Once I was young, and I now claim many years of active service in practice, and yet I have seen very few of my fellow-practitioners acquire any great wealth; in fact, the wealthiest among them have become so by marriage or by being remembered in the will of a hay-seed father. Recently, in an address to the members of a graduating class in medicine, I told them that the surest course to acquire wealth in practice would be to marry it. However, I did not adopt this mature thought, yet for the first year I thought I had; but, for the score of years since, those newly then-formed relations have struggled to consume and eat up their first year's offerings. Rich in having a noble wife and several children, and the most ordinary comforts of life, I am satisfied, like the majority of my fellow-practitioners, with my lot, but expecting, with every assurance, a legacy. I will build greater, and the world will say, "Another doctor has made himself rich."

In *re* tariff of fees, such a schedule we have for our Division, but it fails most decidedly in being adopted, and I have recently written our member to make efforts to secure the endorsement to said tariff (without mental reservation) of each licentiate in the district, and to have each M.D. supplied with a good-sized copy, with the names of the Division's men added as subscribers as proof of general adoption of the fees named. As our own and United States medical journals are giving space to discussions or articles on subjects actually pertaining to the business part of the profession, it is desired by the writer that short articles on this and other subjects of this writing be written on by fellow-practitioners in medicine.

"*Qui non liberè veritatem pronunciat proditor est veritatis.*"

"JUNIUS."

December 13th, 1894.

Hon. G. W. Ross' Address at the Medical Banquet.

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—At the late dinner of the "meds." of Toronto University, the Hon. G. W. Ross, in his *post prandium* address, foreshadows an attack to be made upon the medical profession at the coming session of the Provincial Legislature. While warning the profession that their claims to special legislation will be questioned, severely criticised and even opposed, he at the same time declares himself in favor of

the Medical Council, and of maintaining the standard of medical education as a protection to the public.

This announcement of his views by the Minister of Education will no doubt be pleasing to the majority of the profession in Ontario, as it will be regarded as the index of the mind of the Government regarding the matter. I must say, however, that Mr. Ross does not give any definite grounds for hope that the views expressed at the "meds." dinner will necessarily bind the Ontario Government to a policy of medical protection in the approaching session of the House. The fact is, the Patrons are after our scalp, and if they are strong enough they may get it.

The question may be asked here, Why should the Patrons of Industry or the representatives of any section of the people of this Province, desire to destroy a profession so useful and necessary to the public as that of medicine? I fear it must be admitted that the cause is to be sought for mainly within the profession itself. There are registered traitors, whose sole object is to make money, and secretly desire to remove every obstacle, ethical and legal, in order to satisfy their lust for gain. These men will use the Patrons, or even the devil himself, to gain their ends. The honor of the profession is of no account to these licensed quacks. There is another class in the profession who, though not actually plotting with any political iconoclasts, are more destructive because more numerous—I mean the club or contract doctor. They make themselves the slaves of their employers, and are gradually reducing the already meagre average income of our profession, so that now a good mechanic enjoys an income more certain and more remunerative than the average doctor. In time, our men who are conscientiously striving to live up to the ethical standard will get tired of fighting against these dollar-a-year men, and be driven in the struggle for existence, to sink all scruples of professional conscience and take up the job of the fakir. Indeed, it is to be feared that we are fast drifting into fakirism as it is.

To return to the well-meaning utterances of the Minister of Education, I would ask Mr. Ross how he accounts for the noticeable deterioration in the moral of the profession *pari passu*, with an advancing curriculum and all the efforts of the Ontario Medical Council to stamp out quackery and maintain the dignity and honor of the profession. Is our modern medical student a mere mercenary, with no regard for high and noble aims, and a worshipper of the great god "Get there" no matter how, or are there too many medical schools interested in manufacturing for an already over-supplied market?

Now, I wish it to be understood that I have no desire to make any radical changes in the laws which, with great labor and heroic struggle on the part of a few men, have been enacted in the interest of the public as well as the profession. My object is to point out vices within the professional body politic, so that we may set to work to reform and bring about a change before the diseases have become incurable. Yours,

"PHILO MEDICUS."

Weston, Dec. 13th, 1894.

Selections.

FAUVEL WRITES: "Yes, odors have an injurious influence on the vocal cords, and I have obtained from several directors of singers, managers of opera, a rule forbidding any bouquets or flowers being sent to dressing-rooms or presented on the stage, There is, following the inspiration of strong odors, such as violets, pinks, lilies of the valley and mignonette, a vibratory struggle between sonorous undulations. The vocal cords, at contact with odors, go into a state of paresis, from default of contraction; they become halting, or crippled." —*Cincin. Lancet.*

APPENDICITIS.—*Food* quotes Swain as saying ninety per cent. of cases recover spontaneously, and that therefore early operative interference is not justifiable. The editor of the *Medical Arena* corroborates and asserts, as the result of personal experience, that every case is amenable to persistent conservative treatment. He would, however, advise an operation when abscess has formed. Nevertheless, the fact remains that too many continue to recommend the knife, and that indiscriminate cutting for pain in the region of the cœcum is the rule rather than the exception.—*Medical Age.*

MODERN SURGICAL TECHNIQUE.—Dr. Henry O. Marcy, of Boston, emphasizes the importance of a most careful bacteriological training on the part of him who would become proficient in surgical practice. In the preparation of the operating-room, Dr. Marcy pointed out the ease and safety with which an ordinary living-room, by preference the kitchen, is made comparatively sterile, when from necessity the surgeon is called upon to act promptly and suddenly. In abdominal wounds, where irrigation is not advised, he substitutes for it a slowly flowing stream of oxygen gas from a compressed

cylinder. This sterile gas is heavier than atmospheric air which it displaces, and as a consequence renders the wound less likely to infection from the products of respiration and atmospheric contamination.—From report of Mississippi Valley Medical Association in *Medical Record.*

For Intercostal Neuralgia.—

℞ Linimenti belladonnæ.....f℥j.
Linimenti chloroformi.....f℥iv.
Linimenti opii.....ad f℥iij.
Misce et fiat linimentum.
To be well rubbed over the painful area.—*The Practitioner.*

The Murphy Button.—Dr. Dawbarn said that about the time when the Murphy button was first used in New York, he sent to Chicago and got one which he used in a case of gall-stone, the diagnosis having been confirmed by the operation. The gall-bladder seemed remarkably friable, and at autopsy—death having occurred in forty-eight hours—a distinct tear was found at the edge of the button. There was also a diffuse form of cancer of the liver, and this had probably led to the friable condition of the gall-bladder, although this viscus was not carcinomatous. He had sent an account of the case to Dr. Murphy before the latter had reported a collection of one hundred successful cases, and had afterward written Dr. Murphy to learn why this fatal one had been omitted. The answer was that he did not suppose the author of the case would care to have it reported since it was unsuccessful, and also because it was an attempt to unite a cancerous gall-bladder with the duodenum, which was not true.—From report New York Academy of Medicine in *Medical Record.*

Miscellaneous.

Dr. J. Algernon Temple and Dr. Albert A. Macdonald, of this city, have entered into partnership in the conduct of "Bellevue House," 87 Bellevue Avenue, heretofore Dr. Temple's Private Hospital for Women. Dr. Temple, whose reputation as an operator is so well known, has carried on the work of the hospital with singular success. Increased accommodation has been provided, and in order to keep up with the work, Dr. Macdonald, who has also devoted special attention to gynæcology, has become associated with him.

ALBERT NAPPER, the originator of cottage-hospitals, died on November 16th, at the age of seventy-nine years. He established the first cottage-hospital in 1859.

OUR MEDICAL STUDENTS.—England has but 552 medical students; there are 8,000 in the Germany universities, but the United States has 13,000. We could loan England a few thousand and have plenty to spare.—*Med. Record.*

CHARCOT, like Gull, physicked his patients very sparingly. If he did not, like Sydenham, recommend students to read "Don Quixote" as a part of their medical education, he thought the works of the so-called "naturalist" school of novel writers useful for other purposes. He used to prescribe certain chapters of Zola as the surest emetic known to him; other works of the same master and his disciples were, in his opinion, valuable as narcotics. He used to say the best shop for narcotics was at Medan (where the author of "Nana" lives); there an infallible "drowsy syrup" could always be got for 3.50 fr. To a student who, after a lecture in which erotomania had been touched upon, asked what was the best remedy for incontinence Charcot replied, "Anæmia—or, better still, apoplexy."

THE

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Original Communications.

Tumor of the Middle Lobe of the Cerebellum.*

BY D. C. MEYERS, M.D., TORONTO.

THE history of the case is as follows: The patient, H. W——, aged 26, is unmarried and a dentist by profession. In regard to his family history, his father and mother are alive. He has several brothers and sisters, all of a decidedly nervous temperament. His grandfather died of hemorrhage of the lungs, and there was consumption in his grandmother's family. His father tells me that one of his children by the first wife died of hydrocephalus, and another of consumption. No history of fits or mental disease. The patient's previous health was always good, but he was nervous, and at times was troubled much with headache. He had rheumatism about eight years ago, and some kidney trouble soon after. He has been much confined to his office since he was sixteen.

His present illness began about five years ago after an excess of work from taking his diploma. At this time he had an attack during which he was entirely paralyzed, and was unconscious or partially so for ten days. His temperature was raised to 103° at times during the

* Read at January Meeting of the Toronto Clinical Society.

attack, which kept him in bed for six weeks. His left side, he says, was more affected than the right, and his arms recovered first. Soon after recovering from this attack he went to Picton, where after ten days he had another attack of paralysis, lasting three months. He gradually improved and began practice again until following summer, when he again overworked himself, but after a rest in Muskoka he worked again during the winter. Some stiffness in his legs, however, always continued. During the following summer he suffered much from dysentery, but was again better during the winter. In the spring two years ago he felt badly, and he then did the Salsbury treatment. Since this time his eyesight has been bad. He spent last winter in Nebraska, where he was fairly well. He has not worked for a year and a half, and his walking has been growing steadily worse. His bowels are very constipated, and in the past five years he has scarcely had a natural motion. He has had trouble to pass urine, and he now is often obliged to wait for it to pass, and the propulsion is not good. At times he is very dizzy, so that everything swims, and he can maintain his equilibrium only with difficulty. He does not vomit, but has had a feeling of intense nausea with the dizziness; giddiness much increased when he turns. He complains of a sense of pressure over occiput when the nausea is bad. The patient stands and walks with feet widely separated, and has great difficulty, when standing with his feet together, to maintain his equilibrium. His balance is scarcely more uncertain when he closes his eyes, and he walks with his eyes closed almost as well as when they are open. He fell off the sofa at my office when dressing. His walk resembles that of a drunken man. He has some inco-ordination in legs, and less in arms. He does not stamp feet in walking, and says he can put them where he wants them without trouble, and he does so in walking without marked excursion. He has no tremor of the hands. Dynamometer, R 85, L. 67. Strength good in all the muscles of the legs; no wasting of any muscles. Sensibility quite good over entire body; but he says for a light touch he uses right hand. His knee jerks are markedly increased on both sides, and a distinct ankle clonus on both sides is also present. He tells me that at one time knee jerks were lost. Plantar reflex absent. His eyes show a slight nystagmus on lateral rotation. Except this, movements normal. Discs both show a typical grey atrophy. Dr. Ryerson kindly informs me that five years ago the patient had distinct papillitis in both eyes, and that the patient then required assistance in walking, his gait being very unsteady. Respirations are very slow—seven per minute. Pulse 76 and regular; urine normal; appetite good, and he sleeps well. Patient is bright and intelligent. He is

well nourished. The moral habits of the patient are in every respect good. The hands present no tremor, voluntary or otherwise.

The first question which naturally arises is, Where is the seat of the trouble? The increased reflexes, the inco-ordination, the nystagmus, the optic atrophy, would point strongly to an affection of the cord Ataxic Paraplegia. But the age at which the trouble began, the fact that the atrophy (which of itself is rare in Ataxic Paraplegia) was preceded by choked disc, the muscular strength in the legs being unimpaired, the respiratory symptoms, the slight amount of ataxia, etc., would negative this opinion. That protean malady, multiple sclerosis, presents another difficulty in diagnosis; but the entire absence of tremor, the perfectly natural articulation, the presence of distinct papillitis and the peculiar gait of the patient, are opposed to this view of the disease.

On the other hand the marked giddiness, the respiratory trouble, and especially the fact that papillitis preceded the present optic atrophy and the difficulty in maintaining his equilibrium, indicate an affection of the brain, which a consideration of the symptoms compels one to think a tumor. Under these circumstances (unless we suppose the presence of more than one tumor) the growth must be in such a position as to compress both pyramidal tracts, and cause inco-ordination and disturbance of the equilibrium. The most probable situation for such a growth is the cerebellum, particularly the middle lobe, as you are all aware an affection of the semicircular canals of the ear, or of that portion of the auditory nerve connected with the ampullæ, will cause a loss of equilibrium; and in this case I believe the vestibular portion of the auditory nerve in its course to the cerebellum is affected, having a disturbance of equilibrium as a consequence. The cause of the increased reflexes lies in the fact that the pyramidal tracts of the cord are pressed upon and probably degenerated as a result. The loss of co-ordination may be explained by a derangement of those sensory impulses which, passing through the posterior columns of the cord, go thence to the cerebellum. In fact we have here, in regard to the reflexes and the inco-ordination, precisely the same result that we would have from a primary affection of the cord implicating the motor part of the lateral columns and the mesial portion of the posterior columns, the only difference being that these same results are due to an affection in another part, and are consequently secondary. In regard to the nature of the growth, a gumma need scarcely be considered, owing to its position and the history of the patient. The two most likely forms of tumor are tubercle and glioma; and of these the presence of tubercle in the

family, the fact that tubercle is the most common tumor of the cerebellum, leads me to believe this to be most likely the nature of the growth. I therefore consider the case to be a tumor of the middle lobe of the cerebellum, probably tubercular in its nature.

199 Simcoe Street.

Two Cases of Tubal Gestation.

BY A. B. ATHERTON, M.D.,

Surgeon to St. John's Hospital for Women.

CASE 1.—Mrs. H. T——, aged 25, first seen by me at noon on October 10th, 1894, in consultation with Dr. Sloan, of Parkdale.

History.—Usually has good health; had one child three years ago; not pregnant since; always regular except when pregnant or nursing; menstruated last during the first week in August; has suffered a good deal from morning sickness for three or four weeks.

About three weeks ago, began to have occasional attacks of colicky pain in lower abdomen, lasting from a few minutes to an hour or more, and obliging her to keep still till they passed off. Six days ago had a more severe seizure than any before, which was attended with faintness. A second similar attack occurred yesterday, when, for the first time, Dr. Sloan was called in. During the afternoon the patient had, in addition to the abdominal pain, an acute pain in the top of left shoulder, which, during the night, shifted to the right shoulder. Dr. Sloan had to give several doses of morphine to relieve the patient; and, considering her condition rather alarming, asked me to see her with him.

On examination the lower belly seemed somewhat distended, and was tender, especially on left side. *Per vaginam*—The uterus found somewhat enlarged, and fundus lying to the right side. On the left an irregular, hardish mass felt, which was painful on palpation.

Up to the present there has been no discharge of blood from uterus. P. 96. T. 100°.

Diagnosis.—Ruptured tubal pregnancy. Immediate operation advised.

Removed to St. John's Hospital and abdomen opened at 4 p.m.; assistance rendered by Dr. Sloan, chloroform being given by Dr. Hart.

As soon as the peritoneum was entered, bloody serum, followed by clots of blood, issued forth. The hand was at once passed in and the distended left Fallopian tube withdrawn. Then clamps

were applied and ligatures put on, the tumor being cut away together with left ovary. Abdomen then washed out with hot water and afterwards sponged. Glass drainage tube inserted. Silk-worm gut sutures and iodoform gauze dressing applied.

On examination, the mass removed was found to consist mainly of the distended tube, being about two and a half inches in diameter and four inches long. A perforation three-quarters of an inch in diameter seen at junction of its outer and middle third with pouting edges, filled with protracting clot.

On cutting open tube, the animotic sac was observed, distended with fluid and having a fœtus floating in it about two inches in length.

October 11th.—10 a.m. Some vomiting during night; a pretty free discharge of blood. P. 88. T. 99°.

October 12th.—Vomiting ceased at noon yesterday. P. 98. T. 100°.

October 13th.—Had a good night. Bowels well moved by a Seidlitz powder this morning. P. 84. T. 99°.

October 15th.—Doing well. Drainage tube removed.

Has had a free flow from uterus ever since operation.

November 6th.—Left hospital for home in Parkdale to-day. No discharge from uterus for several days.

Case 2.—Mrs. T. McC——, aged 33. *Multipara*—General health always good; has had five children, youngest being six years of age; three abortions since then, the last one year ago. Catamenia always regular except during pregnancy. Were due about the 22nd of November, but did not appear. Never has morning sickness when *enciente*. A week after this date began to have colicky pains in abdomen, for which she took some cathartic medicine once or twice, but without relief. On December 6th the pain became so severe that she was obliged to take to her bed, and in the afternoon sent for her physician, Dr. Cuthbertson, who after examination came to the conclusion that she had an extra-uterine pregnancy. I saw her the same evening, and concurred in the diagnosis.

On the morning of December 7th the patient was removed from her home to St. John's Hospital, and the abdomen opened. Dr. Cuthbertson assisted, and Dr. G. B. Smith administered chloroform. A large quantity of bloody serum and many black clots were found in the peritoneal cavity. The right Fallopian tube and broad ligament distended with blood clots were withdrawn and ligatured, they and the corresponding ovary being then removed. More clots washed out, and a glass drainage-tube inserted. The usual sutures and dressings.

On examining the specimen removed, the Fallopian tube was found distended to nearly an inch in diameter, with firm and apparently partially organized clot. Posteriorly it was perforated at two points, and the blood had doubtless escaped from these openings into the posterior layer of the broad ligament, and thence into the general peritoneal cavity. No fœtus nor membranes were seen anywhere.

December 8th, 11 a.m.—No vomiting since immediately after the operation. Had $\frac{1}{10}$ gr. morphine hypodermically during the night, and rested fairly well. Two or three ounces of bloody fluid discharged. P. 74. T. 99.4°.

December 9th.—Had a good night. Has taken some milk and lime-water, and kept it down. P. 74. T. 99°. Drainage-tube removed.

December 10th.—Some bloody discharge yesterday. Very little in night. Slept fairly well. P. 70. T. 98.6°. Bowels well moved this morning after two Seidlitz powders and enema.

December 11th.—Doing well. P. 72. T. normal.

December 13th.—Bowels are moved every other day by a Seidlitz powder. P. 70. T. 98.2°.

December 17.—All sutures have been removed. Doing well in every way. There has not however been any uterine flow, and there is more fluid in breasts than before operation. This leads us to suspect intra-uterine pregnancy also.

December 25th.—Very anxious to go home to-day for Christmas. Has been out of bed for several days; may therefore leave hospital, if carried up and down stairs. Still no metrorrhagia, and breasts are growing larger and contain more and more fluid.

January 9th, 1895.—Dr. Cuthbertson informs me that patient began to flow freely on the fifth inst., and aborted on the seventh, being the fifth week after the operation.

Remarks.—So many cases of tubal gestation having been reported during the last few years, it may seem superfluous to add to their number; but we think that there are one or two points in the history of these which make them deserving of being placed on record. And in the first place the fact that, in both, the diagnosis of ruptured tubal pregnancy was made without the aid of that almost ever-present symptom of uterine hemorrhage is worthy of notice, showing that we should not necessarily wait for it before operating. In the last case the concurrence of an intra-uterine fœtation accounts, of course, for its absence; but not so in the other. Besides, if one had placed too much reliance on this very common symptom of rupture of the tube he might have been tempted to try electricity or some other method

of destroying the fœtus, which would not have much improved matters, and might have occasioned a fatal delay before resorting to laparotomy.

As far as I can recall to mind, I do not remember any published record of removal of a tubal fœtation while another child was present *in utero*. The latter would probably have been carried on till full time had not my patient acquired the habit of abortion, for it was not expelled for a month subsequent to operation, and was not, therefore, a result of it.

Finally, we direct attention to the severe pain felt in Case 1 in the tops of the shoulders. If this pain, in one or both shoulder-tops, be a symptom of perforation of some abdominal viscus, (as it seems to be,) then it may in some instances of tubal pregnancy aid in determining the question of rupture, and consequently the propriety of immediate laparotomy. The same pain has been noted by others as well as myself in perforation of the stomach from gastric ulcer. Two such cases are reported by me in the *New York Medical Record* of January 5th of the present year, in one of which the diagnosis was verified by successful suture.

Clinical Notes.

A Case of Malingering.

MURRAY M'FARLANE, M.D., TORONTO.

SOME months since I was consulted by a young woman, aged 22 years, who complained of rapidly-failing vision, dating from an attack of meningitis, the result of a sunstroke. Upon examination I found her vision for distance to be 1/6th in each eye. The field of vision was but slightly affected, though she gave very contradictory answers to all tests. The pupils were widely dilated and fixed, and she was unable to read ordinary print at the usual distance, except by the aid of a strong convex lens, pointing to a paralysis of accommodation. Upon using the ophthalmoscope no departure from the normal was seen in the disc or retina, the blood vessels being of proper calibre and appearance. There was, however, a considerable amount of photophobia, which interfered with the examination to a certain extent.

Upon inquiry she told me she had not been using any belladonna, or drops of any kind in her eyes, which made me doubt the exact nature of the case. The dimness of vision for the distance looking like retro-bulbar disease, a sequelæ of the meningitis, I put her upon

strychnine, advising absolute rest of the eyes. Coming to report progress in a few days, I found the pupils beginning to respond to light, and found that the use of a solution of eserine contracted the pupil to a marked degree.

She came back and forth for about a month, varying in her condition, one day seeming much better than the next, and giving most contradictory answers to my enquirius, all this time being the object of the sympathy and solicitude of her relatives and employers, who were very much alarmed at her growing blindness. One day she came complaining of great dimness of sight, telling me she had to give up her position, and appeared in a pitiable condition. I found the pupils widely dilated and not responding to the light. I instilled a strong solution of eserine, asking her to see me the following day, when I found the pupils as widely dilated and insensitive as before. I immediately accused her of using belladonna. Upon her vigorous denial, I told her plainly she was not telling the truth, and kept at her until finally she admitted that she had been using a four-grains-to-the-ounce solution of atropia sulphate. She could give no reason for it, except an uncontrollable impulse to excite the sympathy of her friends. It is needless to say that her vision for distance had all along been perfect, her answers to the tests being the result of her intent to deceive.

This brief clinical sketch will serve to indicate the necessity for the practitioner being ever on his guard against the machinations of the victims of hysteria.

Society Reports.

Toronto Clinical Society.

(DECEMBER MEETING.)

President, DR. RYERSON, in the chair.

The Treatment of Colles' Fracture* was the title of a paper read by Dr. Britton.

In discussing the paper, Dr. STRANGE said that he looked upon early movement of the fingers as very important. This was of more importance than the kind of splint used.

Dr. MACFARLANE said the splint recommended was somewhat of the nature of the old pistol splint. Where the great difficulty occurred, often leading to malpractice suits, was in the fact that the dislocation was not completely reduced. If reduction were properly effected the necessity for splints was done away with. This reduction often could not be done without the use of an anæsthetic. For some time back he had not used splints in Colles' fracture; but had adopted Moore's method. He advised movements of the fingers from the first day.

Dr. BRITTON said he was afraid to trust his cases without splints, although many cases, particularly of transverse fracture, might be so treated.

A Peculiar Fracture of the Clavicle* was reported by Dr. Cassidy. There was no discussion on this paper.

Double Inguinal Herniæ.—Dr. BINGHAM then presented a patient and said—The reason I am showing this case is, this little chap is going home to the country in a few days and I would not have the opportunity of showing you the illustration I wished at a future meeting. This is a case that was sent into the Children's Hospital from the country of Double Inguinal Herniæ. They had existed from birth; the herniæ were large. It was impossible to maintain them in a state of reduction by any form of truss, and many forms had been tried, and finally the child was sent down for operation. The operations were done at an interval of about two weeks, one on each side. I used a different form of operation in each of the two cases, on one side doing a modification of the old Barker method, and on the other side doing the more recently introduced Holstead method. The sacs were closely adhering to the testicle and to the cord; the first one

*Published in the January number of the REVIEW.

upon which I operated, I think it was the right side, there was little or no difficulty in separating the sac from the cord. Then I simply tied up the sac as high as possible. The second case was somewhat different. In this case I used the Holstead operation. I found in this case the sac was closely adhering to the cord, and without a very great deal of tearing I was unable to separate it. I cut down on the sac at each side of the cord and left the portion of the wall adhering to the cord; in this case stitching up the upper portion of the sac as far as possible, closing the whole canal by means of tape. For five days the child did remarkably well. At the end of that time suddenly the temperature went up to 102 or 103. Considerable swelling took place over the wound. I immediately opened it up, removed the stitches and drained. The temperature dropped, and a good result has obtained.

Case of Tetanus.—Dr. THISTLE reported a case of Tetanus with the following history :—B. T——, aged 8; sent into Victoria Hospital by Dr. Wilson, October 31st. Illness began October 26th, when he complained at tea-time that the bread was too thick and that he had difficulty in opening his mouth. There was some contraction of the muscles of the jaw on attempting to open the mouth widely. That night he was restless and complained of pain in shoulders and stomach, increased on movement.

October 27th.—Better, but still had painful muscular contractions.

October 28th.—About the same, but pains rather more severe and lasting longer.

October 30th.—Was worse, and the family physician was called in and the following condition found: Temperature, 100°; pulse, 120; respiration, 24. Examination excited intense general spasm, tonic in character. Opisthotonos complete and trismus. During the spasm he could not separate his jaws to the slightest degree.

October 31st.—Seen with Dr. Wilson. Condition about as previous day, but somewhat modified, as chloral had been given. During examination a small black puncture was discovered in right heel. The mother stated that on October 12th he complained that his boot hurt him, and on examining the heel the puncture was discovered, and also a projecting nail on the heel of the boot standing up 3/8 of an inch. Wound poulticed and probed, but no pus found. At time of examination it was quite healed. In the hospital he was put upon chloral and bromide of potash in full doses, and the wound was excised. We endeavored to secure some Tetanus Antitoxin, sending to Pasteur Institute, New York, to Johns Hopkins, Baltimore, and to McGill, Montreal, but without success.

November 1st.—Temperature, 99⅘; pulse, 126; respiration 32.

During the day he had some twenty spasms, but none of them sufficiently strong to produce opisthotonus.

November 2nd.—Spasms quite frequently, but for the most part light. Temperature, 100⅘; pulse, 116; respiration, 42. Between spasms is drowsy and sleepy. Urine, per catheter.

November 3rd.—Slightly delirious. Temperature, 102⅘; pulse, 146; respirations, 48. Muscles become at times quite flaccid. Spasms unfrequent, but severe. 9 a.m.—Temperature, 105⅘; pulse, 150; respirations, 46. Given cold pack. He cries out at times, but spasms are rare and very slight. 4 p.m.—Temperature, 104⅘. 6. p.m.—Temperature, 104⅘: pulse, 160; respiration, 38. Has been unable to swallow all day, and is unconscious; cannot retain enemata. Spasms are about gone. Bowels have been freely acted upon throughout. Spasms controlled by chloral and bromides. Death comatose, with implication of respiratory and cardiac centres. No post-mortem. Urine examined, but nothing abnormal discovered.

Dr. MEYERS related a case of tetanus following confinement, in which the spasms began in the leg, and in the course of half an hour attacked all the muscles of the body. The patient was kept under the influence of chloroform for two or three days until the attacks almost ceased. The sight of one eye was completely lost, and the pupil became dilated and has remained so.

Dr. BAINES asked as to the habitat of the bacillus, and referred to Dr. FOTHERINGHAM, who said that Prof. Ramsay Wright had found the bacillus in earth taken from the ravine near the University building. He related a case: Two men were splitting rails in a swamp. One, while holding a wedge, received a blow on the end of his finger, without, however, breaking the skin. Tetanus supervened and death ensued.

Dr. ATHERTON said that he had seen five cases—one following labor. All the patients died. In the first there was a wound in the heel, the second of the leg, the third of the forehead, the fourth of a crush of the elbow.

Dr. CASSIDY believed tetanus was a rare disease in Canada. It was common in France, especially among veterinary surgeons, blacksmiths, and people whose work brought them in contact with horses.

Dr. STRANGE said the last case of tetanus he had seen was in the keeper of a livery stable. Under the influence of chloroform he was quieted, and recovery followed.

Dr. THISTLE said that tetanus was common in cases of labor. Sometimes the child suffered from inoculation through the cord. The germ has been found in every country in Europe. It is only absent

in ground where there has not been organic matter. One reason it produces so few cases, though so widespread, is that oxygen is inimical to its growth. Punctured wounds are favorable to its production. He believed there were certain poisons manufactured in the system whose effects were similar to tetanus, and were probably improperly called idiopathic tetanus. The speaker gave the history of a case in the Children's Hospital, under the care of Dr. Machell. It ran a course of eight weeks, characterized by spasms and high fever, but recovery followed. Bromide and chloral were administered.

Sarcoma of the Jaw.—Dr. STRANGE presented a specimen of sarcoma of the jaw, taken from a girl aged fourteen. She had suffered from a dull aching pain in the growth; its growth was slow. It showed the deposit of new bone and the work of the periosteum in the formation of new bone. The speaker detailed the steps in the operation. The periosteum had been left with the hope that bony union would take place. He had been disappointed in this, for the union was almost entirely fibrous. The operation was done about three years ago. There is little deformity, and there is no return of the disease.

Tubal Pregnancy.—Dr. ATHERTON presented a specimen obtained in an operation for tubal pregnancy. (See page 38.)

Dr. BAINES moved, seconded by Dr. FOTHERINGHAM, that the Fellows of the Toronto Clinical Society respectfully beg the Ontario Board of Health to notice the success of the use of antitoxine in tetanus; and, therefore, request the Board to procure the same, so that it can be procured immediately when such a case may arise, and that through the journals of medicine the profession may have cognizance of the same.

(JANUARY MEETING.)

President, DR. RYERSON, in the chair.

Dislocation Upward of the Acromial End of the Clavicle.—Dr. LESLIE presented a patient who had suffered from a dislocation upward of the acromial end of the clavicle. The patient had made an excellent recovery, which was attributed to his remaining in bed a longer time than is ordinarily done. Being an hostler, his work necessitated much use of the arms above the head. To maintain its position at rest strapping was first used, but owing to the thinness of the patient it cut through his flesh. The ordinary bandage was then used. In some cases there was loss of power in upward movements.

Dr. GRASETT said the upward movements were limited only in the bad cases. Perfect movement in every direction would follow good treatment.

Dr. ATHERTON recommended the use of a broad strip of adhesive plaster passed around the elbow, carried up the back and over the shoulder across the displaced bone, so as to exert pressure enough to maintain it in the correct position. The patient could go about; lying in bed was irksome.

Osteo-Enchondroma.—Dr. E. E. KING presented a case of osteo-enchondroma. He had reported on the case two years ago. Over the knuckle of the index finger was a growth of about half the size of an egg. As the extensor tendon of the finger was involved, it was separated as much as possible to allow of the shaving of the growth down to the normal size of the bone. The finger regained a considerable amount of motions. The question was, in view of its slow recurrence, as to the advisability of any surgical interference at the present. Dr. King wished to get the opinion of the Fellows on this point.

Dr. GRASETT said that as these growths were always slow, and as the patient had good use of his fingers, he would wait and keep the patient under observation.

Displacement of the Liver.—Dr. J. E. GRAHAM presented a patient suffering from some abdominal trouble, in which there appeared to be a displacement of the liver to the left side, probably the result of injury. During the latter part of July the boy slipped off a wagon-load of stone, the wheel passing across the body from right to left, fracturing several ribs on the left side. The wheel, the patient thought, struck the right side, just below the ribs. He was picked up unconscious. The fractures were duly attended to, the patient receiving medical attendance for three weeks. Since then the patient has suffered more or less pain continually. He commenced learning the tanning business, but was obliged to give up owing to severe pains in the upper abdomen. A physician who saw him said he was suffering from ascites, and advised him to return to the Boys' Home. He was seen by Dr. Thorburn and was sent to the hospital.

The abdomen was markedly distended and the limbs dwarfed. There were rickety nodules on the ribs. Under direct and purgative treatment, the ascites disappeared after two weeks' treatment. On cessation of the treatment the fluid collected again. A week's similar treatment relieved the condition, which since two weeks had not reappeared.

On the absorption of the fluid, liver dulness was absent on the right side, but seemed to exist on the left, extending round the body. Inflation of the colon showed the liver to be behind it; the stomach was pushed upward and to the left.

Tumor of the Middle Lobe of the Cerebellum.—Dr. MEYERS presented to the Society a young man where the above diagnosis had been made. (See page 35.)

Dr. GRAHAM said that from what he had learned of the case as presented, he would lean to the diagnosis of ataxic paraplegia. The papillitis and headache might have been due to meningitis.

Dr. ATHERTON asked an explanation of the suddenness of the attack.

Dr. CASSIDY thought the diagnosis of the tumor, as tubercular, was negatived by the absence of tubercle in the rest of the body.

Dr. Ross described a case he had seen of tubercular tumor of the middle lobe of the cerebellum, to which the case reported bore some resemblance. However, he leaned to the diagnosis of ataxic paraplegia in this case.

Dr. MEYERS pointed out that his diagnosis rested mainly on the optic atrophy, the marked decrease in the number of respirations, the limited ataxia, the strength of the leg muscles. The original trouble might have been peripheral neuritis.

Sarcoma of the Ovary.—Dr. Ross presented a specimen of ovarian tumor from a negress. She had suffered from it five years, when suddenly she experienced a rise in temperature of 105°, and great abdominal pain. It looked perfectly healthy on removal, but upon opening it was seen to be undergoing sarcomatous degeneration.

Toronto Medical Society.

(JANUARY 17TH, 1895.)

President, DR. PETERS, in the chair.

Scleroderma.—Dr. MCPHEDRAN presented a patient suffering from scleroderma. It commenced about nine months ago, a white spot being first noticed in the forehead, which presented something of the appearance of a chalk mark. It extended upward upon the head about two inches within the margin of the hair line. Its width was about half an inch. The patch became completely bald. Thickening of the skin and the tissue has taken place. It is slightly anæsthetic.

Urethral Calculus.—Dr. PETERS showed a urethral calculus which he had removed from a boy seven years of age. The history of its presence lasted from the patient's birth. At the age of four he received a blow in the perineum. Since then he has had frequent passages of bloody urine accompanied by great pain. The urine kept continually running away. On passing a sound the stone could be distinctly felt

at the membraneous portion of the urethra. Median incision was made but upon applying the forceps it slipped into the bladder. The opening was enlarged and the stone extracted.

Dr. ATHERTON also presented a large urethral calculus which he had discovered accidentally upon operating on a patient for extravasation of urine resulting from an injury in the perineum, the history of which he had given at a previous meeting of the Society.

Dissecting Aortic Aneurism.—Dr. R. J. WILSON presented a specimen of dissecting aortic aneurism. The patient was forty-two years of age, of good habits and had a good family history. He was called early one morning, when he found the patient suffering great pain in the left groin and in the back, radiating from the region of the left kidney, extending into the left testicle and to the end of the penis. The testicle was retracted. He was treated for renal colic, morphia being given. The patient got up about six o'clock to urinate, but died before he got back to bed. The specimen showed that rupture had taken place at the commencement of the descending aorta. The coats were separated down to the point at which the vessel had been severed upon removal. There was no evidence of kidney disease. Some calcerous deposit was detected on the aorta. No evidence of any cause for renal colic was made out. The pain might have been produced by pressure on the lumbar plexus.

Spina Bifida.—Dr. OLDRIGHT presented a child five weeks old suffering from Spina Bifida. The tumor involves a portion of the sacral, all the lumbar and the lower two dorsal vertebræ. The members examined it by transmitted light, an electric lamp being used for that purpose. Although no portion of the cord could be seen, yet the doctor considered that a portion of the cord was involved because of its large size and its position, and the complete paralysis of the lower extremities. On tapping the lower part of the tumor, distinct twitchings of the legs occurred. As to treatment he had been using pressure. He asked the opinion of the Society as to the wisdom of further interference. The only other child had died, and the parents were much wrapped up in this one, and he felt somewhat loath in resorting to operation. Dr. Peters reported having operated upon a case unsuccessfully. He did not think the involvement of the cord was a contra-indication to operation. He thought he would favor operation on the case.

Dr. ATHERTON said that he would try the injection of Morton's fluid. If this were insufficient to effect a cure, he would state to the parents the possibilities and the probabilities in case of operation, and in case operation were not performed, and would advise operation.

Dr. McMahon said, from his observations on three cases of Spina Bifida, he had concluded the conservative treatment was best. Dr. Wilson, of Richmond Hill, said that looking from a scientific standpoint at the case he would operate, but from the standpoint of the mother he would leave it alone.

Dr. Oldright stated that statistics snow only about three or four per cent. of recoveries. He seemed rather inclined to the non-operative treatment.

Appendicitis.—Dr. Bryans gave the history of a case of appendicitis with the ordinary symptoms. The patient had a somewhat similar attack some months before.

Dr. Atherton said that a twin-brother had suffered from peritonitis. When called by Dr. Bryans to operate on the case he decided that operation was called for because of the previous attacks of colicky pains, which were growing worse and worse, because the patient's symptoms were increasing in spite of opiates, and because of the successful results which accompany early operation.

On opening, a coil of small intestine was found running beside the cœcum and attached to it.. Following this down with the finger to the brim of the true pelvis the appendix was reached, which extended into the pelvis, where it was adherent pretty firmly. Drawing it out its mesentry was torn and the appendix itself was found to be rotten. It was distended to the size of his ring-finger, and its coats were greenish-looking and stinking. A ligature was placed around it close to the cœcum, and the stump touched with pure carbolic acid. An iodoform gauze drain was left in for forty hours, after which the provisional sutures were tightened. The patient is doing well. The members examined the specimen.

Dr. Peters also presented an appendix which had been removed from a patient who had had recurrent attacks. A tumor was noticed in the pelvis by palpation per rectum. A median incision was made. The appendix was hanging over the brim of the pelvis reaching to the aforesaid mass. It was firmly adherent, very thick, and a foreign body could be felt very distinctly. The muscular and serous coats were dissected back, a ligature thrown around the mucous coat. The stump was touched with carbolic and pocketed by an infolding of the muscular and serous coats, the latter of which were approximated by a row of sutures.

Editorials.

Ureterotomy.

In the December number of the *Bulletin* of Johns Hopkins Hospital, Dr. Howard Kelly gives some interesting details of three cases of ureterotomy undertaken for diagnostic purposes. Whilst operating for severe pelvic diseases, he noticed in three of his cases such bulging of the ureters as led him to the belief that one of the ureters had been included in some of the ligatures which had been placed to control bleeding. After locating the ureter over the brim of the pelvis, he cut a slit in it, and passed a catheter through the ureter down into the bladder in two of the cases, thereby demonstrating that the ureter was pervious, and concluding that the dilatation was probably due to pressure upon the ureter by the tumor which he had just removed. In one of the cases he found, as he suspected, that one of the ureters was included in a ligature. This he cut, after which he could pass the catheter freely into the bladder. The slit in the ureter he repaired by mattress sutures. In one of the cases there was leakage of urine, which, however, was controlled by superficial sutures. Care has to be taken not to make the sutures pass into the lumen of the ureter. In these cases the operation on the ureter had no untoward effect upon the patients, recovery having been uninterrupted in each case.

Whilst we admire the advance of surgical technique which now renders it possible to do such delicate operations speedily and without harm, we feel sure that in at least some cases harm is done through hurry, and we would warn those of a lesser degree of experience against attempting such delicate procedures, unless the indications are very definite.

The Honorable Dr. Montague.

The elevation of one of the members of the profession to the honorable position of Privy Councillor and member of the Government of the day, is an event which must interest all who hold the profession in honor, no matter what may be their political creed. In the case of Dr. Montague, his rise has been so rapid that it seems but yesterday that his eloquent words and far-reaching tones were heard as chairman of the annual dinner of the Toronto School of Medicine. The predictions made then as to his career have been fully realized. We extend our hearty congratulations to the honorable gentleman, and

wish him many years of life wherein to serve his country. The success which has attended Dr. Montague in his public life has occasionally been equalled by that of other members of our craft who have added to the cares of practice the cares of State. That we have among us men of ability, of energy, of sagacity, equal to those of other callings, is undoubted. That a larger number of medical men have not reached high political preferment is due more to the facts that the way is long and beset with great financial difficulties, and that sacrifices greater than most men may bear must be made by aspirants to public honors, than to want of capacity. The public are too apt to think, if a doctor is in public life, that he must necessarily neglect his work, or that his mind is distracted by other things. So far from this being the case, we believe that it greatly enlarges and strengthens a man's mental grasp, and need not interfere with efficiency in his profession. The roll of honor of Canada's public men contains, beside a large number of doctors, members of the Senate, Commons and Legislatures, the names of Honorable Drs. W. W. Baldwin and Widmer, Legislative Councillors; the Honorable Dr. Rolph, the father of medical teaching in Ontario; Honorable Dr. Blanchet, Speaker of the Commons; Sir Charles Tupper, M.D., High Commissioner to England; and Sir Etienne Taché, M.D., Prime Minister of the Canadas in two administrations.

Biliary Lithiasis.

Few subjects at the present time occupy more of the attention of abdominal surgeons than gall-stones. Though their causes, modes of formation and pathological results following their presence have been studied with care by many observers throughout the world, we are still at a loss on many points.

In 1886, M. Galieppe showed the presence of micro-organisms in biliary calculi. In this microbic age others have endeavored to prove that, because the coli bacillus could be found in some biliary calculi, the cause was found.

Recent experiments, by injecting cultures of bacilli into the gall-bladder of dogs, have given negative results. Cultures of Eberth's bacillus injected into gall-bladder produced, in one dog, suppurating cholecystitis, double pneumonia and death in one month. In another death took place in three months from vegetating endocarditis. Two other dogs were killed three months after injection, but no post-mortem results were discovered.

Age and sex play important parts in the causation of gall-stones. Women are much more often affected than men, and those who are aged thirty and upwards are most often the victims.

Post-mortem examinations show that gall-stones are very frequently found where no clinical evidence of their presence existed.

Though cholesterine forms the greater part of most biliary calculi, it is only sparingly secreted by the liver, but is secreted largely by the epithelium of the bile ducts and gall-bladder. This may account for the fact that the stones are, as a rule, formed in the gall-bladder, obstruction taking place owing to thickening, or peculiarity in the valves, or the opening into the duodenum.

We are also reminded that as the bile leaves the intra-hepatic ducts it is a non-viscid fluid of a slightly alkaline reaction. It does not assume a viscid character until after admixture with the mucoid secretions from the bile ducts and gall-bladder. This viscidity favors calculus formation.

In young people, the greater activity of the individual and the larger amount of muscular structure of the walls of the gall-bladder do not favor the formation of stones ; whilst in old people, decreased activity and thinning of the muscular coat render the individuals more liable to calculus formations, though hepatic colic is not so common.

Neither nationality nor diet seems to have much influence on the affection.

Great advance has of recent years been made in the surgery of the gall-bladder. It is but a few years since cholecystotomy was unthought of by the ordinary practitioner, and it is well within the recollection of most of us, when it was a common thing for life to be sacrificed on account of cholelithiasis with obstruction, no surgical interference having been mooted as treatment. How careless would be the man now who would allow such a case to slip through his care without an attempt being made by the surgeon to relieve the obstruction !

Diagnosis of biliary colic, in the majority of cases, is made by attention to details. Pain (in the region of the gall-bladder) coming on suddenly of a boring character, radiating upwards, followed by chills, fever, sweating, vomiting, tenderness over gall-bladder and liver, itching and itcheric hue of skin, darkened urine and clay-colored stools —these are the chief symptoms, but they vary with each case. In some there is distention of the gall-bladder, but in the majority of cases of impaction of stones in the cystic duct there is a shrinking of the gall-bladder and no tumor can be felt from without.

Treatment of Acute Attack.—First, relieve the pain. Combined

morphia and atrophia by hypodermic injection is the most efficient remedy, though a host of sedative remedies has been tried. Ferrand's experiments show that glycerine, in doses of ʒv. to ʒj., is capable of provoking a free secretion of fluid bile ; and also that such doses are prompt in alleviating the pain. Olive oil, in doses of ʒvi. to viii., given in two portions, quarter of an hour apart, the patient lying upon the right side, is safe and well tolerated by the stomach, and in some cases produces prompt relief. (The inspissated portions of oil which pass after such doses must not be mistaken for gall-stones.)

Prophylaxis.—For this purpose active exercise, massage, cholagogues and gentle saline aperients are useful. Over-eating or the indulgence in rich foods should be avoided. A course at some of the hot sodium or magnesium springs acts efficiently in some cases. Surgical interference gives good results in a large majority of cases. It may be demanded in acute cases with rupture of the ducts or gall bladder.

In Chronic Cases for the Removal of the Cause.—Cholecystotomy and removal of the obstructing stones, though not dangerous with perfect surgical technique, has the disadvantage of leaving a fistula, which may take a length of time to heal. Cholecystoenterostomy by the Murphy button is giving very good results, and very few failures are reported. Crushing of the obstructing stone in the duct is condemned on account of the injury to the duct ; cutting the duct open, removing the stone and suturing the duct is to be preferred. The escape of bile into the peritoneal cavity, whilst it obscures the field of vision, does not prevent healing. Cholæmia favors bleeding, and has a very unfavorable effect upon the operation.

The most favorable cases for operation are amongst the younger patients, when they are not exhausted by repeated attacks.

Cases of cholelithiasis after operation do not form an extensive part of the literature of the subject.

The Dress Regulations and Medical Officers of the Militia.

In view of the report which is current, that the medical officers are to be obliged to purchase uniforms as now worn by the Imperial Medical Staff, we desire to urge upon the authorities that such an order be not made retroactive, but that medical officers be allowed to wear the uniform of the corps to which they may now be attached. In the event of the creation of a Departmental List, those officers who signify their desire to serve on such a list may then be so uniformed.

The Dress Regulations for the Army, 1894, section VIII., sub-section II., reads: "Medical officers of Militia Battalions who have not elected to serve on the Departmental List will continue to wear the uniform of their regiments, but with cocked hats, plumes, belts and pouches, as for officers of corresponding rank in the Army Medical Staff." We may remark that, under the new regulations, medical officers above the rank of Brigade Surgeon wear the frock, but those below are to wear patrol jackets. An undress sword knot of black leather is to be worn, as are also black morocco cross belts and waist belts (without gold lace) in undress.

THE GERM THEORY OF DISEASE.—Mr. Lawson Tait (*Buffalo Medical and Surgical Journal*, December, 1894), denounces the germ theory of disease in surgery as a phantasm. He contends in vigorous language for rigid cleanliness in all operations. He holds that the great credit for the introduction of aseptic methods is due to Simpson, and not to Lister. The author contends that all that is needed is thorough cleanliness. He states that he has never had a case of erysipelas following an operation. He urges that the improvement in hospitals is not in the introduction of antiseptics, but in the separation of patients, free ventilation and sufficient cubic space to each.

TREATMENT OF NERVOUS TROUBLES IN THE DYSPEPTICS.—Dr. Cuffer, of Necker Hospital, Paris (*Inlerat. Med. Mag.*, Nov., 1894), in the course of a lecture on the above subject, calls attention to several nervous phenomena of dyspeptic patients. One of these is a pyloric crises. In two or three hours after eating there is the feeling of a painful constriction in the region of the stomach. It is evidently due to painful spasm of the pylorus. It is met with in neurasthenics. There is sometimes an effusion of fluid with this pain, on the principle of the old adage—*ibi dolor, ibi fluxus.* There is a neuralgia with congestion. Sometimes there is dilatation of the stomach, with neuralgia of the whole spinal column. There may be vertigo, aphasia or paralysis. These attacks may be repeated and become permanent. In the treatment stimulate the nervous system by friction, hydrotherapy, statical electricity and strychnia, washing out the stomach when impregnated with quassia, and if there is gastritis by an alkaline solution. The pyloric spasm can be at once relieved by ether spray over that region. Vesication over the back of the neck sometimes controls the reflex action of the medulla.

Medullary Glyceride in Paucity of Red Blood Corpuscles.—Dr. Allan McLane Hamilton, of New York (*N. Y. Med. Jour.*, January 12th), states the results obtained by Fraser and others. The cases selected for treatment presented varying forms of red corpuscle poverty and diminution of hæmo-globin. The use of the medullary extract increases very rapidly the coloring matter of the blood. The improvement is equally wonderful to that which follows the use of thyroid extract in myxœdema. The marrow may be given raw or in the form of glycerin extract. One pound and a half of finely comminuted calves'-ribs are macerated for several days in one quart of pure glycerin, being frequently stirred. The glycerin is strained off, and given in doses of one to four teaspoonfuls three times a day. The benefit in the cases thus treated was very encouraging. In two cases of brominized epileptics, the anæmia was greatly relieved by this treatment.

Belladonna in Skin Diseases.—Eliza Dunbar, M.D. (in *Woman's Medical Journal*, December, 1894), speaks in high terms of the benefit she has derived from the internal administration of belladonna in all itching skin diseases. She has employed it in pruritus and eczema. Doses of a drachm daily is usually enough. It may be combined with tr. ferri; and in this form is very helpful in pruritus pudendi. In some old and obstinate cases, not only was the itching relieved, but the cases did well and improved under the administration of the drug. Persons vary in their susceptibility to the drug, and this must be kept in mind. When the person flushes and gets headache from small doses, they will derive no benefit. The author noted that in case of failure she had good results when the drug was obtained from another chemist, showing the need for care in selecting the remedy. When the case is not promptly benefited, it is rarely benefited, however persistent the treatment.

Herpes Zoster in Children.—Dr. J. M. Taylor (*The Phila. Polyclinic*, December 29th), thinks the disease takes from three to ten days to develop. The pain usually precedes the red spots. These grow rapidly into vesicles, that look like closely-set drops of dew, or they may be scattered about. It is generally confined to one side, but may be on both sides and form a girdle round the body. The pain is often very severe. Some regard it as a descending interstitial neuritis, while some say it may be of cerebral, spinal, ganglionic or peripheral origin. In some cases it seems to come as a special chastisement for no known error. To protect the skin from the air,

and to relieve the burning pain, the following ointment is recommended: Acid carbol., gr. 5; menthol, gr. 5; ung. zinc oxide, ℥ss.; ung. hydrarg. ammoniat-dil, ℥ss. This is made stiff by adding dry zinc oxide. It is spread so thickly that the air is excluded. When this is applied there is relief to the pain, and the child usually goes to sleep.

Rheumatic Anæsthesia.—Dr. C. Barlow (*The Cincinnati Lancet-Clinic*, January 12th) calls attention to a form of anæsthesia that he has often noticed to occur in the subjects of chronic rheumatism. The persons that are most frequently afflicted are old soldiers. The rheumatic virus may cause chorea in one case, neurasthenia in another, and anæsthesia in a third. The writer claims that there is some anæsthesia in every case of chronic rheumatism of long standing. The patients have soreness and impaired motion in some or all of the large joints. There is in the majority of cases organic disease of the heart. The power to distinguish between heat and cold is entirely lost. Sometimes two or three points are felt from one touch, and in other cases the sensations may be referred to the other side of the body. In some of these cases the symptoms are doubtless due to organic disease, of rheumatic origin, in the spinal cord, or the base of the brain. There are reasons for believing that almost any form, organic or functional, of the nervous system, may arise from chronic rheumatism.

Diarrhœa from Potassium Iodide.—Dr. D. W. Montgomery, Prof. Skin Diseases, University California (*Med. News*, Dec. 29th), gives an account of a case of diarrhœa caused by the administration of potassium iodide in the treatment of syphilis. The patient was in the twentieth month. He was ordered grs. 16 of the drug, in divided doses per diem. Enough was given to last sixteen days. The patient thought the purgative action was part of the treatment, and, therefore, kept on taking his medicine. When the doctor next saw him he was like a person in the last stage of consumption. From being a fine, robust man, he was reduced to a pale, wan shadow. The patient remarked that on a former occasion he had taken a "blood-purifier" and was seized with an attack of diarrhœa. Most likely this attack was due to the same drug, as it generally finds a place in "blood medicines." The writer mentions similar cases in the practice of Lewin, Koplik and Fournier. He thinks the cause is sometimes due to an impure specimen of the drug, but it will happen when the drug is perfectly pure.

Blood-letting in Over-distention of the Right Heart.—Dr. I. E. Atkinson, of Baltimore (*Maryland Medical Journal*, Dec. 29th, 1894), thinks that blood-letting, in this condition, is of the highest, at times, of life-saving usefulness. Mechanical relief is afforded by the abstraction of blood in cases where the right side of the heart becomes engorged or over-distended, in consequence of increased obstruction to the flow of blood through the lungs, or left side of the heart, as may be seen in severe bronchitis, emphysema, pulmonary œdema, incompetency of the mitral valves, or stenosis of the mitral orifice. In some cases where there has been mitral disease, and the hypertrophy is followed by dilatation and degeneration, the heart may be too much diseased to avail itself of the relief coming from venesection. In cases where the right ventricle becomes suddenly distended beyond the power of its systole, in acute bronchitis in an emphysematous lung, marked benefit comes from blood-letting. The feeble action of the right ventricle is rapidly relieved by this means. The balance of the circulation is greatly improved. The veins are emptied, and more blood flows into the arterial system. The systole of the right ventricle again becomes efficient, and the cyanosis disappears. In advanced cases of mitral disease the benefits are often temporary. In pulmonary œdema and engorgement very brilliant results may be obtained. As the blood flows from the arm the patient feels marked relief. The dyspnœa subsides; the cyanosis lessens; the pulse grows slow and fuller. The patient usually falls into a quiet sleep. From one to two pints may be taken with safety. The author mentions a case where the patient had ceased breathing. He resorted to artificial respiration and venesection. When half a pint had escaped respiration began. The patient made a good recovery.

The Etiology of Tetanus Neonatorum.—Dr. J. Lewis Smith, of New York (*Arch. Pedriatrics*, December, 1894), treats of this subject. In 1886 Rosenbach produced tetanus in two guinea pigs by injecting into them some matter from a gangrenous ulcer on a tetanic subject. He also proved that the bacillus of Nicolaier was capable of causing tetanus. Then Brieger showed that a culture toxine could be produced that would cause tetanus if injected into the body. The bacillus of tetanus is twice to thrice the length of the tubercular bacillus. It is also thicker, and enlarged at one end. W. H. Welch remarks that the bacilli of malignant œdema and tetanus are among the most widely distributed. They have their natural home in the soil. He had found some garden earth in Baltimore extremely rich in

the tetanus bacilli, so that the inoculation of animals with this soil rarely failed to produce the disease. In one portion of New York where the habits of the people were very dirty, where the houses were bad and insanitary, and where horse and cow stables were numerous, the disease was frequent. It was noticed at one time that the surgical cases coming into Bellevue Hospital, from a certain part of Long Island, were liable to have tetanus. The islands of Hiernasy and St. Kilda, covered with guano, have always been troubled with tetanus. The dirty homes of the negro in the South, Demerara and Bombay, are also favorite places for this disease. After severe battles tetanus is frequently seen among the wounded. In such cases most likely the soil of the battlefield was infected with the bacilli. The author is of the opinion that tetanus is due to the bacilli in all cases. Those cases of puerperal tetanus, and the so-called rheumatic form, or the idiopathic of Gower's, is most likely all due to the bacilli finding their way into the system. The tonic contraction of the muscles, the author thinks, is due to meningitis. Some cases that are called tetanus may be cerebro-spinal meningitis.

Celiotomy for Perforating Typhoid Ulcer.—In the *New York Medical Record*, January 5th, 1895, Dr. Robert Abbe reports a recovery after celiotomy for perforating typhoid ulcer. It was a typical case of typhoid of about three weeks' duration. The patient was suddenly seized with great pain, vomiting and collapse. She was treated by poultices and morphia for two and a half days, at the end of which time, though her mind was clear, her heart and respiration were oppressed by her distended abdomen. Tongue dry and coated; pulse, 140; temperature, 104° F. A median incision below the navel revealed intestine deeply congested and smeared with sticky lymph; pelvis and lower abdomen filled with foul, purulent and fetid intestinal extravasation. Two pints of this fluid were removed, and the abdomen irrigated with 1-20,000 sublimate solution, followed by plain warm-water irrigation. An inflamed Peyer's patch showed gangrenous perforation a quarter of an inch in diameter, from which intestinal contents were seen to pump out. This was closed by interrupted silk sutures, over which two layers of Halsted mattress stitches were placed. A large abdominal tamponade of iodoform gauze was placed within the abdomen and pelvis, and no attempt made to close the wound. Tamponade was removed and re-applied forty-eight hours after operation, and 5 grains of calomel were given. This produced free, loose movements, and a little leakage of fæces, which continued at times for two weeks, after which the wound closed by granulation.

The correct statistics of such operations are seventeen cases and three recoveries. The shock of operation on such patients who are almost moribund is severe. This is not a very inviting field for the abdominal surgeon; but when we take into consideration that very few recoveries follow perforation when treated by medicine, it seems that the patient should have the chance—especially is this the case in hospital practice, where every facility exists for surgical treatment.

The Hygiene of the Kidneys.—Dr. J. Henry C. Simes, of Philadelphia (*Diet. and Hyg. Gazette*, Jan., 1895), deals with the care of the kidneys. He calls attention to the relation between the skin and the kidneys, and observes if the skin is not in a healthy condition the kidneys have an extra volume of work to perform. The importance of a healthy action of the kidneys is manifested by the fact that serious trouble may arise in other organs, as heart, lungs, brain and nervous system, when the excretory work of the kidneys is imperfectly done. In watching the action of these organs many factors must be taken into consideration, such as the nature of the diet, the amount of liquids consumed, the nature of the exercise and activity of perspiration. Then again, as the urine varies so much, a correct examination cannot be made unless the entire amount voided in twenty-four hours be collected, and a specimen taken from this. The quantity of urine varies greatly with the amount of liquids holding the solid constituents of the food in solution. When it is remembered that nine hundred and fifty parts of every thousand of the urine are water, the importance of this element in the dietary becomes evident. On this point, the author is strongly of the opinion that the majority of men eat too well and do not drink enough water. As a result of this, there is deposited in the tissues many effete products that should be carried off by the kidneys. The work done by those organs is in this way interfered with; and in time organic diseases often come on. It is owing to the large amount of water that much of the benefit from a milk diet arises. In advocating the use of abundance of water with the solids, the author again calls attention to the danger of washing down the food with it, and taking time to masticate properly. While water is of prime importance, it cannot take the place of the saliva. The benefit derived from a sojourn at a mineral spring is almost entirely due to the flushing out the system gets. Waste products are dissolved and washed away by the kidneys. The opinion is expressed that pure water drank for a lengthy period would have as good an effect. This of course applies to cases where there is no organic lesion, and the efforts are directed against the ill-effects of a sedentary life

and over-eating. In advocating the use of water, its excessive use must be guarded against. The habit of taking too much water may be indulged in. This is the other extreme, and may result in harm. The effect of water is to make the kidneys act, and by over-drinking these organs may be over-worked. The abuse, therefore, of water may prove the reverse of "in aqua sanitas." In the cold season, warm clothing is of much value, as tending to prevent congestion of the kidneys. Should such happen, it must be relieved by acting upon the skin and bowels. Judicious bathing is useful, as tending to maintain the healthy action of the skin, and thereby avoid congestion of the kidneys. If many people drank more water, and used less solid food, kidney diseases would not be so common as they are at present.

CHLOROSIS.—Dr. Seymour Taylor, of London (*Medical Press and Circular*, December, 1894), reviews the subject of chlorosis. The writer is not of the opinion that this condition is of primary blood origin. The cases are generally met with in young unmarried women. They are suffering from constipation, amenorrhœa and leucorrhœa. There is usually a marked systolic murmur over the pulmonary artery, and venous hums at the root of the neck. These cases almost always occur in unmarried young women at the period when the sexual o gans are at their greatest activity. Many chlorotic girls, who are thought too ill to marry, shortly after marriage regain their health and become the mothers of healthy children. In nearly every case of a chlorotic married woman, it will be found that she has never had children. The amenorrhœa is the result of the blood disorder, and not its cause. The catamenia may be very scanty, or colorless, but it is rarely altogether absent. A prominent feature in these cases is a pain in the region of the short ribs. The most thorough examination fails to reveal any disease of heart, lungs, spleen, liver or pleuræ. The cause of the pain is gaseous distention of the colon. This occurs to the greatest extent at the flexures. This pain is removed by a large injection. With regard to the constipation, most of us are familiar with the views of the late Sir A. Clark, that this was really the cause of the trouble; that there was a condition of chronic fæcal-poisoning, a fæcal anæmia or copræmia. The writer is of the opinion that great respect should be paid to this view. In many cases, after a course of Epsom Salts, without other treatment, these patients make good recoveries. A prominent feature of these cases is the strong craving for something sour or tart: vinegar, pickles, an acid apple, are taken with avidity. This craving for acids lasts as long as the disease. It is greatly relieved by giving alkalies. Many

cases of chlorosis suffer from ulcer of the stomach. The author is very positive that this is the result, however, of the chlorosis, and the blood condition induced by it, and not the cause of the anæmia, as contended by some. Altogether, he regards the disease as of nervous origin. The view of Virchow, that the abdominal aorta is too small, is not sustained by experience, as these chlorotic girls recover under proper treatment. With regard to treatment suitable rest is of much value. Where this can be secured, the cases do much better. The diet ought to be of a digestible character. The author does not object to well-made tea or coffee. Hard meats, cheese, pastry, jams, pickles and uncooked vegetables should be avoided. If stimulants are needed, none suit better than good claret or burgundy. Before iron is given, two things must be attended to. The bowels must be freely purged and the dyspeptic symptoms treated. For this latter condition the hospital mixture, containing sod. bicarb., sp. ammon. aromat., acid. hydrocyan. dil., and compound infusion of gentian, is invaluable. When iron is given, the alkaline preparations are best. The author speaks highly of Bland's pills and Griffith's mixture when both are freshly made.

Items.

THE municipal council of Paris has decided to change the name of the street on which the Pasteur Laboratory is, to Rue Pasteur.

FOUR hundred students are enrolled in the Medical Faculty of McGill University, an increase of fifty as compared with the session of 1893-4.

THE New Zealand House of Representatives has passed a bill to exclude from the colony undesirable emigrants, including persons suffering from consumption.

THE Association of Military Surgeons of the United States meets at Buffalo, N.Y., from May 21st to 24th, inclusive. This Association embraces both the surgeons of the National Guard and of the regular army. The membership is about 2,000.

THE pupils of Charcot in Paris are engaged in raising a fund for the erection of a bronze statue of him in the Salpêtrière. The movement is receiving cordial support in Germany, England, Italy and the United States. Canada is also requested to join, and any Canadian physicians who desire to contribute to the success of this undertaking may send heir subscriptions to Dr. James Stewart, Montreal.

According to an exchange, the number of new books published belonging to the domain of medicine and surgery during 1894 was ninety-seven—nearly the same as for 1893.

There are in Russia between 15,000 and 16,000 medical practitioners. A writer in the *Vratch* states that suicides are relatively very frequent among physicians in that country, reaching 8.8 per cent. The cause of this is probably due to the severity of the struggle for existence.

The Montreal *Medical Journal* expresses the hope, now that the Cabinet has a medical man among the number, that the unjust tax on diphtheritic anti-toxine especially, and on instruments, appliances and apparatus used in the investigation and treatment of disease, will soon be a thing of the past.

The antitoxine treatment has been used in seven cases (mostly severe in their character) of diphtheria at the Isolation Hospital in Toronto. Recoveries took place in all the cases except one. The patient in this case being in an extremely critical condition, there was little or no hope of any treatment being helpful.

Ontario seems to be constantly menaced of late by smallpox. Spanish River, St. Thomas, Colchester, Windsor, Sandwich, Kingston, Chatham, Strathroy, Kokoma, Guelph, and the townships of Logan, Raleigh and Norwich have all been visited. Happily, in most of the places, there have been only one or two cases. One good, at least, comes of its presence—a general vaccination in and for a good circle around the locality visited.

History of Medicine.—Lectures on the history of medicine are being given in the Medical Department of the University of Buffalo by Dr. Roswell Park. They will appear in the *Medical Age*. The members of the Medical Faculty of Toronto University have instituted a similar course. On Tuesday, January 22nd, Dr. A. H. Wright delivered the third of the series on "Alexandrian Medicine," and on the 29th, Dr. J. E. Graham followed with a lecture on "Roman Medicine." We append the programme for the remainder of the course: February 5th, "The Eclectics" (Galen), by Dr. John Caven; February 12th, "Graeco Arabian Medicine," by Dr. G. A. Peters; February 19th, "Monastic Medicine," by Dr. J. M. MacCallum; February 26th, "Scholastic Medicine," by Dr. William Oldright; March 5th, "The Revival of the Study of Human Anatomy," by Dr. A. Primrose; March 12th, "The Commencement of Modern Medicine" (Paracelsus), by Dr. A. McPhedran.

At the meeting of the Senate, University of Toronto, held on Friday, January 11th, 1895, the statute granting the retiring allowance to Drs. W. W. Ogden, M. H. Aikins and J. Ferguson was read and passed on a division, for the first time. This is the second time the Senate has declared itself in favor of properly recognizing the claim.

A London physician has asked the Royal College of Physicians to accept the sum of $12,000 in trust, for the purpose of founding a prize and medals to be given biennially or triennially for the best essay on tuberculous consumption. The gift was accepted, and a committee was appointed to arrange the details of the trust.

The conclusions arrived at by Dr. A. H. Wright, in his lecture on "Alexandrian Medicine," were that anatomy, both human and comparative, botany and chemistry were well studied; that every assistance was given to those engaged in original research; that disease was subject to natural laws, and necessitated close clinical observation for its cure; that treatment should be made of prime importance; that the physician should recognize a high conception of his status and duty.

West Toronto Territorial Association.—A meeting of the above Association was held on January 12th. There was a good attendance. The officers for the year were elected: President, Dr. H. T. Machell; First Vice-President, Dr. A. A. Macdonald; Second Vice-President, Dr. Alex. Hamilton; Council, Drs. Ferguson, Spence and McPhedran; Secretary, Dr. Carveth. Several committees were appointed to report at the next meeting, in April, on lodge practice, the best method of collecting accounts, and the repeating of prescriptions by druggist. It is confidently expected that the above Association is destined to accomplish some useful reforms in the interests of the profession.

Toronto has lately had a visit from Dr. Wm. Osler, of the Johns Hopkins University. We are glad to be able to say to his numerous friends in Canada that the doctor is in his usual health and spirits; but it is with regret that we have to announce that he has not been able to see his way to accepting the Principalship of McGill University, Montreal. We congratulate him upon the flattering honor given him in placing the position at his disposal, and we should have gladly welcomed this bright and energetic doctor to his native land again; but his long period of clinical work has, he thinks, unfitted him for executive administration. Besides, his tastes lie in the direction of his present duties.

Book Notices.

Laboratory Guide for the Bacteriologist. By LANGDON FROTHINGHAM, M.D.V., Yale. W. B. Saunders, Publisher, Philadelphia.

The author of this volume has, in a concise way, given the methods employed for making, staining and mounting pathological and bacterial specimens. It will be found very helpful to all students in this department, especially to beginners and those who work alone. The little but important points, without the careful observance of which blunders are made, have received due prominence.

Notes on the Newer Remedies: Their Therapeutic Applications and Modes of Administration. By DAVID CERNA, M.D., Ph.D., Demonstrator of Physiology and Lecturer on the History of Medicine in the Medical Department of the University of Texas. Second edition, enlarged and revised. Philadelphia: W. B. Saunders, 925 Walnut Street. 1895.

This is a handy book of reference, cheap in price, and furnished with a good index. It is with remedies as with books—of the multiplying of them there is no end, therefore all the more necessity of having brief and clear descriptions of them. Dr. Cerna has undertaken the task of supplying the profession with a useful aid in the prescribing of the newer drugs, and his work is a creditable production.

Syllabus of Gynecology. Based on the American Text-Book of Gynecology. By J. W. LONG, M.D., Richmond, Va.; Professor of Gynecology and Pediatrics in the Medical College of Virginia and Philadelphia. W. B. Saunders, 925 Walnut Street. 1895.

The Syllabus of Gynecology, a copy of which we have just received, is a compendium of value to those engaged in teaching the subject and also to the student, or even to the practitioner who wishes to glance quickly over the salient points of a case.

Though the author, Dr. J. W. Long, of Richmond, Va., has done his work with care, we think that in a few instances he might have taken a wider range. Suprapubic cystotomy need hardly have been mentioned (Fol. 124) in the treatment of vesical calculi in women. Rare is the case where the calculus is too large for removal by kolpocystotomy, the preferable route. In diagnosis of tumors of the bladder, digital exploration by way of the urethra, and other methods, should have been mentioned, as well as "symptoms and cystoscopy."

In a few places we might criticise, but on the whole the work is well up to all the author claims.

W. B. Saunders, the publisher, has done his part well. The type is clear, paper good, and the interleaving most convenient for notes.

The Physician's Visiting List (Lindsay & Blakiston) *for 1895.* Forty-fourth year of its publication. Philadelphia: P. Blakiston, Son & Co. (successors to Lindsay & Blakiston), 1012 Walnut Street.

From the time of its first publication until the last issue this Visiting List has been of the utmost service to physicians. The long experience now possessed by the publishers has enabled them to supply an article of great merit, and those who have used the Visiting List for one year invariably require it again.

In addition to its value as a Visiting List, the book contains many excellent tables and remarks upon new remedies, and is in every respect most useful and convenient.

Sexual Neurasthenia (*Nervous Exhaustion*). Its Hygiene, Causes, Symptoms and Treatment, with a chapter on Diet for the Nervous. By GEORGE M. BEARD, A.M., M.D. Edited with notes by A. D. Rockwell, A.M., M.D., formerly Professor of Electro-Therapeutics in the New York Post-Graduate School and Hospital, etc., etc. Fourth edition, with formulas. New York: E. B. Treat-5 Cooper Union. 1895. Price, $2.75.

The making of this book began in 1868, when the author, Dr. Beard, gave some lectures on nervous exhaustion, which were published in the *Boston Medical Journal.* The work has been greatly added to since then. Notwithstanding the fact that Dr. Beard has been dead for a number of years, the accomplished editor keeps it thoroughly up to date.

In the first chapter, dealing with the nature and varieties of neurasthenia, we learn from the authors that their opinion is that sexual neurasthenia is a clinical variety of general nervous exhaustion. The ground here taken is clearly the same as that held by Kraft Ebing in his works, and by Mercier in his "Sanity and Insanity."

In the second chapter the statement is made that the three great centres of reflex irritation are the brain, the stomach and the genital organs. The order in which the main organs of the body are involved is given thus: The heart, brain, eye, ear, nose, mouth and digestive system. The manner in which these organs become disturbed is usually common sensation, special senses and reproductive senses. In

the case of the mind the process of evolution of the disease is that the emotions and moral qualities are first disturbed, and, later, the reason.

Chapter three deals with the relation of this disease to other diseases. Neurasthenics often think they have some form of disease such as malaria. On the other hand, a typical neurasthenic may become the victim of malarial, or afflicted with any other disease. Then, again, other diseases may reduce the general health, and help lay the foundation for neurasthenia.

There is an excellent chapter on sexual hygiene. The extreme ground is avoided on both sides. The authors condemn many of the practices resorted to to avoid conception.

The portion of the work dealing with treatment is specially good. This section can be recommended to the medical profession with much confidence.

The publishers have done their share well. This work is one of the series of medical classics by the publication of which E. B. Treat has become so well known.

Obituary.

John E. White, M.D.

THE medical profession of Toronto was taken by surprise when its many members read, in the morning papers of January 22nd, the announcement of the death of Dr. John E. White. For some time Dr. White had experienced symptoms of heart-trouble, but he did not regard it as at all serious. On the day of his death he attended to his professional calls as usual. When he came home in the evening he complained of feeling faint. He almost immediately afterwards fell on the floor and died in a few minutes.

Deceased was born in Beaverton in 1848. He was, therefore, 47 years of age when death overtook him. He graduated from the University of Toronto in 1870. He practised for four years in Beaverton, and twenty in Toronto.

Outside of his medical work, Dr. White took an active interest in the natural history section of the Canadian Institute. He was one of the founders of the Toronto Art School, and continued to be a steady friend to it. He was also one of the founders of the Ontario Medical Association, which has done so much good. He was its first secretary and continued to discharge this duty for many years. The

late Dr. Workman was the first president, and was actively engaged with Dr. White in building up the association.

Dr. White was genial and affable in manner. He was fond of fun and amusement, and made splendid company. None enjoyed a piece of humor better than he. He was always thoroughly loyal to his friends, and the sin of ingratitude could never be traced to his door. His many friends will long miss his cheery salutations. For his wife and three children we bespeak the kindest sympathy of the medical profession.

Selections.

Doctors and the Right of Way in the Streets.—On days of certain court and military ceremonials, important Berlin thoroughfares—generally the Unter den Linden and some of its approaches—are closed to public traffic, sometimes for hours. An agitation has been going on for some time to obtain leave for medical practitioners, in the exercise of their profession, to pass through the barrier of policemen, and has at last ended in a compromise. Doctors furnished with a proper pass are to be allowed to go through the closed streets henceforth ; but they will have to get out of their carriages to do so, their pass only admitting them on foot.—*British Medical Journal.*

An Improvised Incubator.—Marion Sims' first speculum was the handle of a kitchen spoon, and Sir William Fergusson is said to have amputated at the shoulder with a pocket-knife. We do not, however, remember to have come across a more notable instance of inventive genius rising superior to mechanical difficulties than the following, related by Professor Landouzy, of Paris, in the *Gazette des Hôpitaux:* A pupil of his, M. Queyrat, had occasion to make some bacteriological cultures in the country, far from the simplest apparatus of the laboratory. He was not to be beaten, however. He captured a hen, tied her up, and fixed a tube, containing serum sown with micro-organisms, under her wing. At the end of twelve hours some fine colonies had made their appearance.—*British Medical Journal*

Cauterizing Ovaries Instead of Removal of Them.—Dr. Pozzi, at Hôpital Broca, has now practised cauterization of painful ovaries for over two years, and considers the plan very successful. In one case, in which he operated upon both ovaries, the woman has

since given birth to a child. He performs his laparotomies in the ordinary recumbent position ; draws the ovaries out of the abdominal opening. If the ovary is totally diseased he removes it ; but if a part is found to be healthy, he amputates the affected portion, cauterizes the stump, and sews the end with silk. If there are some small cysts, he opens them by touching them with the Poquelin point. The ovary being returned to the abdomen, he examines and treats the other in a similar manner. Often as many as six small cysts are opened in this way in each ovary.—*Paris Correspondent Therapeutic Gazette.*

Sugar in the Treatment of Uterine Inertia during Labor.—It remained for Mr. Bossi, of Gênes (*Rev. Illust. Polytechnique Me icale*, May 30th, 1894), to make practical application of a theory propounded by Drs. Paoletti and Mosso, that sugar taken internally might be found to exhibit as stimulating an effect upon the group of uterine muscles as it has on voluntary muscles. Bossi administered a dose corresponding to an ounce of sugar in about eight ounces of water. A most excellent effect was observed after the first dose in all but one of the cases, the ecbolic action showing itself in from twenty to forty minutes and nearly always lasting till the birth of the child. In the other case a second dose had to be given. The contractions were always quite regular and free from any tetanic tendency.—*The North American Practitioner.*

Biting the Nails.—Dr. Bérillon, as the result of an extensive inquiry, confirms his previously expressed opinion that onychophagia and similar habits are generally associated with degeneracy. The frequency of onychophagia varies greatly in different institutions. In some, two or three out of every ten children are addicted to biting their nails. A careful examination invariably reveals signs of degeneracy. The children are usually less healthy in appearance than others, presenting deformities of the skull and anomalies of the teeth and ears. In such subjects the teachers notice a marked antipathy to physical exercises and games requiring effort. They write poorly, and show marked inferiority in respect of manual dexterity. They are slow to learn ; they are incapable of continuous application ; in fact, they always exhibit an inferiority in some direction or other. The disciplinary measures usually resorted to to correct bad habits are powerless in this ; in the majority of cases only hypnotic suggestion seems to be capable of effecting a cure. The habit of biting the nails sometimes persists until late in life.—*Medical Week.*

South Africa as a Health Resort.—The eulogy of the climate of South Africa by Max O'Rell in his recent book, "John Bull and Co.," has led the *Cape Times* to draw attention again to the great variety of climate which exists in the colony, and to the special difficulties which beset invalids in gaining the undoubtedly great benefits of climatic treatment in those regions. In the seaboard towns luxuries and comforts can be had in plenty, but the climate is most unsuitable to pulmonary disease. Neither the cold and humidity of the winter, nor the heat, the dust-bearing south-easters, and the moist relaxing air of the summer in Cape Town are an improvement for this class of patient upon the climate they leave behind in Great Britain. If they want to reach the really beneficial districts, they must journey north to the high altitude of the interior, where the air is pure, dry and rarefied. Here, however, unfortunately, invalids will miss many of the conveniences and comforts to which they have been accustomed, and which have in many cases become almost necessities. While it is true that in South Africa, as in most places, money will procure almost anything, it also is the fact that in South Africa a great deal of it is required to obtain a very little in the way of comfort and good food. It must be remembered that in a new country the good things go to the strong, and that for those who cannot either work hard or pay heavily there is but small opening.—*British Medical Journal.*

The Effects of Intense Cold upon the Mind.—Extreme cold, as is well known, exerts a benumbing influence upon the mental faculties. Almost everyone who has been exposed, for a longer or shorter period, to a very low temperature has noted a diminution in will-power, and often a temporary weakening of the memory. Perhaps the largest scale upon which this action has ever been studied was during the retreat of the French from Moscow. The troops suffered extremely from hunger, fatigue and cold—from the latter, perhaps, most of all. A German physician who accompanied a detachment of his countrymen has left an interesting account of their trials during this retreat. From an abstract of this paper by Dr. Rose, in the *New Yorker Medicinische Monatschrift*, we find that of the earliest symptoms referable to the cold was a loss of memory. This was noted in the strong, as well as those who were already suffering from the effects of the hardships to which they had been exposed. With the first appearance of a moderately low temperature (about five degrees above zero Fahrenheit), many of the soldiers were found to have forgotten the names of the most ordinary things about them, as well as those of the articles of

food for the want of which they were perishing. Many forgot their own names and those of their comrades. Others showed more pronounced symptoms of mental disturbance, and not a few became incurably insane, the type of their insanity resembling very closely senile dementia. The cold was probably not alone responsible for these effects, for a zero temperature is rather stimulating than paralyzing in its action upon the well-fed and the healthy. These men were half-starved, poorly-clad, worn out with long marching, many already weakened by dysentery and other diseases, and all mentally depress d, as an army in defeat always is. It needed, therefore, no very unusual degree of cold to produce the psychic effects observed under other circumstances only as a consequence of exposure to an extreme low temperature.—*Medical Record.*

The Nostrum Stamp.—It appears that in 1860 the Government tax on patent concoctions produced £43,600, and that in 1892 this figure had risen to £240,000. A poor country like Italy, with embarrassed finances, declines to fill its exchequer by drawing a revenue from fraud. Every proprietary article in that country must have printed clearly on each box or bottle the name and exact amount of each ingredient. The owner may give to his production what fancy name or price he chooses; he is not required to divulge any particular method or art employed in manufacturing his goods or in rendering them more pleasant to the eye or palate; but he must make no false statements as to the source, nature or power of any drugs used or as to the effect of his medicine. For example, he may advertise his "Pectoral Pick-me-up" as the "sovran'st thing on earth" for coughs, colds, bronchitis, pleurisy, etc. But on the label he must state the name and quantity of each ingredient in every dose. Having to give the plain matter-of-fact prescription, he, of course, does not attempt to gull people by advertising his nostrum as made of "Oriental flowers grown in his own gardens in Arabia." The public buys his goods with open eyes and not from fraudulent misrepresentation. Can we not take a lesson from Italy?—*British Medical Journal.*

Coal Tar in Dermatological Practice. — Leo Leistikow (*Monatsh. f. prakt. Derm.*) has used coal tar very extensively for several years in the treatment of diseases of the skin, and prefers it in many respects to other species of tar. In his out-patient practice he generally uses it diluted with equal parts of spirit. Comparative experiments—such as the application of coal tar in this form to one part of the skin while the oleum fagi, rusci or cadinum was applied

to other parts—has convinced him that the former is much superior as an antipruritic remedy. The objections to the use of coal tar in private practice have hitherto been its penetrating smell, its thick consistence, and the black stain which it makes; the difficulty has been to remove these drawbacks without impairing the therapeutic efficiency of the tar. The author has found it impossible to do so in the form of pastes and ointments, but he has found the following tincture unobjectionable: ℞ Ol. lithanthracis, 3 parts; spiritus (95° C.), 2 parts; æther. sulphuric., 1 part. When applied to the skin with a brush this dries quickly, and can easily be removed when required by means of a little olive oil. Leistikow has used this tincture in 200 cases, and has seen tar folliculitis only twelve times, and tar poisoning (evidenced by deep black discoloration of the urine) twice. The effect was in the majority of cases very satisfactory. The tincture was a much more powerful antipruritic than other preparations of tar, more energetic, more penetrating, and more lasting in its effect, so that relapse was less common. It is not, however, adapted in cases where the whole skin is involved; in these it should be applied only to the worst places. The tincture is indicated: (1) In dry forms of eczema of the hairy scalp, breast, belly, back, nuchal region, genitals, extremities and navel; on the face, as it is apt to cause tar erythema, it should not be used in patients who are going about; (2) in psoriasis, especially in patches on the scalp, elbow and knee; here a combination of it with 2 per cent. chrysarobin is of special advantage; (3) in Hebra's prurigo; (4) in trichophytic affections.—*British Medical Journal.*

In the Treatment of Pleural Effusion Segalea (*La Médecine Moderne*) has employed with success topical applications of guaiacol in the following formula:

℞ Guaiacol ..... ℥ xxxvi.
Glycerin
Tincture of iodin } ..... āā f℥ss. M.

The applications are made by means of a brush to the entire posterior aspect of the chest, which is then covered with cotton and an impermeable dressing and a bandage.

In a case of anasarca, with anuria, in the sequence of scarlatina, in which other measures had failed, applications of the following combinations were soon followed by relief:

℞ Guaiacol ..... ℥ xvi.
Glycerin ..... f℥ss. M.

—*Medical News.*

Miscellaneous.

THE business in connection with the sales of medical practices, etc., conducted by the late Dr. J. E. White, has been transferred, with all the correspondence and papers relating thereto, to Dr. W. E. Hamill, who has recently resumed practice on the corner of King and Yonge Streets in this city. Knowing for a number of years Dr. Hamill's recognized business abilities and tact, we can safely say that he is entitled to enjoy the confidence of the profession in carrying on this necessary department of medical affairs, and cordially recommend all those who have practices to dispose of, or desire to secure partnerships, to communicate with him at once.

THE sixty third annual meeting of the British Medical Association will be held in London on Tuesday, Wednesday, Thursday and Friday, July 30th, 31st, August 1st and 2nd, 1895.

PŒHL has obtained good results in cholera by the injection of spermine. A Russian paper says that erysipelas will arrest cholera when the former supervenes over the latter.—*Times and Register.*

CIGARETTE-MAKERS' cramps have attacked the operatives in the French State tobacco factories. It is very common in Spain, but has not hitherto been noticed to any extent in France. The cramp affects the muscles of the thumb and first finger of each hand.—*N. Y. Med. Record.*

ROBERT LOUIS STEVENSON, the great romancer, whose loss is now being mourned by every lover of English literature and the English tongue, had ever a good word for the medical profession. The dedication of his book "Underwoods," published in 1887 contains one of the finest tributes ever paid to the profession of medicine. He wrote: "There are men and classes of men who stand above the common herd: the soldier, the sailor and the shepherd not infrequently; the artist rarely, rarelier still the clergyman, the physician almost as a rule; he is the flower (such as it is) of our civilization; and when the stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practise an

art, never to those who drive a trade; discretion tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sick-room, and often enough, though not as often as he wishes, brings healing."—*British Medical Journal.*

THE PEOPLE'S LIFE INSURANCE COMPANY.—The People's Life has removed its chief offices, hitherto in Toronto, to Ottawa. The following-named gentlemen constitute the Board of Directors: James Gillies, Carleton Place; R. W. Baxter, late of the Finance Department, Ottawa; W. H. Hunter, Barrister, Toronto; Allan Francis, Renfrew; Robert Bowie, Brockville; James P. Murray, Toronto; Hon. Dr. Sullivan, Senator, Kingston; Alfred Baker, M.A., Professor Mathematics, Toronto University; G. I. Mallary, Brockville; James Masson, Q.C., M.P., Owen Sound; Newton Cossitt, Manufacturer, Brockville; Dr. Bergin, M.P., Surgeon-General, Cornwall; James Minnes, Wholesale Merchant, Kingston; W. Carden Cousens, M.D., Ottawa. The officers of the company are: President, James Gillies; vice-presidents, R. W. Baxter and W. H. Hunter; medical director, W. Carden Cousens, M.D., C.M.L R.C.P. and S. Edin.; secretary, Thos. G. Hand; superintendent, James Wallace; bankers, the Bank of Ottawa; solicitors, Hunter & Hunter, Toronto. It will be noticed that Dr. Cousens is the new medical director. We congratulate the company on securing the services of one so discreet and able.

THE

Canadian Medical Review.

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VOL. I.] TORONTO, MARCH 19, 1895.

The Patrons' Medical Bill.

WE subjoin a letter from Dr. Ryerson, M.P.P., which deals with this most important bill, which is now before the Legislature. It is hardly possible to conceive that any Government could give its countenance to a bill so fraught with danger to the public, and which constitutes such a violation of the rights of the profession, yet were no protest to be entered amendments to the existing Act might be passed which would be prejudicial to all, and which might be very difficult to remove. We would urge upon every member of the profession to exert himself by protesting, through the representative of his constituency, or directly on the Government, against a measure which is so contrary to the interests of the public and the profession. The subject is of such paramount importance that we deemed it advisable to issue this special number dealing with it alone, and we bespeak a careful perusal of Dr. Ryerson's letter, which ably discusses the salient points of the proposed amendments to the Medical Acts :

60 College Street,
Toronto, *March 19th*, 1895.

To the President, Council and Members of the College of Physicians and Surgeons of Ontario:

Gentlemen,—I beg leave to call your earnest attention to a bill to amend the Medical Act which has been introduced in the Ontario Legislature by Mr. Haycock, leader of the Patrons of Industry in that Assembly. I am induced to take this unusual course because of the extreme gravity of the situation, and because the introduction, by laymen, of an amending Act is entirely without precedent, and deserving of the closest scrutiny by the profession whose rights are seriously threatened. The Medical Act, which has been built up for the protection of the public, is threatened with destruction. The bill, if it should come into force, means practically free trade in medicine. It means a retrogression to a state compared with which the condition of the profession, prior to 1850, was order itself. It means that the competition and pressure of to-day will, if this bill becomes law, be redoubled. A calling which has at all times required much self-sacrifice on the part of its practitioners, will cease to return an income for the time and labor expended.

Excessive competition is as little in the interest of the public as it is in that of the profession. Indeed, it may fairly be said that the Medical Acts have been framed not for the creation of a close corporation of the profession, but for the protection of the public from the extortions and overcharges of charlatans and empirics, and to guarantee to the people that the men who are licensed to practise medicine are competent to perform their work.

Those who are entitled to registration under this bill. (8) Subject to the provisions of section 24 of the Ontario Medical Act, every person who—

(*a*) Holds a diploma from any chartered university in the Dominion of Canada, or in Great Britain or Ireland, granting to such person a degree as bachelor of medicine or doctor of medicine, or any similar degree, and who

(*b*) Has attended the full course of lectures and complied with the requirements of the curriculum of any duly incorporated medical school or college in the Dominion of Canada, or of any such school or college in the United Kingdom of Great Britain and Ireland, which has been approved by the Lieutenant-Governor in Council, and who

(*c*) Holds a certificate from the Board of Medical Education, hereinafter mentioned, of having passed the examination and complied with the regulations prescribed by the said board,

Shall be entitled, upon payment of a fee of $5 to the Registrar of the College of Physicians and Surgeons of Ontario, to be registered under the Ontario Medical Act. (Rev. Stat., c. 148.)

The bill is essentially a destructive one. Sections 16, 17, 18, 20, 23, 25, 26, 27, 30, 31, 33, 34, 35, 36, 37, 38 of the Revised Statutes, 1887; sections 1, 3, 4, 5, 6, 7, 8 of the Act of 1891 and section 6 of the Act of 1893 are repealed. Sections 13, 22, 40, 32, 45 and 48 are amended. In fact, there is but little left of the old Acts, that of 1891 being repealed except the last section, which very inoffensively says that the Registrar shall keep the Register correctly, and the unimportant second section. The general tenor of the proposed legislation is to take from the Medical Council the powers which it now possesses, to fix the subjects for examination, and to hold examinations and to hand them over to the Government under the Department of Education. It also proposes to take all fees paid for examination and fund them with the Provincial Treasurer. The chief source of income left to the College is the annual fee of one dollar (instead of two). It is proposed to make this annual amount collectable in default of payment by the Registrar in the Division Courts. As it would cost at least five dollars on the average to collect, this is a polite way of cutting the Council's throat. In short, it is attempted to take all real power of examination out of the hands of the profession as represented by the Council. The board of examiners is to be called (if this precious bill becomes law) the Board of Medical Education, and is to consist of three members of the Council, one representative of each medical school, two homœopaths and two members to be appointed by the Government. The chairman and secretary of this board are to be appointed by the Government. All papers are to be approved by the Government—not the Education Department, but the Lieutenant-Governor in Council; that is, the whole Cabinet. Was there ever a more ridiculous proposal? The Board of Education is to decide upon the subjects in which candidates shall be examined and the fees they are to pay for such examination. The fee for registration is to be five dollars. Persons who possessed a qualification prior to 1870, and who are now entitled to register without examination, will by this Act be deprived of that right. The mode of fixing the tariff of professional fees in the territorial divisions is materially changed. The bill proposes that the Lieutenant-Governor in Council, *i.e.*, the

Cabinet, shall be the arbiter as to what is or is not a reasonable charge to be made for professional services. The local tariff, while proposed by the Divisional Association, is no longer to be submitted to the Council. It is presumed that the Cabinet knows more about what a fair charge may be than the men who are in practice. Could folly go further? Fancy medical men fixing the scale of fees for the legal profession. Would it not be equally absurd?

The power of erasure is taken from the Council. In fact, it is really difficult to discover what is left for the Council to do. A body without functions or income is not likely to survive for long. Perhaps this may be the real intent of the bill. Fraudulent advertising, habitual drunkenness, transmission of contagion or infection, violation of the Public Health Act, neglecting to register births and deaths, giving false or blank certificates of the cause of death, conviction in any action for damages for any injury caused, negligence, ignorance or want of skill, are all and each to be grounds upon conviction of which a practitioner is to have his name erased from the register. The case is to be tried by a judge who is vested with discretionary powers. But the relator or complainant is not necessarily a medical man. Anyone can lay a charge before a magistrate. A man may thus be struck off the register for failing to register a birth if the trial judge so decrees. A man may be subjected to constant annoyance by malicious persons who choose to make charges of violation of the Public Health or Registration of Births, Marriages and Deaths Acts. The time of limitation of action for negligence or malpractice is extended from *one* to *two* years.

The last section of this remarkable bill cannot be done justice to by any pen save that of the gentleman responsible for its introduction. Sub-section 3 refers to the penalty for practising without registration and for falsely pretending. The effect of this sixteenth section, if it becomes law, I leave to my fellow-practitioners to imagine and describe. Efforts will be made to place a copy of the bill in its entirety in the hands of every medical man in Ontario. Here is the section as it appears in Mr. Haycock's bill

"16.—(1) Any person, being a woman, who, within six months after the coming into force of this Act, produces before any local board of health a certificate signed by the head of the municipality or by two justices of the peace that she is a person of good character, and who proves by evidence taken on oath before such board that she has successfully performed the office of midwife in at least ten cases of confinement before the passing of this Act, shall be entitled, upon payment of a fee of $1 to the treasurer of the munici-

pality, to a license, under the hand of the chairman of the board, to practise midwifery in the municipality for two years from the date of such license, and the said board may at the expiration renew such license upon the production of similar evidence of good character."

(2) Any similar license may also be granted to any person, being a woman, who after the passing of this Act applies to the local board of health of any municipality therefor, upon producing a certificate signed by the head of the municipality or by two justices of the peace that she is a person of good character, and proving by evidence taken on oath before such local board and by the certificates of duly registered medical practitioners that she has attended at least ten cases of confinement under the directions and instruction of a duly qualified medical practitioner.

(3) Every person duly licensed under this section shall be exempt from the provisions of sections 45 and 48 of the Ontario Medical Act

Could professional outcasts and exiles seize a more favorable opportunity to wreak vengeance upon an honorable body? At a time when a set of men whose ignorance is only equalled by their lack of fidelity to the principles they were elected to support, at such a time the enemies of order inspire these men to attack our vested interests, to destroy our time-honored rights. It is for you to say if you will endure these wrongs. If you approve this iniquitous bill, do nothing. If you do not approve, write to the representative of your constituency in the Legislative Assembly to oppose it. Combination must be met by combination. If the Patrons of Industry would destroy the present Medical Act, we must fight for our rights and the public welfare. This matter is urgent and brooks no delay. Organize. Call your Territorial Associations together. Petition the Legislature that the bill do not pass.

G. Sterling Ryerson.

Materia Medica and Therapeutics.

PHTHISIS AND ITS TREATMENT.

PHTHISIS is pre-eminently a wasting disease, and by exalting failing nutrition, cod liver oil being little more than a given food, a great advance was made in therapeutics. It has been found, however, that the oil does not in many cases meet the indications; for not only is nourishment needed, but the digestive power is so reduced that but little use is made of the food taken. Hence a demand both for nutritious material and also for something which will aid food suitable for assimilation. The clinical starting-point in the history of the greater number of cases of phthisis is malnutrition, and when that is guarded against much is accomplished.

After a full trial of the different oils and extracts of malt preparations in both hospital and private practice, I find Maltine most applicable to the largest number of patients, and superior to any remedy of its class. Theoretically we would expect this preparation, which has become PRACTICALLY OFFICINAL, to be of great value in chronic conditions of waste and malnutrition, especially as exemplified in phthisis. Being rich in *diastase*, *albuminoids* and *phosphates*, according to careful analysis, it aids in digesting farinaceous food, while in itself it is a brain, nerve and muscle producer.

In practice this hypothesis is sustained. A female patient in St. Luke's Hospital, aged 35, with phthisis, signs of deposit in left upper lobe, losing flesh for six months, poor appetite and night sweats, was put upon Maltine. Within a few weeks her weight was increased to 121 pounds, she ate well, no night sweats, and the evidences of local disease were much less marked.

Another case of phthisis: A gentleman from Alabama, with all the physical signs of phthisis, rapidly losing health and strength. His was the remarkable gain of 10 lbs. *from six weeks' use of Maltine.*

Seven pounds increase in as many weeks is the record of a third patient, a lady of 41 years, who had no other medication than the Maltine. In these and other cases the increase in strength and mental vigor was in proportion to the gain in weight.

These instances are sufficient for illustration, and are *duplicated many times in the experience of physicians everywhere.* There is a universal reluctance always to testify to results from medicinal preparations, but when, as in this case, the composition is fully known, and the profession invited to investigate the manner of preparing it, there is no reason why the remedy should not receive general approbation, provided it be worthy.—*Quarterly Epitome of Practical Medicine and Surgery.*

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VOL. I.] TORONTO, APRIL, 1895. No. 4

Original Communications.

The Treatment of Dysmenorrhœa.*

BY ALBERT A. MACDONALD, M.D.

IN a normal condition women should menstruate without pain every twenty-eighth day, but whether on account of their mode of life or hereditary defect they are subject to a considerable degree of irregularity.

The flow may last from one to seven days, and still be normal; an amount of irregularity may exist, and still the woman may be healthy. But if the amount of pain suffered with menstruation is considerable, the woman is not healthy, and we are called upon to give her relief from her sufferings.

We are apt to think that women are specially prone to disease, and that disorders of the reproductive organs belong to this age; but the more we consult the older books, the more clearly we see that such troubles had a very early recognition, and that some of the means employed for their alleviation were not only of the same class, but were very much the same that are in vogue to-day.

* Read at meeting of Toronto Medical Association.

Writers upon diseases of women have for the past thirty or forty years followed a similar classification of the varieties of dysmenorrhœa. Thus Sir James Y. Simpson, in 1863, gave :

1. Neuralgic dysmenorrhœa. This form occurs in patients who are subject to neuralgia elsewhere ; it becomes localized and intensified in the region of the uterus and ovaries at the menstrual period, lasting as a rule during the whole period.

2. Congestive dysmenorrhœa. An exaggeration of the ordinary amount of congestion which goes on at the menstrual period.

3. Inflammatory dysmenorrhœa. Due to acute or chronic inflammation in or around the cervix uteri or an ulcerated condition of that part.

4. Gouty or rheumatic dysmenorrhœa. Due to gout or rheumatism in the system.

5. Dysmenorrhœa due to organic disease or displacements.

6. Membranous dysmenorrhœa, where there is an exfoliation of the uterine mucous membrane occurring at the menstrual period.

7. Obstructive dysmenorrhœa. Due to stricture of the calibre of the cervix uteri.

If we compare this classification with that of one of our recent authors in the American text-book of Gynæcology, we find that obstructive and mechanical dysmenorrhœa are merged into one class, and are made to include dysmenorrhœa due to organic disease and displacements. The gouty and inflammatory forms are omitted, and ovarian dysmenorrhœa is added as a separate class where the pain is due to ovaritis and peritonitis (I would not add post-operative, etc.). We see, then, that, though we may have to wade through oceans of printers' ink, we do not arrive at anything very new with regard to classification. Such, however, is not altogether the case where treatment is involved, for though there is good evidence to show that the so-called Hegar's dilators of to-day were made of lead in the days of Hippocrates, and that Cook, of Warwick, in the seventeenth century, made use of sponge tents and hollow stem pessaries in cases of mechanical narrowing of the cervix, and that many other men devised various instruments in olden days for use in these troublesome affections, it has remained for those of later years to give us instruments of accuracy and finish which, with aseptic methods and a more perfect technique, may be used with comparative safety, and with regard to medication some of the more recent drugs are of special value.

Though no single plan of treatment can be laid down for all classes of this trouble, it must be borne in mind that the mere correction of general ill health will, in some cases, be sufficient to promote a cure.

It seems almost as if I should apologize for mentioning what is so self-evident and is well known to all of you, but still we do find cases in which so much attention is directed towards the organ chiefly at fault that the general body is somewhat neglected. But, to be more exact, what shall we do for the neuralgic form of dysmenorrhœa during the attack? This form of the trouble may not be associated with any pelvic disease, but may and usually does attack one who suffers from neuralgia in some other portion of the body. There is hyperæsthesia of the lower abdomen, undulatory pain, and pain on pressure in the ovarian region. Rest and warmth, with local heat in the form of fomentations, poultices or the hot-water can, if the latter is made in such a way that it arches over the abdomen without making much pressure. A hot flannel cloth may be applied underneath the can, and a long-continued, comforting heat may be secured. Chloral hydrate and bromide of potash, with hyoscyamus, are often very efficient. Phenacetin, antipyrine, and such remedies, are prompt in many cases. Cannabis indica, in sufficient doses, is very suitable at times, though there are some who cannot stand it. There are many other remedies, but these are the chief ones which have found favor with me. Morphine and whiskey, though prompt, are too dangerous, and anyone who has witnessed, as I have, the painful sequences of their too free use in such cases, would hesitate before prescribing such remedies, as potent for evil as for good. It is in cases of this kind that great good may be done by careful treatment during the intermenstrual period. Constipation, which is usual in this form of dysmenorrhœa, must be removed. The tone of the system at large must be elevated by tonics, fresh air, exercise, and relief from overwork or anxiety, if such exist. The skin and all the secretions of the body must be stimulated to healthy action. As the menstrual period approaches, apiol 5 ℥ in capsules, three times a day, or pulsatilla gtt. v., in the same way, are advised. But I have seen benefit follow the use of valerianate of zinc three times a day for ten days before the flow, and chloral in fifteen-grain doses when the pain appears. Electricity must not be forgotten, for some cases yield to a constant current of 30 to 40 milliamperes applied for ten or fifteen minutes a day for two or three days before the flow, one electrode being placed in the vagina near the painful ovary, and the other, a large flat one, over the abdomen in the ovarian region.

In the congestive form of dysmenorrhœa, where it is ushered in with a sudden onset of pain in the pelvis, scanty flow, irritable bladder, with such general symptoms as headache, fever, delirium and scanty urine, the treatment must be active—warmth, both local

and general, salines, diaphoretics, hot hip bath and douche. Phenacetin is most useful, both to relieve headache, promote perspiration and to allay nervous irritation. Bromide and chloral are also most useful.

In some such cases I used to practise scarification of the cervix and abstraction of blood by means of the artificial leech, but of late years I have found other ways less objectionable, and perhaps just as efficacious.

In the ovarian form, where the ovaries are enlarged, tender and prolapsed, the treatment is often extremely difficult and unsatisfactory. Over and over again I have been tempted to remove the ovaries in such cases where but temporary relief has been afforded by regulating the general system, tamponning with glycerine and belladonna, giving bromides, etc., and rest with warmth, but have resisted the temptation, and in some cases where there has been no ovarian organic lesion complete recovery has followed pregnancy. This has confirmed me in the view that oöphorectomy should only be done to relieve the condition, if organic ovarian disease exists, and even then the pain sometimes persists.

In the membranous form of dysmenorrhœa, we have the labor-like pains, and relief after the extension of a membrane which may be distinguished from that of pregnancy by the absence of the chorionic villi. In my cases there has been almost invariable headache at the onset and sickness of the stomach.

Temporizing by medical treatment alone is of little use. Dilatation of the cervix, thorough curetting and the application of Churchill's tincture of iodine have been the means most useful in my hands. In such cases, if pregnancy follows the treatment, relief of the condition follows parturition at full term.

The constant electric current by the electro-chemical action of the negative pole in the uterine cavity, and about 50 to 75 milliamperes passed through from aluminum or platinum intrauterine electrode to the large abdominal electrode, gives good results in this form of trouble, though I doubt if the results are any better than when the treatment is by mechanical dilatation and curetting. The only advantage of the electricity is that it is done without chloroform, and, if the application is aseptic, it is also without danger.

Mechanical dysmenorrhœa, caused either by a flexion or by a narrowing of the passage from inflammatory changes, is most common. Though the average amount of menstrual fluid secreted rarely exceeds two-thirds of a drop a minute, and that one would hardly think so small an amount capable of producing much pain, we have

sufficient clinical evidence to convince me that even in many cases where the average-sized sound can be passed without much force we have pain as the result of obstructed or tardy flow. I am astonished at the number of young women, in all classes of life, who suffer severely from pain during menstruation, which, to my mind, is due to mechanical obstruction. In many instances it is difficult to arrive at satisfactory treatment. One hesitates to advise local measures in the case of the young and over-sensitive maiden, and still other remedies often prove futile. In these cases the pain is somewhat characteristic, being more of the nature of uterine colic. It increases until a clot is expelled, when a measure of relief follows. In this variety of the trouble medical treatment carried out with care is capable of affording an indefinite amount of relief, but where there is a narrowing of the canal of the cervix, due either to flexion or other cause, such undue narrowing should be removed, and with its removal the troublesome symptoms will disappear. Dilatation and straightening of the cervix may be brought about in more than one way. Sponge and other tents which were used in the earlier days are now superseded by more rapid and less dangerous means.

Electricity by the negative intrauterine electrode, and a moderate constant current applied twice, or, in some instances, three times a week, is productive of favorable results, and the number of reported cases cured, and of pregnancy following such a course of treatment, is truly encouraging. Gradual dilatation by means of instruments that are worked by a screw for their enlargement are useful where the patient cannot spare the time to lay up or where an anæsthetic is objectionable. Treatment twice a week will overcome the difficulty in about six or eight weeks, and with care only a very moderate amount of pain need be given.

Rapid dilatation under an anæsthetic, with strict antiseptic precautions, is, however, the ideal method in these cases. The time chosen for the initiative in this operation should be immediately following a menstrual period, for then the cervix is softened and yields more readily than at any other part of the intermenstrual period.

If the dilatation is done with Hegar's or other solid dilators, the vagina and cervix having been made thoroughly aseptic, the patient being in the dorsal position and a suitable speculum in place, the anterior lip of the cervix is grasped by forceps or hook and the dilators are passed in succession; if there is much resistance, each one is allowed to remain a few moments in place in order to overcome it. Dilatation up to No. 15 or 18 may readily be secured in this way. With the hinged dilators, such as Ellinger's or Goodell's, a consider-

able amount of force is sometimes used, and care must be taken lest we rupture many fibres of the organ and lay the patient open to the chance of inflammatory or infective processes.

Too much stress cannot be laid upon the necessity for the most rigid antiseptic precautions, as well as for a due amount of gentleness in these most important manœuvres. We must not lose sight of the fact that serious results have followed in some cases. After rapid dilatation the patient should remain a day or more in bed. A glass stem may be inserted, and may be kept in place by loosely packing the vagina with antiseptic gauze or wool.

The chief advantages of the slower methods are that anæsthetics may be dispensed with, and that there is not the same loss of time to the patient, but even with gradual dilatation we cannot forget either the necessity for antiseptics or for rest.

Cases of cellulitis are recorded as following undue exercise and exposure to inclement weather soon after gradual dilatation by careful men. By keeping the causes of the trouble in view, and by bearing in mind that in all cases both general and local measures are required, we can bring our patients to such a condition of health that the menstrual period will no longer be approached with dread.

Clinical Notes.

Foreign Body in Œsophagus.*

BY CHARLES TROW, M.D., C.M., L.R.C.P.,

Ophthalmologist and Otologist Toronto General Hospital; Clinical Ophthalmologist and Otologist Trinity Medical College.

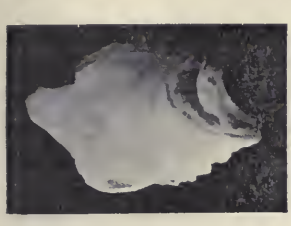
THE patient, B. F. W., aged 24, was sent to me by Dr. E. E. King a short time ago, with the history that he had swallowed a hard piece of biscuit about thirty-six hours previous. He complained of severe cutting pain, locating the position by putting his hand on the vertebræ halfway down his back. On questioning him, found he had been eating oysters with his cracker, which led me to think it was a piece of oyster shell.

He said the pain for the first day was in the throat, but with repeated efforts at swallowing and by taking food he had got it farther down, but the pain had become more severe.

On laryngoscopic examination, found an abrasion on the left arytænoid. With probes or œsophageal forceps of different kinds

* Read at Meeting of the Toronto Clinical Society.

could not feel anything as far as I could reach, which was probably two or three inches down the œsophagus. I then introduced the horse-hair probang nearly the whole length before the end passed the offending body. Expanding the umbrella part and withdrawing, brought up this piece of oyster shell, which measured 1¼ x ¾ inches. You will notice most of the edges are quite sharp and the ends pointed. The patient expressed relief at once. He was cautioned to use only fluid diet for a few days, and report, which he did some three or four days after, saying he was all right.



Piece of oyster shell—actual size.

I don't think producing emesis would have been a fruitful or yet wise measure, as the movements might have caused perforation. A skein of thread swallowed might have entangled the body in its loops, but would not protect the walls on withdrawal. The coin extractor would likely have allowed the edges to cut the œsophagus, as its walls would not have been expanded as with the horse hair. Œsophagotomy, I think, should only be done as a last resort. If left in, it would soon likely have caused ulceration, perhaps perforation, pus formation or severe hæmorrhage.

If he has any symptoms of cicatricial stricture, dilating probangs will be required from time to time; but I don't anticipate this, as there was not any dysphagia or any complaint after extraction.

Would this body have become dissolved if it had gone into the stomach?

Sporadic Cretinism.—Dr. Wm. Osler, of Baltimore (*Archives of Pediatrics*, February), gives the notes of a case of sporadic cretinism. It was a very well-marked case. The child was placed on the thyroid treatment in March, 1893. In April, 1894, the improvement was very marked. The cretinoid aspect had entirely disappeared. In the next place she had begun to develop rapidly. She had grown four inches in fourteen months. She was also acquiring the power of speech. One seeing the child for the first time would not notice anything peculiar about her. In October, 1894, the improvement had continued. She was then very bright and active. The only apparent defect was that she did not talk as plainly as she should for a child at her age.

Society Reports.

Toronto Medical Society.

(JANUARY 24TH, 1895.)

President, DR. PETERS, in the chair.

Hæmoglobin.—Dr. A. B. MACALLUM gave an historical sketch of the comparative views which have been held in regard to the physiological and therapeutic use of iron in the past. Although it was used, he said, as early as the time of Paracelsus, yet it was only within the past fifty years that any explanation of its use was advanced. At this later period hæmatin was isolated from the blood, which was found to contain iron; and it was hinted that the respiratory power of the blood was in some way or other associated with iron. In 1861 and 1862 hæmoglobin was isolated, and it was proven that the oxygen-carrying capacity of the blood was directly associated with it. Previous to this it had been found that iron salts increased the number of corpuscles, and under its influence anæmia disappeared. The speaker related the experiments which were made with the object of ascertaining whether the iron administered really formed an organic compound or not.

About ten years ago this was answered. From experiment on the organic iron compounds in egg-yoke, Bungé discovered that the hæmoglobin of the body was formed out of these, the iron-holding nucleins present in the food, which are derived primarily from the vegetable cell. Bungé stated that the action of the iron-salts was due to the part they played in shielding the organic compounds of the body from destruction, they, the salts, not being absorbed at all. Dr. Macallum stated that from experiments he had made, he had found that iron salts were absorbed in the intestine, and he had traced their presence from the blood vessels to the liver. He also found that the organic salts were absorbed, too. The speaker then discussed the question as to whether all organic iron compounds are alike efficient in anæmia. He decided not, as he had produced siderosis in animals by the administration of hæmoglobin. He detailed the history of a case in which he had seen at the *post-mortem*, a similar condition, where he believed that death was hastened by the administration of defibrinated blood.

Six Cases of Vomiting of Pregnancy.—Dr. POWELL reported the history in brief of six cases of vomiting of pregnancy. In Case I. serious symptoms did not occur until the seventh month. Abstinence

of food per mouth, and the administration of food per rectum tided the woman to term, when recovery followed. Case II. resisted all the classical treatment. Nutrient enemata were tried for five weeks, but despite all treatment premature labor came on and the patient died from exhaustion. Case III. occurred in a young woman during her first pregnancy; had suffered six weeks; a miscarriage relieved the condition. In Case IV. improvement followed the administration of mercury, although 10 per cent. silver nitrate locally and dilatation of the cervix had been previously tried with little effect. In the fifth patient, who had suffered from dyspepsia, there was no improvement from any of the above mentioned methods of treatment. Hypodermics of morphia daily gave relief. In the last case, a marked one, Dr. Powell had tried several full dilatations of the cervix, with benefit following each dilatation.

Gall-stones.—Dr. Ross presented several small gall-stones about the size of a pea, which he had recently removed. He outlined the history of the case, all the typical symptoms being present.

Aneurism of the Aorta.—Dr. Powell presented a *post-mortem* specimen of a ruptured aneurism of the ascending portion of the arch of the aorta from a young man aged 30, who had suffered from pulmonary tuberculosis. The tubercular condition had been arrested. The lungs were shown which confirmed this diagnosis. The pericardium contained about a pint of clot.

Dr. Cameron reported a case of a man, aged 55, in whom death occurred from rupture into the œsophagus.

Dr. Britton reported a case in which death took place from the same cause, in a patient with tuberculosis of the lungs.

Dr. Williams asked the opinion of the members for an explanation of the statement that aneurismal dilatation of the aorta relieved pulmonary tuberculosis.

Cerebellar Abscess.—Dr. MacMahon read the history of a case in which the patient had died from cerebellar abscess. The patient was a gardener, aged 43. Illness began in October, with pain in the head and right ear, lasting with a greater or less degree of intensity for three months. A specialist saw him at Christmas. Result, negative. The patient vomited once on December 1st, two nights preceding the date on which the essayist saw him. Delirium and incontinence of fæces and urine were also features of the case for a short time. There was no evidence of paralysis or loss of sensation. If not supported he would fall backward. Temperature, subnormal. Knee-jerk was exaggerated on both sides, and there was marked ankle-clonus. He was sent to the Toronto General Hospital. Albumen

was found in the urine. The patient became comatose. Eyes, negative. For some weeks past the right hand was cold. A small swelling appeared on the neck behind and below the right mastoid process. Pressure caused pain. Hypodermic needle was introduced, but no pus withdrawn. *Post-mortem* showed pus in the lower mastoid cells, and an abscess in the right lobe of the cerebellum. There was also some evidence of inflammation of the middle ear. In the lateral sinus just within the cerebellum there was a bare piece of bone.

(MARCH 14TH, 1895.)

President, DR. PETERS, in the chair.

Empyema.—Dr. WILLIAMS, of West Toronto Junction, presented a patient upon whom he had operated for empyema. The child was aged eighteen months, who suffered from an attack of pneumonia in July last. It terminated in an empyema. During this attack the temperature ranged from 99° to 102°. There was dulness from the clavicle down to the base of the lung. The heart was displaced, the collection being in the left pleura. Aspiration revealed the nature of the contents. The incision was made in the ninth interspace, below the scapular angle. The pus was sweet. There was no washing out nor special antiseptic precautions, as the surroundings were exceedingly unsanitary. A perfect recovery took place in two weeks.

Dr. POWELL thought such a good result so soon was exceptional. He thought there would be some danger in operating so low down. The patency of the opening might be difficult to maintain, and the diaphragm might be in danger of injury in case of aspiration. He spoke highly of the use of creolin as a washing-out fluid in cases where the pus was non-laudable and irrigation was resorted to.

Dr. PETERS pointed out that the diaphragm would likely be out of reach of the needle if the fluid were sufficient to press it down.

Extra-Capsular Fracture.—Dr. SCADDING reported the history of a case of extra-capsular fracture in an old woman aged 92. No treatment was adopted but rest in bed. The old woman, being restless and mentally deficient, threw herself out of bed twice soon after the fall that occasioned the fracture, falling on the affected hip. However, after lying eight weeks, union took place.

Dr. WINNETT, who did the *post-mortem*, presented the head of the femur, showing how union had taken place. The impaction was well shown. In most cases of this kind the great trochanter is fractured, but in this case it was not. There was also an absence of large processes of bone which are invariably thrown out along the intertrochanteric lines.

Dr. WILLIAMS said that the woman must have had a great deal of vitality, for at that age, with such a fracture and the necessity of keeping the recumbent position so long, there was a danger of her dying before union took place.

A Pedunculated Tumor was presented by Dr. POWELL, which he had removed from the gluteal region of a woman aged 65. It was superficial, pedunculated, and appeared like a fungating sarcomatous mass before removal, but on gross examination it appeared more of a fibrous character. He would present microscopic specimens at a later meeting, when the nature of the growth could more positively be ascertained.

Mitral Stenosis.—Dr. GARRATT presented a heart showing mitral stenosis. He related briefly the history of the case. The woman suffered extremely from pre-cardial pain and dyspnœa, despite everything he administered to relieve her. He had aspirated the peritoneum and the œdematous legs, withdrawing a large quantity of fluid. There was no history of rheumatism in the case.

Dr. CARVETH said he had seen it stated that these cases do not die after exertion, as is commonly supposed, but after lying quietly in bed.

Dr. ADAMS said that, after following the history of a number of these cases, he had come to the conclusion that it was a wise thing to warn patients with heart disease to be careful as regards exercise; that their lives would be prolonged by so doing. He outlined the history of two or three cases he had observed.

Dr. GARRATT said that he considered exercise a very necessary element in the treatment of such cases. The fresh air was very helpful to the respiratory functions.

Dr. DWYER presented a heart showing a condition of mitral stenosis, with dilated and hypertrophied left auricle. Unlike Dr. Garratt's case, it caused absolutely no symptoms. The woman died from nephritis of the chronic interstitial variety, from which she had been suffering for eight years. He also showed the kidneys, which were large and red in color. The capsule was adherent. He outlined the symptoms. Another kidney was shown by Dr. Dwyer, showing the condition of parenchymatous nephritis. He also related the clinical history of this case.

(MARCH 21ST, 1895.)

President, DR. PETERS, in the chair.

Fracture of the Ulna.—Dr. WINNETT presented a patient who while sparring had fallen forward on the palm of his hand, fracturing the ulna at the junction of its upper and middle thirds and dislocating

the radius head forward and upward. A right-angled splint was applied and the dressing taken down at the end of twelve days. The dislocation had not improved. Under chloroform it was reduced and the arm was put up in the straight position. It was now five weeks since the accident. The radius appeared to be dislocated forward at its head, as only partial flexion of the elbow could be made. There was also paralysis of the muscles supplied by the posterior interosseous nerve.

Dr. MacKenzie advised that these cases should be put up with the elbow flexed at an acute angle, the wrist being tied close to the neck. Authorities were generally agreed that this gave the best result. It had worked well where he had tried it. He was not in favor of any sort of splint that would restrict the circulation around the joint, such as plaster of Paris cases.

Dr. Primrose advocated the use of absorbent cotton splints after dislocations of the head of the radius, and firmly bandaged. The pressure would promote the absorption of the inflammatory material about the joint. The elbow could be perfectly flexed in this way.

An Analysis of 6,777 Cases of Midwifery.—Dr. J. F. W. Ross gave an analysis of 6,777 cases of midwifery which his father had conducted. He referred to many interesting features connected with the cases. Although a busy practitioner, the late Dr. Ross kept a full account of all the important items connected with each case. The mortality of mothers was 39, the largest losses being from two epidemics of puerperal fever. The reader traced the disease in its course through each epidemic, and showed how careful his father was in regard to cleanliness and change of apparel in those pre-antiseptic days. He had made two runs of 650 cases without a death. There were 15 deaths from placenta prævia. There were 19 cases of version. There were 5,409 head presentations, 148 breach, 58 foot, 5 breach and foot, 25 face, 7 brow, and 34 arm and shoulder. Forceps were used 491 times. Latterly he had used them oftener, with a lessened mortality rate and a less number of lacerations of the perineum. He believed the forceps properly used were conservative to the perineal body. Chloroform was used in 458 cases. There were 48 cases of retained placenta, and 27 perinea were torn.

Dr. A. H. Wright pointed out that in very many respects this was a phenomenal record. There were many lessons to be learned. One was that of cleanliness. Dr. Wright also spoke of the success that had attended Dr. Ross in his management of occipito-posterior positions of the head, and the ease with which he manipulated them into the anterior position. Another good lesson was the infrequent use of

forceps. He believed in these latter days these were too often used. Another good example he set was in using chloroform so seldom.

Dr. MACHELL pointed out the excellent results as regards the mortality of mothers. That there were only 11 cases of eclampsia was also an astonishing part of the record.

Dr. Ross closed the discussion. He went carefully into his father's management of the cases in many points, showing how his good results had been attained.

It was moved that the Society petition the Provincial Legislature to reject Bill No. 96, the Patrons' Medical Bill, which was aimed at hurting the profession. Carried.

Toronto Clinical Society.

(MARCH 12TH, 1895.)

DR. MACFARLANE in the chair.

Case of Pericarditis.—Dr. N. A. POWELL gave the following history of a case: Woman, aged 50. Always healthy till a year ago, when she suffered from an attack of la grippe, from which he understood she had made but an imperfect recovery. She was sick about a week before he saw her with grippal symptoms, some of the features of which were headache, cough and general malaise. She recovered partly from this, went downstairs, sat in a draft, and returned to bed with increased bronchial symptoms and sub-sternal pain. This was her condition when first visit was made. Fearing the supervention of pneumonic or pleuritic trouble, he went over the chest pretty carefully. He did not think he would have missed a pericarditis if it had been present at that time. But it developed subsequently, while he was treating her. These cases were likely to be overlooked. It was related of a medical man who apologized to a celebrated consultant in London for having overlooked a case of pericarditis, that the reply was, "Don't let that trouble you; if you had discovered it you might have treated it." The speaker did not think the condition in the present case was due to the treatment. The patient had a normal temperature and pulse of eighty-five or ninety for two or three visits, and was doing apparently very well. Suddenly she was attacked with a pain in the left side. Going carefully over the side he heard a to-and-fro friction rub limited to the costal cartilage of the fourth rib on the left side of the sternum. This was heard close to the ear, and was heard when breathing was suspended. The pain was intense, and the action of the heart was tumultuous and rapid, reaching 120 or 125.

The temperature rose to 102. He saw her twice a day after that till the time of death. After two or three days the pain was measurably relieved, but the action of the heart increased in rapidity to 140 or 150, and the dyspnœa became very marked. The heart became very irregular. There was not at any time, as far as he could recognize, any pericardial effusion. The diagnostic point of such effusion in limited amount, as Roach and others had emphasized, is the occurrence of dulness in the fifth interspace in the right side of the sternum, the normal heart projecting to the extent of half an inch to the right of the sternum in the space. There was no increase of dulness there whatever. Being a spare woman, this could be marked out with reasonable accuracy. The pulse, after reaching its maximum rapidity, came down to 120—even less. It was very irregular from minute to minute, and intermittent. The bronchial trouble increased, but the cough was not accompanied by any mucous expectoration. The cough was progressive. The patient died from prostration with signs of heart failure. The interesting features of the case were:

1. The causation of the trouble. It was well known that traumatism and Bright's Disease were factors in its causation, and that the purulent forms often accompany Bright's; but pre-eminently it was met with in connection with rheumatic attacks. There were none of these causes present in this case. A sample of urine gave negative results. The only toxic element he could think of in connection wtth the case was the grippal poison, whatever that might be.

2. The absence of effusion. There were cases of pericarditis undoubtedly with formation of fibrin upon the surfaces, and it was notable in these cases that the friction sound was heard where the heart was closely hugged by the pericardial sac, not in its lower part where the motion was at its maximum. There were cases of dry pericarditis, just as there were cases of dry pleurisy. There were cases with fibrin thrown out and cases with serous effusion and with purulent degeneration or purulency of that fluid, *ab anitio;* and a fourth form, the tubercular. This case, of course, was limited to the first.

3. Why did the woman die? Was it the pericarditis that killed her or something else? It was to be remembered that she was a weakly woman and there was an associated bronchitis. The best explanation that has been given in such cases of the cause of death is given by Bland Sutton. The cases where he (the speaker) had opportunity to examine the bodies after death bore out the statement. Where pericarditis does cause death it was not from the pericarditis but from the associated myocarditis not made out during life by physical examination so much as by the presence of dyspnœa. In the case

the breathing did not fall below fifty; it even exceeded that number even after the temperature and the pulse were hardly above normal. The marked dyspnœa was due to the extension of the inflammation along the fibrous tissue extending from the pericardium itself into the structure of the heart. The inflammation extends along the fibrous structures of the left heart, and in this way the nutrition of the heart is interfered with. In every case where death has followed pericarditis the left heart has been found to be soft and flabby. Heart failure followed as a direct result, not from an inflammation of the covering but of the walls. He did not know that it was necessary to speak of the treatment. The anti-rheumatic treatment was often resorted to as rheumatism was so often an associated condition. Statistics proved that the least perturbating treatment produced the best results. He had had one other case in which the diagnosis was very difficult. It belonged to that class of cases with which there is associated a limited amount of pleurisy, in which there is present at the time, or subsequently developed a dry pleuritic friction sound limited to about the area where the pericardial friction sound would be heard. He did not think anyone, no matter how expert, could make a diagnosis from physical examination alone. A study of subsequent events was necessary to clear up the uncertainty that might be present.

Dr. C. A. Temple—I would like to ask Dr. Powell if there was any lessening in the quantity of the urine.

Dr. Anderson—I would like to ask Dr. Powell about what time the dyspnœa appeared. The pericarditis might have been due to some toxic element in the blood, and that same toxic element might have affected the heart muscle which would be the cause of the dyspnœa. But from the acuteness of the symptoms I would be of the opinion that the inflammation of the heart muscle was rather due to an extension of the pericardial inflammation.

Dr. Powell—In answer to Dr. Temple, I might say there was a notable diminution in the quantity of the urine, particularly in the latter days of life. Coincident with the development of the inflammation there was increased rapidity in the breathing and accompanying pain. But after the pain was relieved and the temperature had fallen, and the pulse rate decreased, the dyspnœa still continued. The rapidity of the breathing was noticeable even when the patient was resting quietly and sleeping.

Dr. MacFarlane asked Dr. Anderson what form of toxic agent he considered the affection of the heart might be due to.

Dr. Anderson said that it might be due secondary to Bright's Disease, or as Dr. Powell had said, due to the poison of la grippe.

The dyspnœa might be accounted for by the action of the poison on the nerve mechanism of the heart.

A Case of Pericarditis.—Dr. C. A. TEMPLE then read a paper, "The History of a Case of Pericarditis."

Dr. GREIG—There are one or two points in Dr. Temple's paper that call for remark. I could not help noticing the high temperature present; I think it was unusually high—104°. Under such circumstances one would expect to find pus. However, I suppose that can be ruled out, because in children, if the nervous element is present, the temperature rises from slight causes. But in older persons, with a temperature of 104°, I would strongly suspect pus. I had a case of pericarditis with effusion two years ago which was secondary to an attack of sub-acute rheumatism, which was very well marked. The diagnosis of pericarditis was not difficult. There was a to-and-fro friction rub on the left side of the sternum. The effusion was excessive, causing dulness on the left side. If I had not heard the friction rub I would have suspected pleurisy. The case did well and finally recovered. The treatment I followed was the administration of the salicylate of soda, but I found that it inclined to depress the patient. The salicylates have a well-known tendency to deteriorate the blood. The patient was losing ground. As soon as I noticed this I put the patient on iron, arsenic, and cod liver oil, and stimulants. As soon as the effect of these began to show itself recovery was rapid. During convalescence the girl was indiscrete, going out and getting her feet wet. A relapse followed. She was sent to the hospital. I heard no more about the case.

Dr. POWELL asked Dr. Greig a question—If, at the base of the heart, the friction rub having been heard in the early stage, and the effusion subsequently becoming very large, he found it to be the case that the friction sound persisted throughout the existence of the effusion? Dr. Powell said that he had noticed in the last edition of "Quain's Dictionary" the statement that when once heard in this location it did not disappear, no matter how much the effusion. He did not know of any other author who made the statement so positively. With regard to the iron used in these cases it seemed to him that there were two forms especially useful. One was used largely by Loomis. He (Loomis) said it was nonsense, qualifying it with an expletive that he (the speaker) would not reproduce, but which was very emphatic, to give the syrup of the iodide of iron in any less quantity than a dram every three hours. Thus kept up it produced rapid absorption. It should be given largely diluted. The other form was the ferri-salicylic acid mixture, advised

by Cohen, of Philadelphia. This combination was rather hard to make. But it was the only combination of these two drugs according to Rice, one of the revisers of the Pharmacopœia, that could be given together.

Dr. GREIG said that the friction rub did disappear during the effusion. It reappeared during the process of absorption. It was heard during the latter stages as distinctly as at first.

Dr. FOTHERINGHAM said in the last case he had the double rub was heard until the patient had almost recovered. It was heard about half-way between the base and apex, at the left of the sternum.

Dr. TEMPLE said in his case he was a little puzzled about the diagnosis at first, as the patient had slept with the one that had died from diphtheria four or five days previously. He was not sure whether the pericarditis was due to the diphtheria or the rheumatism. He gave salicylate of soda to relieve the pain, and when this was relieved, administered the iodide of iron.

Dr. MACFARLANE asked Dr. Temple if there were symptoms of rheumatic trouble.

Dr. TEMPLE replied that the only symptom was pain in the knee-joint, but there was no swelling or local heat.

Cystitis or Stone in the Bladder.—Dr. GREIG then detailed the history of a peculiar bladder case in a boy. He said: "I have not a paper for you, but I think I can give you the points in the case as well without as with one. The case to me is rather interesting, and a little out of the usual line of such cases. About a month ago, a lady brought to my office a boy, complaining that there was a large amount of deposit in his urine on standing for some time. He passed a sample for me, and it was very muddy in color, thick, and very suggestive of pus. The reaction was intensely alkaline. The specific gravity was 1012. On filtering and making the reaction acid, I could not detect any albumen, nor did it give the chemical reaction for pus by the liquor potassa test. However, I could see pus cells under the microscope. There were no casts. The boy was aged 12, not very robust, but appeared to be in good health. He went to school regularly, and was always ready for his meals. There was no constitutional diathesis as far as I could make out. There was no tubercular history on either side. The peculiar feature of the case was that there was no frequency of micturition nor increase in the quantity of urine passed; nor was there any pain. He passed urine four or five times a day. Four years ago, when they were living in Winnipeg, he had symptoms of gravel. He was taken to a surgeon, who sounded him for stone. No stone was discovered. I might say

that on examining the urine under the microscope, there was to be seen a profuse precipitation of triple phosphates, the most extensive display I have ever seen. I sounded for stone three times, but I could not detect any. I have been treating him by washing out the bladder and administering internal remedies. Internally I have given boracic acid and salol, combined with tonics. The effect from this was not very satisfactory. I changed to the benzoates, giving first the benzoate of soda, and afterward the benzoate of ammonia combined with buchu. The effect not being satisfactory, I have been giving a preparation containing benzoic acid, buchu, uva ursa and several other drugs. The drugs I have used for washing out the bladder were, first, boracic acid, 10 grs. to the oz. The effects of that appeared to be nil. It produced no pain. I found that a very large quantity could be injected with no discomfort—as much as twenty ounces—and the bladder was not full then. It appeared to be a very large amount to pass into the bladder, especially in a boy aged 12. I next tried bichloride 1-10000; the result was beneficial in one way. The next visit, the urine was perfectly clear, and the reaction was not so intensely alkaline, but it caused him much pain; he could not sleep that night. I reduced the strength until he could bear it, but when it was diluted this much it seemed to lose its effect. I am now using permanganate of potash 1 gr. to 1 oz. But this, again, produced a great deal of pain. I next used ½ gr. to 1 oz., but this also produced pain. Last night I used ¼ gr. to 1 oz., and while the pain was not so great as before, yet it was considerable. The 1 gr. and the ½ gr. solutions caused a spasmodic action of the bladder. Its force was so great as to raise the fluid almost to the top of the funnel when nearly empty. A spasmodic contraction of the rectum also took place. This was so violent that I was obliged to cease the washing while the boy went to the closet. This case is interesting in a good many ways. You would expect to find stone; and yet stone in children is easily diagnosed. You generally strike the stone immediately on introducing the sound. In this case I have manipulated most carefully, and can get no indication of stone. Nothing can be felt per rectum. The liver is normal. A fair-sized catheter can be passed without difficulty. If the permanganate is not successful in curing the case, I am going to try silver nitrate. However, it is so powerful I am a little afraid to use it.

Dr. MacFarlane (to Dr. Greig)—What did they consult you about first?

Dr. Greig—The deposit in the urine. The boy was suffering no pain. There was no irritation, no frequency of micturition; simply a deposit of phosphates and pus.

Dr. Powell—I would like to ask a question and get Dr. O'Reilly to answer it. I know he has had a good deal of experience. Has anyone any knowledge of the use of creoline as an irrigating fluid for the bladder? I have had some experience with it that makes me think it better than other remedies we have been using for this purpose. For example, in two recent cases of empyema I have used it after using saturated solutions of boracic acid. The pus discharged was extremely offensive, and continued so, notwithstanding the use of boracic acid. The first injection of creoline, 1-120, wiped away the odor completely, and it did not return. The case went on to recovery sooner than any I had seen before. Eight ounces of creoline by mistake have been swallowed, and recovery followed. I suppose we have all used it in intra-uterine irrigation. Prof. Shuttleworth has made experiment with regard to its efficiency as a germicide and antiseptic. He finds it one and a half times stronger than carbolic acid in similar strengths—(quoting from memory). If its efficacy be greater than that of carbolic acid, and it be non-poisonous, it should be a proper fluid for irrigating the bladder. I have used for bladder irrigation silver nitrate solutions. I am not surprised at 1-500 permanganate solution causing pain. My experience is that 1-1000 or 2000 solutions are sufficiently strong, and should then be increased gradually.

Dr. O'Reilly being called on, said that he did not hear the paper, but was interested in the subject, as very many cases came under his observation at the hospital.

Dr. Macdonald said the case was one in which a person would naturally look for stone as the cause of the trouble. The urine was apparently the urine of irritation, but it appeared on careful sounding that no stone was present. Even that did not exclude the possibility of stone being present. It might be there and be sacculated. It might be lodged in a pouch that was partly pervious and yet miss sound. There was one point that he had heard Dr. Greig refer to, and that was there was an amount of residual urine. It had likely disappeared since the washing had been carried out. If there was a want of tone in the bladder and residual urine was present, the case would resemble one of advanced prostatic disease. The question, however, was practically one of treatment, and Dr. Greig had certainly treated the case in a way that he (the speaker) would approve—by washing out the bladder with antiseptics. He had not yet tried turpentine. As this had the effect of changing the odor to that of violets, he thought it was worth trying. He did not know the manner Dr. Greig had followed, but some were in the habit of injecting small injections slowly. His plan was to allow large amounts to flow in freely. He

used the ordinary fountain syringe, with "Y" in the main tube leading to two branches, the one being clamped while the bladder was filled, then released, and the other one clamped while the bladder was emptying. (Dr. Macdonald here produced the apparatus for inspection.) At the end was an ordinary soft catheter. For women he used a glass catheter, and found it very satisfactory. He commonly used much weaker solution of the permanganate and the bichloride than Dr. Greig had used. The bichloride was apt to produce considerable pain. A large injection would wash out the folds better than a small one. As to frequency he would wash out two or three times a day at least. If this treatment did not effect a cure the best thing would be cystotomy and drainage. It was easy to cut a hole in the bladder and drain; but such cases were not invariably successful, so he considered it wise to persevere with the washing out and the general systemic treatment for a considerable time before resorting to operation.

Dr. MacFarlane said that he had listened with a great deal of interest to the report of the case. From what had been said, he could not see that the symptoms were those of cystitis, as there were no subjective symptoms. There was no frequency of micturition, no increase in the quantity of urine, and no constitutional effects of the disease. In his experience, cystitis acted entirely differently, whether from stone, tubercle, or from whatever cause. Frequency of micturition was invariable. There was also a certain amount of restlessness on the part of the patient, especially at night; and then there were constitutional disturbances. The washing-out with strong escharotics would do more harm than good, whether permanganate, bichloride, or silver nitrate. He did not think it wise to throw them into the bladder where there were no other symptoms than the presence of pus.

Dr. O'Reilly asked if Dr. Greig had used Skene's mixture, containing benzoic acid and carbonate of potash, internally.

Dr. Greig said that he had used benzoic acid and buchu. He had found a number of drugs that would purify the urine, but when he ceased using them the urine would again become foul.

Dr. Cook suggested that there might be some trouble in the pelvis of the kidney. He asked if there were any symptoms referable to the kidneys. He spoke of administering the turpentine by inhalation. This was useful in the case of children. Half an ounce to two ounces might be used in this way during twenty-four hours.

Dr. Fotheringham asked if any of the Fellows had tried oxalic acid in small doses for these bladder cases. He had seen it act promptly in one or two cases. He had seen no rational explanation of its use.

Dr. MacFarlane asked if there was any phimosis present.

Dr. Greig replied that there was some adherence of the prepuce, but not enough to account for symptoms. The authorities stated that stone in children was easily recognized. There was one peculiar point, and that was, on the sound entering the bladder it always had a tendency to fall to the left side. He was not able to bring it to the right side at all. He did not know if that indicated any malformation of the bladder, but it suggested it. He had not tried oxalic acid. He had thought of trying creoline, but as he had never heard of its being used he did not like to initiate the treatment. In regard to Dr. Macdonald's plan, he thought there was danger of too much force being brought to bear on the walls of the bladder.

Dr. Macdonald said that by raising or lowering the bag any degree of force could be obtained.

Dr. Greig continuing said that he followed Skene's method of washing out the bladder. He stated that in this case he could not use a large catheter, so that irrigation was necessarily slow. He pointed out that the amount of residual urine amounted to about two ounces, which he withdrew with the catheter. He had asked the patient to pass his water while on the hands and knees so that the bladder would be more completely emptied. As the urine was alkaline he thought there was no kidney trouble, unless the acidity of the pyelitis was hidden by the alkalinity caused by the cystitis.

Dr. Trow then read the report of a case of a foreign body in the œsophagus. (See page 124.)

Dr. Powell related the history of a case of which he heard, in which a fish-hook had been swallowed. A boy upon his return home from a fishing expedition found his grandmother asleep with her mouth open. The temptation being great he dropped his baited hook into the old lady's mouth. Awaking with a start and a swallow, down went the hook with the line attached. A young physician who had just settled in the place was hastily summoned. He asked the boy for another of his hooks, took a bullet from his pocket, made a hole throught it so that it would fit over the hook. Then he threaded it on the line and with a catheter pushed it down, so that it slid over the hook in the stomach, which was then withdrawn without injury to the walls of the stomach or œsophagus. [We have not yet received a statutory declaration under the Canada Evidence Act of '93 bearing upon this case.—Ed.]

Dr. Bingham presented a double-headed monster which he had recently delivered.

Editorials.

The Patrons and Medical Education.

The Review extends its congratulations to the College of Physicians on the overwhelming defeat of the iniquitous Patron Medical Bill. Of course there are wiseacres who say, "I told you so" We happen, however, to be in a position to know that had not a vigorous course been pursued, which this journal inaugurated with the assistance of Dr. Ryerson, amendments of a more or less objectionable character would have been enacted, and the precedent established that every Tom, Dick or Harry can amend the Act at any time, if he has a sufficient political pull. To Sir Oliver Mowat's eternal credit, be it said that he stood up manfully for our rights, and delivered a most effective and able speech in favor of the medical profession. He was ably seconded by Mr. Whitney, of the Opposition. The latter was particularly facetious, alluding to the "squad of adventurers" who had invaded the House, and who proposed to reorganize the medical, legal and clerical professions. The end is not yet. In spite of the tremendous majority against the bill—71 to 15—these bucolic buccaneers have given notice of another bill. The object of this new attack is said to be political. It is intended to reduce the registration fee to $50. The remote object of this move is to capture the medical student vote in the Province. It is hoped that this bill may meet the same fate as its predecessor. The profession, through the Council, is quite able to determine what shall be the fee for examination.

The Honorable Dr. Baxter's Re-election.

Congratulations are the order of the day, and in each instance the subject of congratulation is the defeat of the Patrons. In the late general elections, the members of our profession were especially singled out for vindictive and venomous attacks, chiefly of a personal character, and relating to charges for professional services rendered. Drs. Willoughby, McKay (Oxford), McKay (Victoria), and Preston succeeded in defeating their opponent Patrons, but Drs. Barr and Baxter were not so fortunate. Patron Senn, who opposed Dr. Baxter, was unseated by the Courts, and on the bye-election Dr. Baxter was returned by a triumphant majority, who took this very effective way of testifying to his worth and to their detestation of the tactics of his opponent and his friends. Dr. Baxter is especially held

in esteem in the House on account of his kindly and genial nature, and because he is the "father of the House," being the only member who is now in the House who was elected at Confederation. He has been Speaker of the Assembly. The honorable and worthy doctor has our hearty congratulations.

The Ludicrous Excess of Physicians.

It is an easy matter for a young man to say to himself, "I am going to study medicine." Having formed this resolve, it becomes a more difficult question to find the means needed for a long and expensive sojourn at college. What with loss of time, clothes, books, board, etc., the expense may safely be set down at $3,000 as the price of the piece of parchment on which a few Latin words are printed and a large red seal stamped. But the question, "Where am I going to practise?" is the hardest of all. Every city is full to overflowing; the towns have two doctors for one that is really needed. Some time ago Dr. Lauder Brunton stated that the average income of medical men in Great Britain had greatly decreased. It is certainly so in this country and in the United States. In some American journals it has been shown that the incomes of medical men have decreased at least fifty per cent. The London *Lancet* pointed this fact out very forcibly, and drew attention that many who graduated in medicine disappeared from practice, showing that their professional work had been a failure. It is an actual fact that in many cities in Europe and the United States, the incomes of the majority of the doctors are not better than those of the ordinary mechanic. When the profession of medicine ceases to bring in a fair income, it will soon cease to bring dignity to its members. When the competition becomes excessive the fees will be cut down, in the hope that cheap attendance may bring some patients to the office. Doctors will be forced—as in many large cities they are now forced—to do other things to increase their incomes. From all sources the same cry comes forth that the profession is fearfully overcrowded. The notion that there is plenty of room at the top is too visionary for everyday life. Of the thousands who graduate every spring, only a few, a very odd one, attains to eminence or affluence, and then only after a life of the most arduous devotion to his duties. What a writer in the *Medical News* says of the United States is, we believe, equally applicable to Canada. We have a perfectly ludicrous excess of physicians half starving and competing with others all over the land. While France finds one

doctor enough to two thousand of the people, Germany, the home of scientific medicine, finds the proper proportion one to three thousand, and Sweden one to seven thousand, we, in our suicidal intoxication, run the proportion up to one to six hundred.

Syphilis and the Nervous System.

It is well known that this disease is the cause of some very important affections of the nervous system. These affections do not often happen before six months have elapsed, and are not at all so likely when the disease has been well treated in its early period.

Syphilis must, according to Gowers, be regarded as an organismal disease. Some of the effects of this disease on the nervous system must be regarded as the result of a chemical agent produced by the organism of the disease. This poison acts on nerve elements in same way as the poison of the diphtheria organism. This poison appears to possess the power of causing degeneration.

Then syphilis may give rise to inflammatory troubles, such as meningitis, neuritis and myelitis.

Another form of disease in the nervous system from syphilis is the gumma. This peculiar tissue is the result of syphilitic action.

When syphilis affects the arteries, it is almost always the larger cerebral ones that are involved.

In many cases the iodides cease to exert a beneficial influence, and mercury controls the disease, causing many of the nervous symptoms to disappear.

Ontario Medical Association.

The meeting of the above Association is announced for June 5th and 6th. The programme of papers will contain the names of distinguished visitors as well as those of eminent men from our own province. It is hoped that much valuable work will be done, and that the papers presented may be full of scientific interest. This is expected from men whose medical training has been so thorough.

We would suggest that every man who has a case in practice of interest—and who has not?—should report it at the meeting. To many men this society is the only one to which they can belong, and its privileges should be taken advantage of.

The profession in Toronto have borne a name for hospitality and cordiality, and we can assure our outside confreres that a visit to the

Queen City in the balmy month of June will prove a delightful holiday as well as a season of practical helpfulness. Let the membership of eight hundred swell to a thousand.

Re Patent Medicines.

A BILL has been introduced into the New York State Legislature, giving the Board of Health power to regulate the sale of patent medicines. Such measures are to be commended. If our Patron friends in Ontario would turn some of their energies in a similar direction, much good might result.

If our people were made aware that many of the nostrums sold as patent medicines are made up of inexpensive and sometimes harmful compounds, they would not feel like paying large prices.

If the formulæ were printed clearly upon the labels, it would go a long way in the direction of educating the people towards self-protection. It is true that the manufacturers might not make such large profits, but the people would be the gainers.

Militia Medical Service.

WE desire to extend our congratulations to Dr. Ryerson on his promotion to be Assistant Surgeon-General, and while doing so we express the opinion of the majority of the profession, that the evidence thus given of a desire to reconstruct the Militia Medical Service meets with approval. Appointments of a similar character will, it is believed, be made in other provinces. The principle of selection—not in the strict line of seniority—is one which has of late been in vogue in the British army. It has also been the rule in the Canadian Militia. No more common example can be found than the appointment of gentlemen as medical and combatant officers of superior grade without previous service. We trust that the struggle for a better militia medical service has now passed its crisis, and that better times have come.

Alcohol in the Manufacture of Drugs.

SOME time ago the well-known house of Parke, Davis & Co. applied to the Excise Department for the privilege of importing alcohol in bond for the manufacture of pharmaceutical preparations. They claim that they can buy and import in bond a pure alcohol cheaper than they can obtain the same grade in Canada. This was taken

by some to mean that the firm wished to import a "low grade" alcohol for their house. This is entirely false. All that was sought by this firm was the right to import in bond the best quality of alcohol, as they can do so to the advantage of all concerned. The firm has been fully vindicated in this matter. What was sought was a legitimate business transaction, and it was granted. This house has no proprietary interest in any patent medicine, nor does it advertise or sell any of its products to the public. It confines its operations entirely to the medical profession, which it reaches through the usual channels of the wholesale drug trade and retail pharmacists.

Immunity Conferred by an Attack of Infectious Disease.

To no one class of men does this weighty subject more strictly demand attention than the general practitioner. How many physicians in general practice have had their diagnoses questioned, and have felt that possibly they are mistaken when told that scarlet fever, or diphtheria, or typhoid fever is impossible as the patient has had it before?

Should one look back but a few years he will find in fact that such an idea was not only prevalent, but the mass of authority claimed it to be incontrovertible. Mr. John Simon wrote as late as 1882 ("Quain's Dictionary of Medicine") on contagion: "There is the extremely suggestive fact with regard to our best known febrilizing contagia, that they run a course of definite duration, and that in this course, provided the patient do not die, all present, perhaps all future, susceptibility to the particular contagium is utterly exhausted from the patient, so that reintroduction of the same contagium will no more renew that patient's disease than yeast will excite a new alcoholic fermentation in any previously well-fermented bread or wine."

Again, in looking over the hand-books on pediatrics we find no mention of a secondary attack, or simply mentioned in the most casual matter, "Keating's Cyclopædia" being an exception. In the articles on the various contagious diseases, attention is more markedly called to second or third attacks.

How long the immunity from a second attack lasts is not at all clear, it simply at the present time being a matter of speculation. This question will possibly be answered when the effects of the various antitoxines in use are clinically better understood and data more reliably tabulated.

Nearly every practitioner of some years' experience has had cases of, say, scarlet fever, typhoid, etc., recurring in the same individual. Small-pox also has in our own experience attacked two patients twice. A case of syphilis has come under our care in which the true Hunterian chancre developed with the regular phenomena of secondary and tertiary symptoms, exactly as had occurred in this patient ten years previously.

The following extremely interesting abstract from the *Boston Medical and Surgical Journal*, commends itself as forcibly illustrative of this important question:

"Maiselis has published important statistics bearing on the subject of the length of the periods of immunity conferred by attacks of infectious disease. This well-known principle, which is the basis principle of the work of Jenner, Pasteur, Koch, Behring, and of all the workers in the field of serum therapeutics, has been misstated by various writers on medicine, some of whom affirm that the survival from one attack of an infectious disease confers life-long immunity. Gregory, for instance, says: 'The immunity against a second attack of an infectious disease is one of the most universal and important principles in pathology. It is applicable not only to variola, measles, etc., but to all diseases which are due to a poisonous influence or miasm.' Samuel says: 'By the survival of a single attack of an infectious disease, immunity is generally conferred for the remainder of life.' The same opinion has been expressed by Hebra, Henoch, Thomas, with regard to the acute exanthemata; by Griesinger, Murchinson, Zuelzer, as to typhoid fever; Audouard, as to Asiatic cholera.

"On account of the great theoretical and practical interest of the question, Maiselis has collected from literature the following authenticated cases of repeated attacks of infectious diseases in the same patient:

"Small-pox.—Two attacks, 526 cases; three attacks, 9; seven attacks, 1; total, 536.

"Scarlet Fever.—Two attacks, 144 cases; three attacks, 7; four attacks, 1; eight attacks, 1; seventeen attacks, 1; total, 154.

"Measles.—Two attacks, 103; three attacks, 3; total, 106.

"Typhoid Fever.—Two attacks, 203 cases; three attacks, 5; four attacks, 1; total, 209.

"Asiatic Cholera.—Two attacks, 29 cases; three attacks, 3; four attacks, 2; total, 34.

"In order to avoid the danger of including cases in which relapse might have been mistaken for a second attack, only those cases have been included in the preceding tables where the interval between the

attacks was sufficiently long to preclude the possibility of the second and third attacks being relapses.

"Considering the fact that all cases of second attacks of infectious disease are not recognized, and that the deeply-rooted belief in immunity among the laity, as well as among physicians, often renders the diagnosis of a second attack difficult to establish, one is led to believe that repeated attacks of infectious diseases may not belong to the rarities in medicine. This consideration also tends to establish the analogy between the immunity conferred by natural and artificial processes. The quantitative principle of immunity suggested by Erlich and systematically elaborated by Behring applies also to the natural processes of immunization.

"It seems probable that so many difficulties would surround an exact determination of the period of immunity conferred by a given attack of infectious disease, that no exact statement of the safety period could be applied to particular cases. If a child is taken with scarlet fever, we have no means of estimating the amount of toxine absorbed, or the length of time the so-called natural antitoxine of the disease is present in effective quantity. The period of immunity conferred by the injection of given quantities of the artificial antitoxine of approximately known strength is a matter of doubt and study; and the estimated length of the period of immunity, as defined by Behring himself, has lately been changed. If the period of immunity is so difficult to compute in a case where we can approximately calculate the amount of antitoxine injected, how much more difficult will it be to calculate that conferred by the absorption of an unknown amount of toxine, and consequent antitoxine production?"

PHENACETINE BAYER.—Dr. J. B. Clausen, of Philadelphia (*Times and Register*, March 9th, 1895), claims that this drug is specially valuable in the following conditions: 1. In scarlet fever he finds phenacetine very useful, especially when there is much rheumatism. It acts promptly and effectively in relieving the acute pains, while at the same time it reduces the fever. 2. In the treatment of rheumatism both acute and chronic, it is very valuable in relieving the pains. It will succeed in many cases where the salicylates and iodides had failed. 3. In spinal meningitis it is of marked use in relieving the severe pains and controlling the fever. It acts as an excellent sedative to the nervous system, and guards the patient against some of the worst and most distressing symptoms. Of all the drugs that reduce fever and relieve pain the author thinks that phenacetine is the least depressant on the heart.

Cancer of Stomach.—In an article on the physiological treatment of cancer of the stomach in the *New York Medical Journal*, March 9, Dr. Keefe holds, in view of the rule that the circulation of a viscus is in direct ratio to the work it does, recommends rest to the stomach by administering foods in liquid form digested in other parts of the alimentary tract. The neoplasm thus will share with the stomach a minimum supply of blood and a consequent slowness of growth.

"Report of a case of septic poisoning, following the use of antitoxine," by Dr. Edward J. Ware, *Medical Record*, March 30th, 1895, is worthy of perusal. The chief points of interest are that there was a peculiar rash thirteen days after injection, and that there was a continuously subnormal temperature for eight days, commencing on the fifteenth day after injection. The child's mother had a deposit on the left tonsil—was injected, the rash appeared in five days, was evanescent, and was unaccompanied by constitutional disturbance.

Dietary in Phthisis.—In consideration of the great importance of sufficiently nourishing the phthisical patient with food of the proper quality, Dr. Loomis, in the *Practitioner*, gives the following dietary: On awakening, eight ounces of equal parts of milk and seltzer, sipped slowly. Breakfast of oatmeal and cracked wheat with a little sugar and abundance of cream, rare steak or loin chop with fat, soft boiled or poached egg, cream toast, half pint of milk, and a small cup of coffee. Early lunch, half pint milk or small tea-cup of squeezed beef juice with stale bread. Mid-day meal, fish, broiled or stewed chicken, scraped meat-ball, stale bread and plenty of butter, baked apples and cream, and two glasses of milk. Afternoon lunch, bottle of koumyss, raw scraped beef sandwich or goblet of milk. Dinner, substantial meat or fish soup, rare roast beef or mutton, game, slice of stale bread, spinach, cauliflower, fresh vegetables in season (sparingly).

Blood Changes in Ether Anæsthesia.—Dr. John Chalmers Da Costa (*Med. News*, 2nd March) concludes that the following changes take place in the blood in ether anæsthesia: 1. There is a diminution in the hæmoglobin of the blood. 2. The red corpuscles and hæmoglobin are especially affected in anæmic cases. 3. The white corpuscles show irregular changes which are not characteristic. 4. Age does not affect the results. 5. Ether pneumonia may be due to the intense cold upon the lungs arising from the ether vapor. 6.

Œdema of the lungs may be due to the ether vapor causing contraction of the capillaries and thus producing venous engorgement. 7. The chilling of the blood stream may be the cause of the nephritis that occurs in some cases of ether inhalation. 8 Prolonged anæsthesia damages the blood seriously, and greatly retards recovery.

Castration for Hypertrophy of the Prostate.—In the *Western Reserve Medical Journal* for March, there appears an editorial on the above caption. It refers to the connection of Dr. J. William White, of Philadelphia, with the introduction of this operation. Experiments on the lower animals show that after castration the prostate gland undergoes rapid degeneration and atrophy. White's first operation was performed in January, 1894. Prior to this, however, the operation had been performed a few times. It has now been done by Ramm, Fremont Smith, Finney, Powell, Mayer, Moullin, Thomas, Ricketts, Swain, Bereskin and others. In some cases where the urine had to be removed for years, and the patients were regarded as hopeless, a speedy improvement took place. The prostate rapidly decreases in size and the urine becomes healthy. Where the use of the catheter has still to be continued, it becomes easy and painless. Those who have done the operation regard it as very successful.

Epiphora.—Dr. G. E. DeSchweinitz (*Philadelphia Polyclinic*, March 2nd) classifies epiphora as follows: 1. When it is caused by refractive error. It is common in persons nearing the presbyopic age. It is also found in astigmatism. In exophoria there is often extreme epiphora. In some of these cases, as soon as near work is begun the eyes fill with tears. In other cases there is a sudden rush of tears, with a sense of relief of pain. The treatment is, correct the error in refraction. 2. The epiphora of intranasal origin. When the nasal mucous membrane is irritated there is often a free flow of tears. This is markedly the case in hay fever and irritable rhinitis. Again, the anterior end of the middle turbinated bone and adjacent mucous membrane may be hypertrophied or displaced, causing obstruction to the nasal duct. Such cases must be treated by relieving the irritability of the mucous membrane and correcting the pressure. 3. There is a form of epiphora of nervous origin. In neurasthenic and hysterical patients this condition of lachrymation is frequent. It is found also in connection with some central nervous disorders, as in locomotor ataxia. 4. The cases of epiphora due to obstruction in the ducts from chronic inflammation.

INFANTILE VACCINATION.—Ernest Hart, in the *British Medical Journal*, refers to the great falling-off in infantile vaccination, and says it is due largely to the absence of a small-pox epidemic and the opposition of the anti-vaccinators. In his advocacy of the efficiency of vaccination he quotes many statistics to show the enormous lessening of the occurrence of this dread disease, and the lessened mortality rates. From the tabular result of the outbreak in '87 and '88 in Sheffield, as regards children under ten, we quote:

Per 1,000 of the number of children in each class:

The attack rate of the vaccinated was	5.00
The attack rate of the unvaccinated was	101.00
The death rate of the vaccinated was	0.09
The death rate of the unvaccinated was	44.00

THE TREATMENT OF INFLUENZA.—Dr. A. F. Plicque (*Med. Presse*, February 6th, 1895) gives thè following as the main features in the treatment of this disease: 1. In the majority of cases good hygiene is sufficient. Hot drinks should be employed, and milk is among the best as it is nutritive and diuretic. 2. As to drugs, antipyretics relieve the pains and restlessness, but often increase the bronchial irritation. Tincture of aconite in frequent doses relieves the fever and the larynx, trachea, bronchial catarrh, but has the disadvantage of rendering the patient restless. Quinine is the favorite remedy with the author. A gentle purgative should be given, and, when there are thoracic complications, manna or castor oil is to be preferred. 3. The nasal and oral congestion may be greatly relieved by the use of some lotion or gargle as boracic acid. 4. For the thoracic catarrh a mixture containing tincture belladonna, tincture of aconite, tincture of drosera, and tincture of myrrh is one of the very best. Daily dry cupping is of much service in these chest complications. Blisters do more harm than good. Tea, coffee and brandy should be employed. When there is much bronchial catarrh an emetic does good, particularly in children. 5. For restlessness and delirium there is no drug so useful as potassium bromide. Chloral may be added to the bromide mixture when there is marked insomnia. Cool compresses to the forehead aid these measures. 6. In adynamia the greatest attention should be paid to the hygiene. Stimulants are of the utmost value. Kola and caffeine are very helpful. Strychnia is useful as a heart tonic. Subcutaneous injections of ether and caffeine may be tried. 7. The gastro-intestinal form should be treated in children from the first with emetics, and in adults with saline purgatives. For diarrhœa,

salol, bismuth salicylate, and naphthol should be used rather than opium. 8. In the convalescence, arsenic, cinchona, coca, kola, and iron are useful.

Insomnia in Surgery.—Dr. George VanSchaick (*New York Medical Journal*) has an article on the above subject. He divides insomnia in surgery into the following classes: 1. The insomnia due to fear of the operation. In some cases the announcement that an operation is necessary causes great excitement. The patients do not sleep. Some hypnotic should be given, and one that does not depress ought to be selected. 2. Insomnia due to some exhausting diseases and long suffering. Before operating it is well to improve the patient's health. This requires a fair amount of sleep. Chloral is a good hypnotic, but too depressing. Trional is the one recommended by the writer. 3. Then there is insomnia due to pain. For this form of sleeplessness there is no remedy to take the place of morphine. It relieves the pain, and sleep results. 4. There is a form of insomnia with restlessness, jactitation, and nervousness following such operations as passing sounds, urethrotomies, etc. For this form trional is very safe and reliable. 5. In alcoholism and *delirium tremens* as a complication of surgical cases, trional is of special value. The dose is from 15 to 30 grs. The lesser dose may be given and repeated in an hour if necessary. It acts promptly. This of course is a great advantage over sulphonal. It does not cause depression, and is not followed by headache. The sleep obtained by trional is very nearly the same as that without the aid of a hypnotic. It does not inhibit the secretions. It is readily absorbed from the stomach or rectum.

Lead Poisoning.—Prof. Wannebroucq (*Med. and. Surg. Reporter*, February 23rd), on lead poisoning, states that in the making of white-lead by the Dutch process there is much dust, which contains carbonate of lead. Lead, when introduced into the system, acts especially on the nervous system in its central as well as peripheric portions. But in *post-mortems* it is found in other portions of the body, as liver, spleen and kidneys. When a person begins working with the lead salts, and is of careless, dirty habits, he notices that his health begins to fail, as shown by loss of appetite, disgust of food, nausea, vomiting, constipation, general weakness and, later, colic. The teeth come to be covered with much tartar, and at the gums there is a blue line, caused by the action of sulphur on the lead. This sulphate penetrates into the mucous membrane and becomes fixed, as a sort of tattooing. A tattooed line is often seen on the lip. With regard to the abdominal

pains, it should be noted that these pains are not found all through the abdomen. Pressure on one part will cause pain, while in another there may be no pain at all. It is also noteworthy that in some cases the pain is in the abdominal muscles, and especially in the recti. The pain, often called colic, is often only a myalgia. The application of mustard or tr. iodi. to the abdomen often relieves the pain, and then the vomiting. The abdomen becomes soft, and usually the bowels move. If they do not move, give a purgative. Two or three sulphur baths will remove the lead in the skin. Sulphurous mineral waters will precipitate the lead in the intestinal canal. For the lead that may be stored in the tissues, good hygiene is the best treatment. The author is inclined to think that iodide of potash does more harm than good. Hypodermics of chloroform are sometimes of greatest value in treating the abdominal myalgia of lead poisoning. The three main points, then, are : 1. Tincture of iodine for the abdominal dermalgia, or pain in the skin. 2. Sinapisms for the myalgia. 3. Sulphur baths and sulphurous water for the removal of the lead from the system.

Items.

Sir Wm. Savory, the well-known surgeon to St. Bartholomew's Hospital, died on March 4th, aged 69 years.

Professor Dujardin-Beaumetz, the distinguished French physician, died at his home in Paris on the 16th of February.

With the March issue of the *American Lancet*, Dr. Leartus Connor ends his editorial work on that paper, and with his retirement its publication is discontinued. The *Lancet* will be greatly missed from our exchange list.

Dr. Alfred Loomis left an estate of $1,000,000. To the Loomis Laboratory he left $25,000, and $10,000 to the New York Academy of Medicine. The hope is expressed that some of our millionaire physicians in Toronto may remember the Ontario Medical Library when making their last will and testament.

Dr. Edward D. Worthington, of Sherbrooke, Que., died on Monday, the 25th of February, in his 75th year. For over fifty years he had been engaged in active practice, and was respected and beloved by the members of the profession in the Eastern townships, where he was best known. It is stated that he was the first surgeon in Canada to perform a capital operation under an anæsthetic.

Mr. J. W. Hulke, F.R.S., the skilled and learned President of the Royal College of Surgeons, died on the 19th of February, as the result of pneumonia, following a cold which he contracted during a night visit to the hospital in response to a call to operate for hernia.

A recent visit to Bellevue House shows that under the auspices of Drs. Temple and Macdonald it has lost nothing of its popularity. During the past month, not only has the work there been heavy, but applications have been received in excess of the power of accommodation.

Dr. D. Hack Tuke, the eminent alienist, died last month in England. Some of the alienists of this country have reason to remember him, for he visited Canada in 1884, and the following year published a work entitled, "The Insane in the United States and Canada." "He had in truth, a loving and gentle spirit, zealous ever for the good of his afflicted brethren; zealous always for the honor of the profession."

Dr. Geo. Wright died at Redlands, Cal., last month. For many years he was a resident of Toronto, and when here enjoyed a large practice and held many positions of trust—chairman of the Public School Board, member of the Public Library Board, physician to Toronto General Hospital, member of the teaching staff of Toronto School of Medicine, etc. Owing to failing health he removed to California in 1888, but unfortunately the change did not materially improve his physical condition, and he died at the age of 57 on the 10th of March.

Book Notices.

A Manual of Bandaging: Adapted for Self-Instruction. By C. Henri Leonard, A.M., M.D., Professor of the Medical and Surgical Diseases of Women, and Clinical Gynæcology in the Detroit College of Medicine. Sixth edition, with 139 engravings. Cloth, octavo, 189 pages. Price, $1.50. The Illustrated Medical Journal Co., Publishers, Detroit, Mich.

This volume is profusely illustrated with cuts, showing bandages applied to all parts of the body. The turns are numbered, and the direction shown by arrows, so that a student can acquire the art without a teacher. It is a book of much interest to the medical student and young practitioner, and even the older medical man will find many new features.

Dose-Book and Manual of Prescription Writing. By E. I. THORNTON, M.D., Ph.G. Philadelphia: W. B. Saunders. Price $1.25.

This is an interesting little work for students, although the Canadian student may not relish the section devoted to the Latin declensions and conjugations after his long pre-matriculation drill in that subject. It is based on the U.S.P. for 1890, and, as a book of reference by the busy practitioner to the later official and officinal preparations and the best methods of their administration, it will be useful and convenient. The typographical portion of the work will commend itself to the eye of the reader.

Suggestive Therapeutics in Psychopathia Sexualis; with Especial Reference to Contrary Sexual Instinct. By Dr. A. VON SCHRENCK-NOTZING (Munich, Germany). Authorized translation from the German by CHARLES GILBERT CHADDOCK, M.D., Professor of Diseases of the Nervous System, Marion-Sims College of Medicine, St. Louis; member of the American Medico-Psychological Association; Attending Neurologist to the Rebekah Hospital, St. Louis, Mo., etc., etc. One volume, royal octavo, 325 pages. Extra cloth, $2.50 net; sheep, $3.50 net. Sold only by subscription to the medical profession exclusively. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

This work, as Cæsar said of Gaul, *divisa est in tres partes.* The first part deals with sexual hyperæsthesia, the second with sexual impotence and anæsthesia, and the third with sexual paræsthesia. Under each of these headings there is much useful information. Some of the historical portions are particularly good, such as those treating of boy love, satyriasis, nymphomania, etc. The treatment employed in sexual perversions by the author is suggestive. To those who cannot make use of suggestive therapeutics, the book loses much of its interest. Apart from treatment, however, there is much in the book to interest the reader on pathology, history, habits, etc., of these cases. The publishers have certainly made a handsome book.

THE Buffalo *Medical and Surgical Journal,* which was founded by the late Dr. Austin Flint, will be fifty years old in a few weeks. Its semi-centennial anniversary will be signalized by increasing its reading pages from 64 to 80. There are very few medical journals that have reached this age, but this journal will never grow old or out-of-date with Dr. W. W. Potter in the editorial chair. We extend our congratulations and best wishes for its continued prosperity.

Correspondence

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

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—With respect to the alleged animus of our attack and bitterness of our letters, allow me to say that our critics, perhaps, wilfully or otherwise, mistake mere vigor and earnestness for violence and rancor. Personally, I am not conscious of having, throughout the controversy, penned anything in a spirit of bitterness or with malicious intent, and I am quite sure the same can be said of my associates. Once it became patent that an attack on the late Council was inevitable, it necessarily had to be made a strong attack. Determined men do not attempt to remove a mountain by blowing thistle-down at it, or to break up a long-established system of legalized injustice, by being mealy-mouthed, or carefully young-ladyish, in the choice of the language they employ in its exposure. Whether we should have made our strychnine more palatable, or increased its tonicity, by administering it in syrup is open to question. We can look back with great satisfaction on the fact that our modes of warfare, if ungentle, were in no case dishonorable. If there was hard hitting, on the part of the Defence Association, it was, at all events, hitting straight from the shoulder. There was, on our part, at least, no striking below the belt, no stabbing beneath the fifth rib, no descent into the regions of epistolary blackguardism, no resort to the coward's chosen methods of innuendo, anonymity, moral attenuations, and personal vilification. We neither invoked nor accepted the assistance of professional outcasts. We, in no case, forgot the amenities of public debate, or violated the decencies of reputable journalism, or subjected any newspaper or periodical that published our letters, to the stinging suggestion that, before being issued, it ought to be thoroughly disinfected and deodorized by the Board of Health, or, failing this, should be carefully lifted with a pair of tongs out of the post-office into the stove. We severely left to our opponents a rigid monopoly of these and all kindred methods of being *strong*. We confined our criticism to the public acts of public men, carefully avoided misrepresentation and vituperation, and kept to established facts and hard-fisted arguments. That our articles were vigorous and forceful, we are glad to believe, especially in view of the fact that those of our adversaries were strong only in the sense already referred to. When, as now and then chanced, we found an official editor or an ex-president flaunting his nakedness in our face and, shamelessly,

rioting, *sans culotte*, in trickery, double-dealing and untruthfulness, we did not hesitate to give him the cobbing he seemed to invite, and, to make it more effective, we occasionally, I confess, dipped the shingle, before applying it, in a weak decoction of sarcasm. But even then, sir, we only mildly satirized offenders who richly deserved to have been severely lampooned—we did but gently fret the cuticle which we ought, in strict justice, to have excoriated or scorched. And yet, so violently do even an honest man's sympathies and associations warp his judgment and bias his sense of fair play, that, notwithstanding our careful avoidance of all that is low and reprehensible in controversy, the able and ordinarily just editor of one of our best medical periodicals ventures, in a recent article, to class us with our opponents, and professes to regard our methods as being no very great improvement on the questionable tactics pursued by them! From such a partial judgment we confidently appeal to the intelligence of the great body of our unprejudiced fellow-practitioners, who have probably perused the literature on both sides with a less jaundiced eye.

My own letters have especially offended our critics by their number and their length, and by their faults of style. My position as secretary of our association has naturally, in a large measure, imposed upon me the onus of correspondence, and I have not grudgingly devoted myself to it. I would gladly have made my published letters fewer and shorter had my opponents left me any option in the matter. In all serious public controversy, charges that are explicitly made, and facts and arguments that are distinctly set forth, are either frankly admitted or categorically refuted. Our adversaries, however, in this dispute, did neither the one thing nor the other. They adopted the unusual and somewhat fatuous course of pooh-poohing our whole indictment, and then trying to pose, before the medical electorate, as having triumphantly disproved every count thereof. This unworthy procedure compelled us, more than once, to repeat the entire arraignment, and to insist that our charges should be squarely met, or judgment suffered to go by default. Hence our long letters and a good deal of iteration and repetition. But, while freely admitting that my letters were long and frequent—necessarily so from my point of view, and that my style is by no means free from serious blemishes, I claim that it must be a matter of opinion whether it is justly open to the charge of verbosity. I may be permitted to point out that even a very short letter may be prolix to tediousness, while, on the other hand, a very long one may be sententious almost to laconism. I greatly admire a nervous, pithy and racy style of composition, and I have, in my humble way, earnestly striven to attain to it. If, as charged, I have been diffuse where I

sought to be terse, it is my misfortune, and would seem to indicate that my long-unused pen hath lost whatever of cunning it may have been once thought to possess. If such be the deliberate verdict of my confreres, I might plead in extenuation, the very unfavorable conditions in which these letters of mine were penned. A private correspondence with the medical electorate involving, during the last three years, written replies to nearly three thousand letters and post-cards, and an official connection which led to some twenty-five visits to Toronto, each causing one or two days' absence from home, superadded to the professional claims of a country practice, have left, at my disposal, but little time to devote to the mere graces of epistolary composition, and may be held to excuse the shortcomings and faults to be found in my press correspondence. My whole claim is that I have written with honest intent, without malice, and with the single desire to elevate the status and to advance the best interests of the medical profession in Ontario.

Yours, etc.,

JOHN H. SANGSTER.

Port Perry, March 11th, 1895.

To Blow or Wash.

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—Having been afflicted with the pervading epidemic la grippe in the form of a persistent influenza for four weeks, using all kinds of sprays locally and medicaments of all sorts internally; feeling as miserable as a man could feel; taste gone, even had I appetite to eat, which I had not; one ear entirely deaf from inflammation of Eustachian tube; stock of handkerchiefs nearly used up from constant use; nose very sore from constant blowing, the supply seemingly as inexhaustible as the widow's cruse, a lucky hit brought to my notice the enclosed short article from the *British Medical Journal.* I did not use plain water, but very hot, in which I put sufficient boracic acid to make the strength 1 to 40. The relief experienced was almost immediate, hearing returned in the deaf ear inside three hours. The widow's cruse began to give signs of bankruptcy in about four hours, and the sense of smell and taste returned next day. I used this method every hour for six hours, and next day every two hours. This is, of course, but an isolated case and, there-

fore, not at all positive, but the article itself is well worth everyone's perusal and digestion, and I think the simple remedy deserves a trial.

MEDICO.

"TO BLOW OR WASH?

"In these days of warfare against dirt, why don't we wash our noses? Surely they get quite as dirty as our teeth, which we brush so laboriously every day. The civilized nose is, in fact, one of the dirtiest organs of the body; for, so long as civilization, which mostly means crowding, involves the breathing of dirty air, the nose, which is the organ by which the air receives its first preliminary purification, must become loaded with all sorts of nastiness. The man with a cold, who is always sneezing and slobbering with a handkerchief, is not a pleasant companion; but, for all that, by dint of much "running," his nose at least is washed, and is cleaner within than that of the fine lady who has trained herself never to use the highly-decorated little bit of lace which she carries about and calls a handkerchief; for in that nose condense and accumulate the soot, the dust and microbes of our far from cleanly cities. People who suffer from nose diseases have, of course, to apply various lotions, the efficacious part of many of which is the water they contain, and this they commonly do either by placing the fluid in the palm of the hand and snuffing it up—a process which only draws it through the more open lower passages of the nose; or by means of a nasal douche or syringe, a process somewhat more effectual, but also more irksome. The simple plan is to plunge the face into a basin of clean water, cold or tepid, and take slight snuffs, in and out, while under water. By practice it will be found that before the face has to be withdrawn for breath, water can be drawn in and out of the nose several times, filling and emptying the nasal cavities every time, without using any force, and without drawing the water into the throat or causing any choking. The state of the water after the performance indicates the necessity for this little operation."—*British Medical Journal.*

Miscellaneous.

THERE are many preparations offered the profession for treatment of dyspepsia—some good, and some of little benefit. Of the former variety, Lactopeptine admittedly stands at the head, and we have recently made trial, with most satisfactory results, of this preparation in its new form—Lactopeptine tablets. The formula, as is well known to the profession, comprises a perfect simulation of all the ferments necessary to perfect assimilation, and in the tablet form preparation, can be carried in the pocket of the patient, and used at such intervals as his physician may direct. They are very neatly put up, and can be secured through any druggist.

ANTISEPTIC LAVAGE OF THE STOMACH.—

℞. Sodæ biboratæ ..... ℥ij.
Creolini ..... gr. iv.
Acid. salicylici ..... gr. xviij.
Thymolis .....gr. iv.

M. Use with a syphon tube after clear water lavage once a day.—*Rosenheim.*

Dr. ROBERT H. BABCOCK, of Chicago, has been using Maltine with Coca Wine, and says he is convinced of its great service when it is desirable to check undue tissue waste, or to enable a patient for a time to endure unusual demands upon his strength. He recently prescribed it for a female patient with tubercular induration of one apex. The tendency was to fibroid transformation rather than caseation, but for some reason she had come to a standstill, and his efforts to improve her condition seemed futile. Her chief complaint was a feeling of weakness. After using Maltine with Coca Wine for a week, she reported herself as feeling better and certainly appeared stronger and more cheerful. She continued the preparation for a month, and the decided improvement in her condition dates from that time. Malto-Yerbine is, in his opinion, a good stimulating expectorant, and in one case of broncho-pneumonia contributed much to the patient's recovery. He says it seems to be a good vehicle for the administration of other expectorants in the case of children, and it has been occasionally so employed by him.—*Maryland Medical Journal.*

THE

Canadian Medical Review.

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Original Communications.

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

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

Fellow of the American Gynæcological Society, Gynæcologist to the Montreal Dispensary, and Surgeon to the Women's Hospital, Montreal.

IN compliance with the request of our Secretary to read a paper at this meeting, I have taken the opportunity to contribute my mite towards the general stock of knowledge rather than read a compilation merely of all that has been written on this subject. I shall, therefore, give the conclusions to which I have been led from my own experience, comparatively limited though that experience must necessarily have been. I shall not attempt to touch to any extent upon the causation or prevention or the prognosis of these diseases, for the discussion of the treatment of them will alone be enough to fully occupy all the allotted time.

I will, however, endeavor to carefully review the different methods of treating the various diseases of the uterine appendages and to give

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

to each method its due share of importance and praise, according to the results which it has given in my hands.

From the point of view of treatment, diseases of the uterine appendages may be divided into organic and functional ; for in the former the most satisfactory treatment is generally surgical, while in the latter medicine and hygiene will usually effect a cure.

Let us then take in turn the principal organic diseases, first, of the Fallopian tubes, and, second, of the ovaries.

By far the most serious disease of the tubes is tubal pregnancy, a condition by no means so rare as was at one time supposed. There is only one treatment for it, and that is removal. The various methods so far employed other than extirpation are so uncertain and so much less safe than the treatment which removes the whole disease in a few minutes that we hardly need to mention them, while on the other hand total removal of the tube is one of the simplest and safest of abdominal operations.

A few years ago a woman called at my office one afternoon about five o'clock to consult me for pain in her side which she had had for several months. I had left that afternoon at 4 p.m. for Philadelphia, to spend a month with Dr. Joseph Price. She was disappointed at my absence, but went home and proceeded to finish her ironing, when at six o'clock she suddenly fell unconscious to the floor. At eleven o'clock that night she was dead. The *post-mortem* revealed the abdomen full of blood, coming from a ruptured tubal pregnancy.*

A year ago, a former pupil called me to a consultation on the case of a woman who had a pain in her side. A lump was felt, and the history of the case pointing that way, tubal pregnancy was diagnosed. Next day, my young friend, with my assistance, removed a tube which had ruptured into the broad ligament, and the patient forthwith made a rapid recovery.†

The general practitioner who is watchful enough to discover a case of tubal pregnancy deserves far more credit than the specialist who operates and saves the patient's life. And yet the diagnosis is not so very difficult ; the pain in the side, the signs of pregnancy following a long period of sterility, the mass the size of a walnut or even as large as a small orange filling one side of the pelvis and pushing the uterus to the other side, all point to tubal pregnancy before rupture ; while the sudden shock of hæmorrhage into the abdomen or the more gradual symptoms following bleeding into the broad ligament point

* "Transactions, Medico-Chirurgical Society of Montreal," Vol. IV., p. 308.

† "Transactions, Medico-Chirurgical Society of Montreal," Vol. VI., p. 100.

to rupture of a tubal pregnancy. If a lump can be felt, its removal is absolutely necessary in any case; while if on removal it proves to be an unruptured tubal pregnancy, the physicians deserve the gratitude of the patient for saving her from either sudden death from hæmorrhage on the one hand, or from slow death by suppuration, if on the other hand the case goes on to full time. The condition, however, by far the most common for which I have opened the abdomen is that of pus tubes or tubo-ovarian abscess. Would that we had back to-day in the light of our present knowledge the thousands of women who have gone to their graves from and with this disease unrecognized, but labelled on their death certificates with such causes of death as diarrhœa, dysentery, consumption of the bowels, inflammation of the bowels and decline. A young and healthy woman marries an apparently healthy man who has sown his wild oats and wants to settle down. She receives as her marriage portion, and on her wedding night, a gonorrhœal infection, followed by some pain and burning and frequency of micturition, and after a few days a thick yellow discharge appears. She takes all this as a matter of course, having been told beforehand that she would experience some pain, but not knowing that from that day forth she will never be as well again. By the time she reaches Philadelphia or Baltimore on her wedding tour she can go no farther, and is laid up there at the hotel. A physician is called in, who finds her in bed, lying on her back with her knees drawn up and her temperature high. She has pelvic peritonitis from extension of the gonorrhœal infection up the uterus and tubes to the ovary and pelvic peritoneum. From this attack she soon recovers under the skilful treatment of the local doctor, who wisely and in mercy keeps his suspicions to himself, but she is not really well. She cannot walk far, coitus is painful, and any great exertion lays her up in bed for a week or two with a poultice to her side. Her periods become more and more painful, and she passes most of her time laying around upon the sofa or in bed. She loses flesh, so that the plump fresh features and complexion of a few months before her marriage are now becoming wan and sallow. The gonococcus of Neisser has travelled up the tube, destroying the mucous membranes and leaving in its path a heap of dead and dying cells called "pus." At the first sign of oozing of this pus from the fimbriated extremity of the tube, nature quickly comes to the rescue and throws out a wall of plastic lymph with which the tube is sealed. The pus then escapes towards the uterus but ere long a cicatricial contraction of the uterine opening of the tube takes place, and an abscess cavity or collection of pus is formed. Then one of two things takes place—either the pus accumulates and the

tube wall becomes thinned by distention until one day it bursts among the bowels and the patient falls prostrate and collapsed; or the pus is gradually absorbed and the tubes and ovaries remain prolapsed and tender in Douglas' cul-de-sac, of no use for the purpose for which they were made and unfitting the patient for her duties as a woman and as a wife, and she can never be a mother. Coitus is extremely painful; some of my patients have told me that they would implore their husbands for weeks and weeks not to come near them, and when at last it could no longer be postponed, they have fainted away with pain. An instance of the former termination was the case of Mrs. R——, elsewhere reported,* a woman twenty-four years of age, the mother of one child, three years of age. She began to menstruate at the age of fourteen, and was normal in this respect until her marriage, at the age of twenty. She has never been well since the birth of her child, after which she made a slow recovery. She had a miscarriage four months ago, and bled steadily afterwards for one month, keeping her in bed, and for which she was treated by her family physician without avail. For this reason I was called in and found the uterus large and heavy and retroverted and resting upon a pair of tubes and ovaries which were large and hard and tender. Lest there might be either retained placenta, or fungous endometritis, the uterus was curetted very thoroughly and Churchill's iodine applied to the cavity. There was no retained placenta, but the endometrium was very velvety and vascular. The uterus was packed with iodoform gauze which was left in for two days. The bleeding ceased immediately, but she still complained of pelvic pain and dysmenorrhœa for the next two months or more. But she was so much better after the curetting that she did not send for me until four months later, when an urgent message was received to come at once, her husband stating that something had burst in her inside and that she had fallen on the floor unconscious.

The condition of her appendages being known, ruptured pus tubes were suspected and immediately preparations for an abdominal section were made, the patient being carefully brought to my private hospital for the purpose. When she arrived there she appeared to be in a condition of shock, the pain having almost disappeared but her pulse being fast and thready. As soon as our preparations could be completed her abdomen was opened, and at the first cut through the peritoneum an ounce of thick yellow pus flowed out. This was carefully cleaned away, after which the tubes and ovaries were removed with great difficulty. The pelvic peritoneum was full of freshly

**American Journal of Obstetrics* for August, 1894, p. 224.

organized lymph, and there was a hole in the tube from which the pus had poured. The tubes an inch from the uterus were thickened to the size of the finger, and at that point were almost solid fibrous tissue, but of very brittle consistency. The walls of the tubes were much thinner at the fimbriated extremities and formed veritable abscesses. The abdomen was washed out with the usual care and a drainage tube was inserted from which about eight ounces of lymph were drawn. This patient made a rapid recovery, being up in two weeks and going home in three. The pain which she had endured for several years previously disappeared the day after the operation, and coitus, which was before so painful, is now performed without inconvenience. I have mentioned this case to show the danger a woman runs in keeping such appendages in her pelvis. She was infected about the time of her first confinement, whether with gonococcus or staphylococcus I cannot say. But she certainly would have died if her appendages and the escaped pus from them had not been removed. Bernutz, in Paris, reported a similar case.* The patient was twenty-nine years of age, and was admitted to La Charite with very severe symptoms pointing to pelvic inflammation and subsequently peritonitis. She died four days after admission, and on a *post-mortem* examination suppurative peritonitis was found to have spread up from the pelvis, having arisen from the rupture of a tubal abscess.

An instance of the other termination is the following: †The very large tubes and ovaries which I now show you were removed from a Mrs. F——, an emaciated and sallow-looking woman thirty-five years of age, who gave us the following history: She began to menstruate at the age of 13, always profuse but otherwise normal. She was married at 23, but never had any children. Two weeks after marriage she was taken with pelvic peritonitis and very nearly died. She was five weeks in bed, and it was three months before she could get about. That was eleven years ago, and ever since that time she has had attacks of pelvic peritonitis about four times a year or oftener which confined her to bed for about a week each time. During most of that period her menstruation has come on every two weeks and lasted a week. Her bowels were moved every four to eight days, and always caused her great suffering as did also coitus, during which she generally fainted with pain. Bladder was all right. On examination the uterus was found in normal position, but the cul-de-sac of Douglas

* Lawson Tait, "Diseases of Women and Abdominal Surgery," 1889, p. 387.
† *American Journal of Obstetrics*, August, 1894.

was filled with an irregular shaped mass the size of a small orange. A diagnosis of pus tubes was made and their removal strongly advised. She entered my private hospital on the 11th April, and cœliotomy was performed on the 13th, when the appendages were removed; the operation occupied nearly an hour owing to the density of the adhesions; but they were eventually detached, the abdomen flushed out with hot water and a drainage tube was inserted. The incision was closed with silk-worm gut stitches four to the inch. The tube was pumped out under strict aseptic precautions, at first every half-hour and afterwards at longer intervals, almost four ounces of serum being removed altogether, until the tube was taken out at the end of thirty-six hours. This patient did not require any morphine, also stating that the pain which she had suffered for more than eleven years was entirely gone since the operation. She made a nice recovery, getting up at the end of two weeks and going home on the twenty-first day, on which date the stitches were removed.

On the 16th February, 1894, Mrs. M——, aged 37, presented herself at my office. She was a medium-sized but thin woman, with a very dark, almost bronzed complexion, such as we generally see in those who have for a long time been poisoned either with retained fæces or retained pus. She had also the prematurely wrinkled face and anxious expression of one who had suffered acutely for a long time. She gave me the following history of her life, beginning with menstruation at the age of 17: As a girl her periods had appeared every three weeks and had lasted eight days, and were always profuse. She was married about the same time, and during the course of the next few years had four children, the last child being born thirteen years ago. She had one miscarriage eleven years ago, since which she has never been well. From her physician I learned that her husband gave her gonorrhœa about the same time, but of this she was never aware. Eight years ago she stopped menstruating for seven months, and two years ago she stopped menstruating for four and a half months. Since then she has been menstruating every three weeks for three days and suffering great pain. Last month, however, the period was a week late and only lasted one day. For many years her bowels were moved only once in eight days, but latterly by the aid of medicine they have been moved every three days. She states that she passes water fifty times in twenty-four hours, more often at night. She has had several attacks of "inflammation of the bowels," as she called it, properly speaking pelvic peritonitis. The last attack occurred six months before seeing me, and was so severe that she was not expected to recover. Since eleven

years she has hardly been a day free from severe pain in her right side and down her leg. On examination, the perineum was found to be slightly lacerated, the vagina bathed in pus and the cervix badly lacerated. The uterus was in normal position, but the tubes and ovaries could be felt as a mass the size of an orange, glued together and completely filling the cul-de-sac of Douglas. The diagnosis of pus tubes and ovaries was at once made; the condition of affairs was fully explained to her, and she was strongly advised to submit to abdominal section and a Schroeder's operation at the same sitting. After fully understanding the relative gravity of the two operations, she refused to have the appendages removed and insisted upon having the lacerated cervix repaired first. This was contrary to my rule which is to remove diseased appendages before or at the same sitting as that at which the cervix is repaired. On the 21st February I performed Schroeder's operation, taking the greatest possible care not to disturb the appendages, and succeeded so well that there was not the slightest rise of temperature or acceleration of the pulse until the twelfth day when I allowed her to get up. She was only up for an hour when her temperature suddenly dropped, and then as suddenly rose to 103 and her pulse ran up to 140, accompanied by a rigor. The abdomen swelled and the patient vomited a great deal. I was perfectly aware that the pus tubes were leaking and I felt pretty sure that their removal would put an end to the peritonitis, but I had to wait a few hours for the consent of the family and, during that time, the abdomen became so much distended that I saw that I would have the greatest difficulty in getting the bowels back should they escape during the operation, and that afterwards I should lose the patient from intestinal obstruction. I therefore decided to wait until the acuteness of the attack was over. By the aid of quinine and plenty of asafœtida, and salines by the rectum and afterwards by the mouth, the abdomen became soft and flattened down, and the patient was carefully prepared for cœliotomy. This was performed on the 16th March when these enormously distended tubes and ovaries were removed with considerable difficulty. The masses were tied close to the uterus and cut off; but just as they were being placed on the tray, thick yellow pus began to pour out of the cut ends of the tubes so as to cover the bottom of the dish. The ends of the stumps were thoroughly cleaned with bichloride, the abdomen was well washed with water as hot as could be borne, a drainage tube passed to the bottom of Douglas' cul-de-sac, and the abdomen closed with silk-worm gut stitches so close as four to the inch. The drainage tube was left in for two days, being frequently pumped out. What was remarkable was this,

although the patient's sufferings during the attack of pelvic peritonitis caused her to scream for hours together so that she could be heard in the next house, she was hardly ever heard to complain after so painful an operation as this must have been of tearing out those adherent and distended pus tubes. As a matter of fact, the patient herself declared that the pain after the operation was as nothing compared with the agony she had endured with each of her attacks of pelvic peritonitis. She also stated the very day after the operation that she was entirely free from the pain she had had for so many years, although the cut in the abdomen was still very painful. Her convalescence was uneventful, her bladder trouble disappearing of itself; she was up in four weeks and walked downstairs in five weeks to go home, since when I have seen her nursing a sick daughter, and going about the house with considerable activity.

Since the above was written this patient has been seen several time. She states that she now looks forward to the approach of her husband with pleasure instead of with dread, and that she never experienced sexual pleasure until after her operation. Another patient with pus tubes, who has not yet consented to an operation, told me a few days ago that, although she loved her husband very dearly, she had never, since her first attack of pelvic peritonitis, cared to give him a kind look or say an endearing word for fear of arousing his passions, sexual intercourse not only causing her such dreadful pain at the time, but confining her to bed for several days afterwards. Few men, even among physicians, realize what terrible suffering women with certain diseases of the ovaries and tubes patiently endure in their attempt to fulfil their duty to their husbands. As Tait says, "The marital act is associated in her mind with something little short of horror." Many a time I have seen the tears fill the eyes during the gentlest possible digital examination, and yet these same women bravely endured the pain after abdominal section almost without a murmur. It is simply absurd to talk about the importance to the woman of retaining such appendages as these, because their removal will prevent her from ever experiencing the joys of motherhood or of feeling the proper affection for her husband. These things have been done already by the disease. The ciliated epithelium which wafts the ovum down towards the womb has disappeared from the tubes; the uterine end of the tube is strictured; the fimbriated end is sealed. The tube itself is full of pus, and the surface of the ovary is covered with several layers of organized lymph. The exquisitely tender organs are lying hopelessly imprisoned in Douglas' cul-de-sac, directly in the road of the male organ and only a couple

of inches from the vaginal entrance. The woman is sterile, and has been so ever since her first attack years ago, and as for the duties of a wife, they are, in most cases, absolutely impossible of being performed. When we remove these painful pus sacs, we not only save her from years of married misery, during every day of which her life is in danger, but we, in many cases, give her a year or two of sexual pleasure, followed by no worse a state than the natural menopause, which does not prevent millions of women from doing their duty to their husbands. I have mentioned a few cases of operations with its gratifying results; I would like, if time permitted, to relate a few more, which emphasize more strongly the danger of delay. I was called a year or two ago to see a lady in Nova Scotia exhausted with suppuration, who had at one time a pus tube, which afterwards broke into the pelvic cellular tissue, setting up cellulitis, and then finding openings for itself through the abdominal wall, the vagina and the rectum by half-a-dozen openings. She was too far gone for operation then, and she died a few weeks later unrelieved by surgery. Her case impressed me very much, and helped to make me see clearly that pelvic cellulitis, apart from a lacerated cervix infected during labor, is a very rare disease.

Another case from which I learned a bitter lesson, but which eventually resulted favorably, was a Mrs. E——, to whom I was called in consultation. She had an undoubted pelvic cellulitis, but what it was caused by, it was, at the time, difficult to say. It was three months since her confinement, which was an easy one, and as the baby was born before the doctor arrived, no one examined her. It is true she had a rise of temperature, but only for a couple of days, and she made an apparently good recovery. She was a very sick woman with a high fever when I saw her, and I should have operated then, but had to go out of town for a few days. She was so much worse next day that another gynæcologist had to be called in, and he promptly opened the abscess and inserted a drainage tube through the vaginal vault. She recovered from this, but the most horrible smelling pus continued to be discharged for six months, until she became sick of life, neither her husband nor her friends being able to remain in the room with her. To a sensitive and pretty young woman this was unbearable, and she placed herself in my hands, as she said, "to kill or cure her." An examination by the vagina at once disclosed the true cause of the trouble, for there was an immense and imperfectly drained pus tube filling the pelvis and in close contact with the rectum. Although the operation promised to be a formidable one, it was undertaken, and with the assistance of two skilful

brethren, the tumor was removed, necessitating, however, the tying off of most of the broad ligament of that side. The operation was a terrible one, the bowels being stripped bare of peritoneum in many places, and for some days her life was trembling in the balance. She recovered, however, but with a fœcal fistula. A month afterwards she was taken with a severe pain on the opposite side, and on examination the other ovary was found to be as large as an orange. She returned to hospital, and a second section was performed, which was comparatively easy, and the ovary removed. This ovary was carefully examined during the first operation, and appeared, and I have no doubt was, healthy at the time, but was probably infected by handling it, quantities of pus having escaped into the pelvis, although, of course, this was carefully washed clean afterwards. That woman is now able to walk three or four miles a day, although she still has the fœcal fistula, from which also many loops of strong silk ligature have come away. Her case at first was merely a pus tube, which should have been taken out at once, but, failing that, it formed adhesions to Douglas' cul-de-sac, and bursting through into the pelvic cellular tissue, caused cellulitis, and eventually broke into the vagina.

In ninety-nine cases out of a hundred, probably when we feel the vaginal roof as hard as a board, the disease is not situated in the pelvic cellular tissue, but in the pelvic peritoneum.

I could mention many other cases to bear out my contention that a woman with pyosalpinx, hydrosalpinx, hematosalpinx, or even in some cases with chronic salpingitis, when there is at the same time pelvic peritonitis binding the tubes and ovaries down in the pelvis, will never be a well woman until these organs are removed. The question of diagnosing the exact nature of the tubal disease is of secondary importance, and is, moreover, often impossible. A hydrosalpinx sometimes causes more suffering than the more dangerous pyosalpinx. I am not unmindful of the fact that the removal of the appendages in a young married woman has many inconveniences both for her and her husband, troubles for the most part of a psychical nature, a subject too long for the present paper. Whenever only one is diseased, we should never remove the two, unless in the case of a large floroid, it is our object to endeavor to bring on the menopause prematurely. I believe in saving the two ovaries, or, if we cannot do that, then in saving one, or even the half of one, if there is that much of it healthy, and that, too, when the tubes have to come out.

But I have regretted my conservatism more than once. Thus, a Mrs. R—— was sent to me from the country for retroversion with

fixation, the tubes and ovaries lying in Douglas' cul-de-sac with the uterus on top of them. Every step she took caused the uterus to hit the ovaries a little blow, and coitus was very painful. She was young and pretty, and naturally begged me to spare the ovaries if possible. When I had my finger in the abdomen, and found the ovaries adherent, I was inclined to remove them, but, knowing how disappointed she and her husband would be, I dug them out of their bed, brought the uterus forward, and sewed it to the abdominal wall (ventrofixation). The retroversion is cured, so that she can now walk without pain, and her husband does not hurt her; but she is still sterile, and she has two painful ovaries, of which she complains to me by letter about twice a year.

(To be continued.)

Clinical Notes.

A Peculiar Case of Periodic Hæmaturia.*

BY ALLEN BAINES, M.D., L.R.C.P., LOND., ETC.
Lecturer Clinical Medicine, Trinity Medical College.

F. S——, aged 42, married, by profession a civil engineer, has never had any illness in his life, except from the cause about to be mentioned. His frame is large and very strongly built, muscular development far above the average, weight at present time 190 pounds, temperament sanguine, complexion dark and clear. In the early part of May, 1880, while playing lacrosse, he received a severe blow over the right kidney. The blow was given by the butt end of the stick, whilst he and another man were fighting back to back to obtain the ball, therefore, it was a jab or prod, delivered with a good deal of force, causing him to fall to the ground with a faint, agonizing pain, and nausea and vomiting which lasted for nearly an hour. He then pulled himself together and walked to his home, a distance of about half a mile, went to bed and sent for his doctor. Two hours after receiving the blow, he passed, *per urethram*, more than a pint, by the physician's measurement, of nearly pure blood. This hæmaturia kept up for about forty eight hours, during which time ice was applied over the injured kidney and appropriate remedies administered, and the great amount of blood diminished. On the fourth day after the accident, peritonitis developed. The pain, commencing over the injured kidney, passed down the line of the ureter towards the

* Read before Toronto Clinical Society, April, 1895.

bladder, and from there became general all over the abdomen. On the sixth day, pneumonia set in, attacking the right lung only. He was now, as may be inferred, in a critical condition, and the three physicians in attendance advised his sending for his friends, as they believed he had but a few hours to live. However, his strong constitution and steady mode of living was in his favor to such an extent that he ultimately pulled through, and by the end of July, was feeling fairly well. The attack had pulled him down very much, and it was found that he had lost sixty pounds during his illness. In the end of August he again went to work, and could do a fair amount of it in a day, although he did not yet feel quite himself. In September, he again passed bloody urine for a couple of days at a time, on three occasions at intervals of ten days. He then had a respite from the hæmaturia for three months, in which time the tenderness which had existed over the kidney since the accident disappeared.

In January, 1881, he had another attack of hæmaturia, preceded by an attack of pain over the kidney and great distention of the bowels, which caused his girth rapidly to increase about six or eight inches. When the hæmaturia put in an appearance, the distention disappeared inside an hour. After each attack, the urine would be bloody for two days, and then he would have perfect health.

This state of affairs kept up for eight years, the attack coming on every four to six weeks—every four weeks, if he made any extra effort in the way of lifting weights, or taking sharp walks or running. For the past six years,—during three of which he has been under my observation,—the period has been lengthened in which the attacks would supervene. It now shows itself every three months—the only difference being that the bloating before the attack is more marked and lasts longer, while the pain over the kidney is not so intense. The phenomenon of the immediate flattening of the abdomen on the appearance of the bloody urine continues precisely as stated.

I have several times examined him and cannot find any enlargement of the kidney. Tenderness is certainly not marked during the period of quiescence, throughout which he enjoys perfect health, doing hard work, such as constructing breakwaters, building canals, etc. The urine has been repeatedly examined by myself and others. It is always of the same color during these paroxysms,—a deep crimson, throwing down a flocculent deposit on standing. Under the microscope, blood corpuscles are found in large quantities, also mucus, but no pus corpuscles or casts. Many of these blood corpuscles are found to be crenated, which would suggest the idea that he might be suffering from uric acid diathesis, but the examination of the blood itself gave negative results.

Saundby, in his excellent lectures on Bright's Disease, gives as causes of hæmorrhage from the kidneys the following classification :

I. *Local Lesions :* External injury, twisted or movable kidney, calculus, tubercle, cancer, syphilis, embolism, parasites, congestion, Bright's Disease.

II. *Symptomatia :* Blood diseases (purpura, scurvy, hæmagobruæmia, leucocythæmia), specific fevers, malaria, cholera.

III. *Toxic :* Turpentine, cantharides.

IV. *Neurotic or Vicarious :* Hysteria, insanity, asthma, menstruation, hæmorrhoids.

Now, there are many other well-defined conditions in which blood may be found in the urine. These, however, need not be discussed in connection with this case, as its history shows that the sufferer never had any symptoms of bladder trouble in any way whatever, neither has he suffered from cystitis, even in a mild form ; therefore, I think we may conclude that the blood certainly comes from the kidney, and thus exclude the question of the bladder or urethra from discussion.

I can only think that he might possibly have a calculus in the kidney, the nucleus of which was formed at the time of the injury. At the same time there are many classical symptoms wanting to make such a diagnosis at all clear. Prout says, and he is endorsed by Henry Morris, that the various calculi give rise to different and distinctive pains, *e.g.*, *Uric acid calculus* produces the least pain, and that of a dull, oppressive character, and a sense of weight ; *Oxalate of lime* causes a more severe pain of an acute character, referred to a particular spot, as well as shooting to the ureter, shoulder or epigastrium ; *Phosphates* give rise to great and unremitting pain, attended, however, wtih exacerbations. The symptoms of *indigestion* are also peculiar.

The symptoms of dyspepsia, nausea and vomiting are very common, not only at the time of actual colic, but during periods of less acute suffering, and are explicable through the connection of the renal plexus with the pneumogastric. But this patient never has any of those pains, nor has he ever had the pain produced by the passage of a renal calculus, so that it makes the case to me very dubious in regard to the diagnosis of stone in the kidney. Various causes given in Saundby's list can, I think, be one by one excluded, leaving only *paroxysmal hæmorrhage* or *stone*, as already stated.

Foreign Bodies in the Auditory Canal.

BY MURRAY M'FARLANE, M.D.,

Laryngologist, etc., St. Michael's Hospital; Aurist, Western Dispensary.

It is quite a common occurrence for medical men to be called upon to remove foreign substances from the auditory canal, which have come there either by accident, or were introduced by the patient knowingly.

These substances may occasion all sorts of reflex mischief, not to speak of the deafness resulting from their presence, as two cases in my practice will illustrate:

Case 1.—Mrs. B——, aged 60, consulted me regarding her hearing, which was almost entirely gone. The deafness had been of eleven years' standing, and her doctor in England had informed her it was nerve deafness, due to taking too much quinine, and advised her not to spend any money in treatment, as it would be useless. She informed me, however, that the doctor did not examine her ears in any way, which seems hard to credit.

Having unlimited confidence in the gentleman, Mrs. B—— came to Canada, and tried to bear her burden as philosophically as possible.

Upon looking at her I thought I had a hopeless case, the marked alteration in her voice and features being such as are met with in cases of incurable deafness.

I found the watch could only be heard upon contact on each side. She carried a long tubular ear-trumpet, but could scarcely hear me speak even with its use.

Prior to six months since she had been able to hear, though with difficulty by the aid of this instrument, great dizziness was complained of, as well as a hard, irritating cough which had lasted for several years.

On closer examination I found the external auditory meatus of each ear completely occluded by a mass of impacted wax nearly as hard as bone, and about as hard to remove, and before the operation was completed I was a firm believer in "the parable of the loaves and fishes," for in addition to the wax there were splinters of toothpicks and matches which had been used to pick the ears—sufficient, one would imagine, to fill a dozen ordinary ears.

I was only removing the wax in order to inspect the membrana tympani, not expecting any improvement in hearing, being of the preconceived opinion that I had a case of middle ear sclerosis to deal with from the history of the case. I was greatly surprised, however, to

find, when the last of the wax had been removed, and the middle ear inflated by Politzer's method, that hearing was for all practical purposes restored, the watch being heard at twelve inches on the right side and nine on the left. I subsequently have heard that the cough and dizziness disappeared at the same time, and has not returned, pointing to its reflex origin in aural irritation. Here is a case of a woman, for eleven years debarred from the use of her ears by a little carelessness upon the part of her physician in England.

Case 2.—Mrs. W—— consulted me regarding some trouble she was having with her ears, complaining of great pain and giddiness. Upon examination with a speculum, I found the auditory canal of each ear completely blocked by hard pieces of garlic, which had been inserted upon the advice of a friend who extolled its virtues in restoring hearing. Mrs. W—— had followed this advice, and had entirely forgotten about the garlic, which began to swell, causing intense agony and dizziness from its presence. Upon removal all the symptoms disappeared, and garlic is banished from the family medicine-chest forever.

Society Reports.

Toronto Clinical Society.

(April Meeting.)

The motion made two months ago with regard to those Fellows in arrears, that their names should be dropped from the list, was put to the meeting and unanimously carried.

Osteotomy.—Dr. King presented a paper and also a patient, on whom he had performed an osteotomy for ununited fracture. The patient had sustained a fracture of the tibia near the ankle of the right leg, a railroad car having passed over the joint. The fracture was put up in a box-splint, with a pad under the lower end of the upper fragment. Although compound communated the wound healed; but the ankle was stiff and the leg movable at the seat of fracture. He removed a wedge-shaped piece of the tibia and a portion of the fibula. A perfect recovery ensued. He asked how much deformity was due to contraction of the tendo-achilles, and how much to the presence of the pad under the lower end of the upper fragment.

Dr. Atherton said that the ankylosis was, no doubt, due to the extension of the inflammation from the seat of fracture. He understood that the tendo-achilles had been divided in the operation described; he thought that would hardly have been necessary when such a portion of the bones had been removed.

Dr. MacFarlane asked if both bones were broken at the same level.

Dr. King replied that they were.

Dr. Fotheringham thought that the good result obtained was one that would not have been thought of, occurring fifteen or twenty years ago. Then, most likely, amputation would have been done at the time of the injury.

Dr. MacFarlane said that fifteen or twenty years ago they were guided much in the same way as they were to-day in such cases. If there were signs of circulation in the limb below the fracture, they tried to save the limb. The results now were more favorable, owing to the advance in antisepsis. As to what effect the pad had on the deformity it was difficult to say. It had been used, no doubt, to protect the heel, and was partially accountable for the deformity, but he considered that the contraction of the tendo-achilles was the major factor in its causation.

A Case of Periodic Hæmaturia.—By Dr. Baines. (See page 169.)

Dr. Atherton thought the swelling of the abdomen must be connected with the kidney in some way. One would think the enlarge-

ment, if present, could be made out at such a time. Was there any evidence of hæmophilia? It would seem unusual if due to stone. There was no appearance of stone in the interval. The crenation of the red blood corpuscles might be due to their retention in the urine in the pelvis of the kidney. Was the amount of urine noted that passed during the attacks? Was there an increase when the swelling disappeared?

Dr. FOTHERINGHAM asked if the flattening of the abdomen was accompanied by the escape of flatus. The case was one like a case he had seen where a testicle had been crushed, accompanied by distention of the bowels, which led to a diagnosis of peritonitis. But there was no inflammation. A high injection relieved the condition. The paralysis of the bowel was sympathetic, partly. So in the case related, the paralysis of the muscular coat might occur from such an occurrence as a twisting of the pedicle of the kidney.

Dr. ANDERSON asked with regard to the presence of mucus, and how its corpuscles were diagnosed from the pus corpuscles.

Dr. KING asked if there was no hæmaturia until the distention began to recede. That was an important point to note. He did not think the absence of pain excluded the diagnosis of stone. He had one, obtained at a *post-mortem* in which the patient had died from some other disease. It was one-third the size of the kidney and had produced no symptoms during life. If there had been any symptoms the patient would have spoken of them, as he was given to complaining about small troubles. The calculus might block up the ureter and the hæmorrhage occur behind it until sufficient collected to push it out, and then the process of accumulation might go on again.

Dr. BAINES said that he had examined the patient frequently during the distention, and could not make out any difference in the size of the loin. He was sorry that the patient was unable to be present that the members might examine him. He had been anxious that someone else should see the patient, but the patient had not agreed, thinking he was doing very favorably.

The amount of urine was always about the same. He had not thought of the damming back process referred to by Dr. King. In regard to the presence of mucus, he said acetic acid did not have any effect. He had spoken of the case to a number of men with wide experience, but the only one who had any case like it was Dr. Cameron. It was that of a little boy who, while running, had fallen and two others had fallen across him, and who had suffered subsequently from these paroxysmal attacks of hæmorrhage.

The Trinity Medical Alumni Association.*

(April 4th, 1895.)

President, DR. G. A. BINGHAM, in the chair.

A Few Notes on Cerebro-Spinal Pathology, by Dr. Daniel Clark, was the first paper presented. It referred to the advances made in the way of pathological inquiry during the last fifty years. Nasse, in 1840, discovered the change in character of nerve structure after injury. Walter, ten years later, showed that regeneration to the normal never occurred, and as a consequence function could never again be perfect. This was important as bearing on the prognosis of insanity. The essayist then discussed the question of nerve influence on nutrition—the trophic centres. If these are diseased various symptoms ensue connected with the skin, muscles and joints. It was striking what a small injury to certain insane will produce ecchymosis. Metastasis in disease was no doubt due to changes following mal-nutrition of the great nerve centres. The nervous condition antedated the pathological change in the supra-renal capsules. Many diseases, formerly attributed to impurity of the blood, now were known to be due to nerve depreciation. The abnormalities in the nerve structures in a number of diseases were then detailed. The fact that morbid processes wherever found are in essence identical and depend much on nerve influence and blood supply, has tended to abolish the specifics of empirics, and to the use of those agents which supply material to the system for upbuilding the depraved tissues. The relation of systemic diseases was dwelt upon. Many diseases could be traced to nutritive derangements of the sympathetic or spinal centres. The study of zoo-chemistry was important. The amyloid material, so often found, was explained as a degeneration from cerebrin.

The Antitoxine Treatment of Diphtheria.—This was the subject of an address by Dr. Chas. Sheard. The apparatus for cultivating bacteria and for preparing the serum, the different varieties of serum and the needle used for injecting it were shown. He described the method of making cultures and of obtaining the antitoxine. He had observed its action in twelve cases which had been bacteriologically diagnosed diphtheria. There was a mortality of twenty-five per cent. From his experience with it, and with the results of the use of Koch's tuberculin in mind, he did not feel in a position to pronounce upon its value

* Held in Trinity University, Toronto.

yet. Calomel fumigation and sprays of bichloride of mercury gave very satisfactory results. The Doctor stated that any practitioners who wished a bacteriological examination of any of their cases might have it done *gratis* at the Medical Health Office.

Philosophy of Abdominal and Pelvic Surgery was the title of a paper read by Dr. JOSEPH PRICE, of Philadelphia. Dr. Price deprecated the revival of the doctrine of pelvic cellulitis; he believed it to be a retrograde step. The attacking of tubes and allied diseases through the vagina was irrational and unscientific. Such could be dealt with best by opening the abdomen. This procedure demanded the strictest asepsis, and the fewer and simpler instruments the better. All adhesion should be broken down, preferably with the finger, and all bleeding points attended to. To irrigate when the element of sepsis was present was necessary. The hot abdominal douche was an excellent stimulant.

Dr. TEMPLE agreed with the remarks of Dr. Price as to the preference of operating by the abdominal incision rather than through the vagina for pelvic diseases. However, he was not, he said, a convert to the idea that there was no such thing as pelvic cellulitis.

Dr. KENNETH FENWICK related what he considered a case of pelvic cellulitis, where an abscess had followed removal of pus tubes.

Dr. PRICE believed the cause of the trouble in the case related by the last speaker to be a septic ligature. He did not belittle antisepsis, but it should not take the place of asepsis.

Radical Cure of Hernia.—This was the title of an able paper by Dr. A. H. FERGUSON, of Chicago. There were accompanying it, illustrations of the various methods of dealing with herniæ in a radical way. He pointed out the pathological condition present in oblique inguinal hernia. There existed, first, a congenital depression at the internal ring, then an infundibuliform pouching of the transversales fasciæ by the hernial mass, often an enlarged cord, then a thinning of the abdominal aponeurosis, and a certain amount of displacement of Poupart's ligament and the conjoined tendon. The operation he used was not a laparotomy, which Halstead's virtually was. However, the removal of the superfluous veins of the cord was correct. He utilized the sac like McEwen in making a pad to fill the funnel-shaped cavity. The transversalis was reefed by a figure of eight stitches, the ridge corresponding to the line of suture and being thrown inward. Then the opening through the aponeuroses was sutured in such a way as to produce a certain overlapping, thus giving additional strength to the heretofore weak place. His treatment of femoral hernia radically was then dealt with.

Infection Within the Cranium.—By Dr. ROSWELL PARK, of Buffalo. The paper discussed in a most scholarly way the various organisms found in brain infections, the paths of infection, the pathology of these affections, the symptoms, diagnosis and mode of healing.

[Owing to Trinity Convocation at 5 p.m. there was no time for discussing the last two papers.]

Editorials.

Ontario Medical Association.

THE Ontario Medical Association, whose meeting is announced for June 5th and 6th, under the presidence of Dr. R. W. Bruce Smith, of Hamilton, was organized in 1880, and is now consequently entering the period of adolescence. The objects of the Association at its inception were the cultivation of the science of medicine and surgery, the advancement of the character and honor of the medical profession, the elevation of the standard of medical education, the promotion of public health, and the furtherance of unity and harmony among its members. How well these objects have been striven for, and to what extent obtained, are well known to every observant practitioner. To maintain the high standard the profession has already attained against the onslaught of those who would drag it down, is the duty of every physician in the Province. The members of the profession should embrace all such opportunities for friendly intercourse and scientific discussion as our annual provincial association meeting affords. As a rule, the live men are found in the various medical societies of the Province.

The Committee on Papers, chairmaned by Dr. Powell, have been very active in securing papers, and their invitations for contributions from members have been well responded to. It is hoped, in consideration of the usual large number of papers to be presented, that those contributing to the programme will make their communications short and to the point. The valuable time of the Association should not be taken up by long, theoretical and abstract dissertations; only those of a practical nature will be appreciated.

The Number of Medical Men and Medical Schools to the Population.

FROM *Buffalo Medical and Surgical Journal* of April we glean the following interesting figures, which bear out our contention in last issue that there is a ludicrous increase in the number of physicians. The ratio of medical men to the population is as follows:

Italy ..... 1 to 3,536.
Germany ..... 1 to 3,038.
Austro-Hungary ..... 1 to 3,857.
France ..... 1 to 2,666.

But the following table is still more instructive:

	Population.	No. of Physicians.	No. of Schools.	Schools to Population.
Sweden	4,802,751	.....	3	1 to 1,600,917
Italy	30,347,291	8,580	21	1 to 1,445,109
Germany	49,428,470	16,270	20	1 to 2,471,923
Britain	37,740,285	22,105	16	1 to 2,358,767
Austro-Hungary	41,231,342	10,690	8	1 to 5,153,917
France	38,343,139	16,593	7	1 to 5,477,591
United States	62,622,250	100,000	140	1 to 440.151
Canada	*5,000,000 (?)*	.....	*10*	*1 to 500,000*

The above figures account for the fact that in Canada and the United States we have one medical man to every 600 persons, while in Britain there is only one to every 1,700.

It is absurd for this thinly populated and comparatively poor country to attempt to keep up ten medical colleges. One for the North-West, one for Ontario and two for Quebec is ample to supply all the medical men needed. The teachers would be better paid and do better work. The student would get the benefit of this, and ultimately the people.

From 1880 to 1890 there graduated in the United States no less than 40,996, or over 4,000 a year. This is certainly a ludicrous increase in the numbers.

In Canada, Britain and the United States the time spent in medical studies is much below that of many other countries.

We would again caution the young man to think twice before he decides to study medicine. It is a long road to travel and very difficult to retrace if the person should not be successful.

The Removal of the Uterine Appendages for Nervous Diseases.

At the Boston Society for Medical Improvement the above subject was recently fully discussed. The question was introduced by a paper from Dr. W. H. Baker. Two things were strongly brought out in the paper. The first was that the greatest care should be taken not to operate on healthy appendages for the relief of nervous diseases; and the second was that if there was clearly some pathological condition of the uterine appendages, giving rise to constitutional disturbance, or nervousness, an operation might be the only means of treatment. Dr. Baker summed up his paper as follows: Diseases of the ovaries and tubes are sometimes the cause of nervous diseases. The adhesions that result from pelvic peritonitis may cause nervous diseases. The extent of pelvic disease is no test of the amount of nervous disease that follows from it. In all cases of obscure nervous disease, the pelvic organs should be thoroughly examined. Some forms of uterine disease may cause so much nervous disturbance as to justify the removal of the healthy ovaries.

Dr. J. Homans, in the discussion of the paper, gave his experience and reported his cases. He concluded his remarks with the following words: "My belief in the efficacy of removal of healthy ovaries and tubes for the relief of nervous disease is very slight. I think it may once in twenty times, perhaps, do some good; but I should never do it without the advice of some alienist in whom I had confidence." It may be remarked regarding the above opinions of Dr. Homans, that any severe injury or operation might have a very decided effect on nervous disease, though not done to the pelvic organs.

Dr. R. T. Edes then followed with sound words of caution. He held that healthy ovaries and tubes had been removed on far too many occasions. When a man began reporting his hundredth case of such operations for the treatment of nervous diseases, he thought something was decidedly wrong. He had known where the operation had been strongly advised, that a recovery took place by waiting a while. He had also seen death from the operation, by shock and depression, where there was no sepsis. He was glad the surgeons of Boston were more conservative than in some places.

Dr. F. H. Davenport held that the removal of healthy ovaries for the relief of nervous disease should be exceedingly rare. He was of opinion that all other methods of treatment ought to be well tried. Those who were readiest to remove the appendages for very slight

disease, should hesitate to do it when there was no disease found in them, with the hope that such an operation would cure nervous disease that could not have arisen from these organs when they are found normal.

Dr. P. C. Knoff remarked that he had never yet advised such removal on account of nervous disease. He had never yet seen good results from it, and he had seen the patient's condition rendered worse. When there is distinct disease of the appendages, causing pain and suffering, an operation should be performed. He did not believe that there would be disease of the uterus or appendages, giving rise to nervous disease, without, at the same time, pointing to its local nature and origin.

Dr. M. Prince spoke very strongly against the removal of healthy ovaries and tubes for the relief of nervous disease. He thought the cases where such treatment was required to be extremely rare. He contended that such operations were founded upon an entirely wrong pathology of the nervous system. Various operations had been suggested and tried for epilepsy, and they had fallen into disuse. When the pelvic organs were healthy, the removal of a toe or finger would be as likely to do as much good as the removal of the ovaries.

Dr. Baker, in reply, stated that he was glad to be assured that the healthy ovaries and tubes of this locality were so carefully guarded. He was sure that this was as it should be.

In the face of the above, when we hear of a young man in a small town performing one hundred normal ovariotomies for the relief of many functional nervous troubles, we are strongly inclined to call a halt. The opinions of the above gentlemen would be more likely to form a safe guide.

Dr. McKay's Bill to Amend the Medical Act.

This bill, which has passed and become law, has for its object the settlement of the question of the old tariffs. Inasmuch as most, if not all, the territorial divisions have been changed and meetings of the members represented in the new divisions have not been held, the old tariffs have no longer any *locus standi* in law. Therefore, to avoid the enactment of seventeen different tariffs in the Province, this bill was introduced to make it clear that the old tariffs are not effective in case of dispute arising as to charges for professional services. It is proposed that the Council shall have the power to enact a tariff for the whole Province, which will no doubt be done at the next meeting of that body. That being done the Legislature will be called

upon to ratify it. It seems to us that it would have been much better to have introduced a clause in this bill empowering the Council to make a general tariff while wiping out the old one. Until the Legislature meets there is no legal tariff in any part of the jurisdiction of the College of Physicians and Surgeons. Whether this will be found to be in the interest either of the profession or the public remains to be seen. In the various States there is no legal tariff, yet our colleagues across the line manage to make a living. That being so, perhaps we can contrive to worry along without one.

A Uniform Curriculum for Training Schools.—Miss M. A. Snively, Superintendent of the Training School, Toronto, in an excellent article in *The Trained Nurse and Hospital Review*, suggests an association of well-recognized hospitals, a uniform admissional examination, a uniform period of training in medical, surgical and gynæcological nursing, and a final examination.

Midwives and Manslaughter.—Recent English papers are filled with a gruesome account of the doings of a licensed midwife appropriately named Rake. Among the misdeeds for which she was tried was that of causing the death of one Hilda Gray by communicating to her puerperal fever after having been warned that she must cease from attending patients until free from possible contagion. The jury disagreed and the defendant was admitted to bail until the next Sessions, when she will have to face other charges. This case points a moral and adorns a tale. The culpable negligence exhibited in this case would have had many congeners in Ontario had the Patron Medical Bill become law.

Treatment of Wounds in Pre-antiseptic Days.—Sir George Humphrey, in the *British Medical Journal*, March 30th, 1895, compares the treatment of wounds in pre-antiseptic days with that of to-day. The principle he followed then was to stop all bleeding completely, so that nothing would intervene between the opposed edges and in many cases to leave the wound exposed to the air. The principle now is to reduce to a minimum the media upon which bacteria act, and to reduce to a minimum the germs themselves, the former of which was unconsciously done in the earlier mode of treatment. The later treatment has the advantage of lessening the risks of secondary hæmorrhage, causing septic conditions.

Hereditary Insanity.—Dr. R. H. Chase, in *Maryland Medical Journal*, 30th March, holds to the view that insanity in many forms is hereditary. He regards the child as inheriting many of the peculiarities of the parents, and these peculiarities show themselves in the nervous system more readily than anywhere else. The prognosis in cases of insanity with a history of inheritance is not good. Experience shows that if the insanity comes on suddenly, the chance of recovery is much better than if the incubation is slow and insidious. In all cases of insanity in the parents, the greatest care should be taken to secure the best of health by good food and careful sanitary conditions. The utmost care should be taken in the training of the child's temper to regulate it and maintain as good a balance as possible. The teachers for such cases should be of an even temper.

Speech Development in an Adult after Operation for Tongue-tie.—Dr. G. Hudson Makuen reports in the *Times and Register* for 6th April an interesting case where a young man, aged 19, was unable to use articulate speech, and had made very little progress in learning, at which he was very much discouraged. The opinion had been given to him that his trouble was central or cerebral. He had made many attempts to talk and recite in school, but his teachers had to guess the meaning of his jargon. He had learned to write, and was obliged to use this means of communicating his thoughts. The frænum was found to be very short, so that he could not protrude the tongue beyond the lips. The frænum was freely divided. He was placed under a teacher, who gave him several hours' drill daily on vocal culture. Several adhesions that had formed were broken up. There was considerable glossitis. In one year he had acquired a perfect use of speech.

A Year's Work in Dermatology.—Dr. J. Abbott Cantrell, in *Philadelphia Polyclinic*, 6th April, makes some remarks on the experience of the year on certain drugs. (1) With regard to bismuth subgallate for such conditions as excoriations, intertrigo and moist eczema, he contends that it is not worthy of much confidence. It is not clear that it acts as a germicide. It appears to be decidedly irritating, and sometimes almost caustic. (2) Alumnol has been employed in the same class of cases. It may be used as a powder from 10 to 20 per cent., and ointments of varying strengths. In eczema and intertrigo of an acute character it acted well. In more chronic forms of eczema, ulcers of non-syphilitic type, in non-parasitic

sycosis, in tubercular syphilitic eruptions and scabies, the drug acted well, though rather slowly, and was curative. In herpes zoster, it acted as a protective only. (3) Laborrague's solution of chlorinated soda was specially valuable in the dermatitis of poison ivy. (4) Salol has proven useful in chronic eczema, in tinea circinata and tinea versicolor. In tinea sycosis and tonsurans it is of no value.

Antitoxine Treatment of Diphtheria.—Dr. James Jay Mapes, in the *New York Polyclinic*, has a very excellent paper on the above, which may be summarized as follows: 1. Klebs discovered the bacillus in 1883. Lœffler separated the bacillus and cultivated it, and produced the disease experimentally. In 1888, Roux separated the toxines from the germs. In 1890, Behring used the toxine on small animals, and found in their blood antitoxine which produced immunity. 2. Roux reported 448 cases of diphtheria last September treated with antitoxine, with a death rate of 24.5 per cent. At the same time, physicians in Berlin had been using it and weighing its effects carefully. 3. Roux has now over sixty horses at the Pasteur Institute, undergoing preparation. The blood is removed from these with the greatest antiseptic care. When the serum separates, it is bottled for use. The horse is then sent to the country to feed up. The toxine is at first weakened with iodine before it is used on the horse. When the horse can stand strong doses of the toxine, the cultures are used. 4. The dose for a child under two years is 5cc.; for a child two to four years, 10cc., and over four, 20cc. The treatment should be commenced early. As the serum does not do any harm, it is better to make the mistake of giving it early, even though the case should not turn out to be diphtheria, than to wait too long. In the first 2,000 injections, there was only one abscess. 5. In 3,900 cases, from 1890 to 1893, the death rate was 51.5 per cent. Since the antitoxine treatment has been used, Roux claims that the death rate has varied from 10 per cent. to about 15 per cent. in the recent cases treated in this way. The writer states that antitoxine has now passed beyond the stage of doubt, and is an assured success.

Dr. Sir J. Russell Reynolds was re-elected President of the Royal College of Physicians, London.

Dr. de Bossy, of Havre, who is still youthful at the age of 102, continues in active practice. He was born in 1793, and graduated in 1818.

Items.

Mr. Christopher Heath was elected President of the Royal College of Surgeons, of England, in the vacancy caused by the death of Mr. J. W. Hulke.

Dr. J. L. Davison, the representative of Trinity Medical College, has resigned from the Senate of Toronto University. Dr. G. Sterling Ryerson has been appointed to the vacancy.

We understand the emolument received by the senior professors of the Medical Faculty of Toronto University for the past session's work was somewhat less than $400.

The Cottage Hospital, 27 Montague Place, continues to grow in favor. All classes of cases, other than infectious, are received. Patients may be attended either by their own physician or by the Medical Superintendent.

Sir Joseph Lister was presented with the Medal of the Society of Arts in recognition of "the discovery and establishment of the antiseptic method of treating wounds and injuries, by which not only has the art of surgery been greatly promoted and human life saved in all parts of the world, but extensive industries have also been created for the supply of materials required for carrying the treatment into effect."

Longevity in the Titled Classes in England.—A recent return of deaths, and ages at death, of persons of title from dukes to baronets, for 1894, gives the following figures: Sixty-nine persons of both sexes died in the year. Of these, five were between 90 and 99, sixteen between 80 and 90, nineteen between 70 and 80, sixteen between 60 and 70. So that fifty-six persons of rank out of sixty-nine lived to be sixty and upwards, only thirteen dying before that age was reached—all of which goes to show that idleness and plenty does not shorten life, as some people suppose.

The Qualification Necessary to Practise in some States of the Union.—A doctor may practise in the following States of the Union by presenting a diploma for inspection: California, Colorado, Connecticut, Delaware, Illinois, Iowa, Kentucky, Louisiana, Missouri, Montana, Nebraska, New Mexico, Oklahoma, Oregon, Tennessee, Vermont, and West Virginia. In the following States the diploma must be registered with the County Clerk, who is a qualified judge as to the physician's fitness to practise: Arizona, Georgia, Idaho, Indiana, Kansas, Michigan, Nevada, Ohio, South Carolina, Wisconsin, and Wyoming.

The Meeting of the American Military Surgeons at Buffalo.—As already announced in the Review, the Association of Military Surgeons of the United States will hold its fifth annual session in Buffalo on May 21st, 22nd and 23rd. The officers for 1894-1895 are: President, George M. Sternberg, Brigadier General and Surgeon-General, U. S. Army, Washington, D. C.; Vice-President, Louis W. Read, Colonel and Surgeon-General, N. G., Pennsylvania, Norristown; Second Vice-President, Albert L. Gihon, Medical Director, U. S. Navy, Washington, D.C.; Secretary, Eustathius Chancellor, Lieutenant-Colonel and Medical Director, N. G., Missouri. Monday, May 20th—Receiving guests and quartering them at hotels and private houses. The hospital corps of the National Guard will be detailed for duty at the railway stations to see that the visitors as they arrive are properly cared for, and also to furnish any information which may be desired. Tuesday, May 21st—Opening meeting at 10 a.m. at the Star Theatre; addresses by Mayor Jewett, Gov. Levi P. Morton, Gen. George M. Sternberg, President of the Association, and others. Wednesday morning and afternoon will be devoted to the business of the Association, and in the evening there will be a reception. The business of the Association will be continued on Thursday morning, and in the afternoon there will be a carriage drive about the city. In the evening there will be a parade and review of the 65th regiment and a promenade concert by the band of the regiment. On Friday there will be an excursion to Niagara Falls, Lewiston and other points of interest. On arriving at the Falls the Association will be the guests of a committee representing that city. The following is a partial list of the papers to be read: "The President's Address," by Brig.-Gen. George M. Sternberg, Surgeon-General, U. S. Army; "Experiments Illustrating the Degree of 'Powder Burn,'" by Louis A. LaGarde, Captain and Assistant Surgeon, U. S. Army; "The Location and Removal of Missiles from the Cranial Cavity," by George R. Fowler, Major and Surgeon, N. G., N. Y; "Ambulance Construction," by Dallas Bache, Lieutenant-Colonel, Deputy Surgeon-General, and Charles R. Greenleaf, Lieut.-Colonel, Deputy Surgeon-General; "Conservative Surgery on the Battlefield," by Nicholas Senn, Surgeon-General, N. G., Illinois; "The Relation of Concentrated Food to Active Service Demands," by Austin Flint, M.D., ex-Surgeon-General; "Infected Bullets," by Louis A. LaGarde, Assistant-Surgeon; "Instruction of the Hospital Corps," by H. S. Turrill, Surgeon; "Field Hospital Service," by Dallas Bache, Lieut.-Colonel, Deputy Surgeon-General; "Gunshot Wound of the Kidneys," by Lieut.-Col. A. L. Wright; "On the Travois Litter," by Waldmir F. de Niedman,

Surgeon; "Method of Caring for Wounded in Field and Hospital of Chinese and Japanese Armies," by C. U. Gravatt, Surgeon, U.S. Navy; "Measures for the Prevention and Suppression of Dangerous Contagious Diseases in Garrison and in the Field," by H. Lincoln Chase, Assistant Surgeon; "The Effects and Treatment of Heat and Sunstroke at Camps of Instruction," by Orlando J. Brown, Assistant Surgeon; "The Mental Evolution of the Citizen Soldier," by Charles W. Galloupe, Assistant Surgeon; "Report on Diagnosistag for Field Use," by William H. Forwad, Surgeon, U.S.A. Medical officers of the Canadian Militia will be welcomed. Undress uniform is to be worn at the meetings and full dress at the social functions.

Book Notices.

A Manual of the Modern Theory and Technique of Surgical Asepsis. By Carl Beck, M.D. Philadelphia: W. B. Saunders.

This practical little volume is an outcome of the influence of bacteriology on surgery. It discusses the various surgical bacilli, the methods of securing asepsis by disinfection of various parts of the body, instruments, sutures, sponges, operating room, the treatment of various sorts of wounds, and the subject of anæsthesia. The illustrations are numerous and good, the type, paper and binding up to date.

The International Medical Annual and Practitioners' Index. Thirteenth year, 1895. E B. Treat. New York: 5 Cooper Union. Chicago: 199 Clark St. Price, $2.75.

Most practitioners have come to recognize the great value of a good annual. In a convenient, reliable, and readable form the best of the year's progress in medicine is brought within the reach of the busy physician, who may not have the time nor the books or journals where the original article appeared. The "International Medical Annual" has long ago proven its right to existence, and has become a welcome yearly visitor to the bookcase of many a doctor. The work this year is fully equal to any of its predecessors. There is a very full index, which renders the task of looking up any subject easy and rapid. The work has been arranged by a staff of thirty-seven of the leading medical men of Britain and America, and this is saying much for the book. The work is well printed on good paper. We cheerfully commend the "Annual" to all.

A Book of Detachable Diet Lists and a Sick-room Dietary. Compiled by JEROME B. THOMAS, A.B., M.D. Published by W. B. Saunders, 925 Walnut Street, Philadelphia, Pa. Price, $1.50.

To the busy practitioner who has a large and varied practice, and little time to write out systems of diet for his patients, or to describe the proper preparation of foods for the sick, these lists will be most useful. The following conditions are considered: Albuminuria, Anæmia, Debility, Constipation, Diabetes, Diarrhœa, Dyspepsia, Fevers, Gout, Obesity and Tuberculosis.

Transactions of the Antiseptic Club. Reported by ALBERT ABRAMS, a member of the San Francisco medical profession. Illustrated. New York: E. B. Treat, 5 Cooper Union. San Francisco: Johnson & Ernigh. 1895.

This work is a keen satire upon the peculiarities of the medical profession, and in a humorous way shows up the weaknesses of our profession. In perusing its pages, one finds the mirror held up to reflect many of our deeply cherished fads, and to expose some peculiarity whereby we fondly hope to get ahead of our brethren and yet remain within the pale of the Ethical Code—that misty, elastic, ill-defined list of rules and regulations which is intended to guide the poor devil who has no practice into the certain way of never getting one.

This book is amusing throughout, and with the exception of a few stale jokes, is racy and fresh. We commend it to many of our friends, particularly the *posers*, and there are many such.

In view of the near approach of the time for the meeting of the Medical Association, we can, with a great deal of confidence, recommend the thoughtful study of Dr. Compressor Nasi's strictures. Dr. Nasi was incensed at the inanity of the preceding speaker's remarks. "He can talk more and say less than anyone I ever knew. His complaint," continued the speaker, "is altogether too common in medical societies. It is characterized as a 'diarrhœa of words and a constipation of ideas,' but he would be more charitable, he would call it vocal incontinence and mental sterility. He ventured the opinion that presidents of medical societies were not stringent enough in checking these vocal monstrosities. No one should be permitted to speak unless he had something original to say. He would rather bow to the superior intelligence of the man who counted the number of drops of urine expelled in a given unit of time, than to the plagiarist who, by skilful transposition of words, succeeded in presenting an original paper to the club."

Medical Gynæcology. A treatise on the diseases of women from the standpoint of the physician. By ALEXANDER J. C. SKENE, M.D., Professor of Gynæcology in the Long Island College Hospital, Brooklyn, N.Y., etc., etc. With illustrations. New York: D. Appleton & Co. Canadian agency: N. G. Morang, 63 Yonge Street, Toronto. 1895.

Surgical gynæcology has in recent times advanced so rapidly, and occupied so pronounced a place in medical literature, that it is a relief to read a work dealing with the purely medical side of this subject. This volume is divided into three parts. The first treats of the primary differentiation of sex, development and growth during early life, and the conditions favorable to the evolution of normal organization and the attainment of a healthy putrity. Part second considers the characteristics of sex, the adaption of structure to function, the predisposition to particular diseases, and the causes of certain affections peculiar to women, etc. Part three deals with the menopause and the diseases of the latter period. As is to be expected, the work is well written and contains many practical and useful suggestions; among the more interesting sections are those relating to massage, hysteria, neurasthenia, sex and its relations to insanity; functional diseases of the bladder and derangements of mensturation and of the sexual function. In dealing with mental therapeutics, Dr. Skene presents his compliments to the "Christian Scientists" as follows: "A sad and pitiful show they make of themselves when trying to do impossible things. While they are doing an endless amount of harm, they do good occasionally; but it is by accident. When by chance they get hold of a case that can be relieved by hypnotic suggestion, and they succeed in hypnotizing the sufferer, they do good. But the harm they do far outbalances the good in their efforts to do impossible things, by using their faith cure in cases that cannot be helped by it, and by keeping the poor sufferers from proper treatment. They offend against the right in this way as all charlatans do, by insisting on being able to cure all diseases by one agent. They should be suppressed. They are a bane to the world. . . . Prayer is a therapeutic agent; the hypnotic state can be induced by prayer. If relief is sought in prayer, and it is possible that it can be obtained through hypnotism, that prayer will be answered. The laws of psychology and physiology are so arranged that certain prayers are answered and others are not. This is the only scientific explanation of the efficacy of prayer in healing the sick that I can find."

Clinical Gynæcology, Medical and Surgical, for Students and Practitioners. By Eminent American Teachers. Edited by JOHN M. KEATING, M.D., LL.D., and by HENRY C. COE, M.D., M.R.C.S., Professor of Gynæcology, New York Polyclinic. Illustrated. Philadelphia: J. B. Lippincott Company. 1895.

This work, even though it follows so closely upon others in the same line prepared by men of eminence and advanced thought, comes to us with peculiar interest. Owing to the untimely death of Dr. John M. Keating, the gifted editor who commenced the work, we have from him but the outline, which, however, has been carefully filled in and brought to completion by Dr. Henry C. Coe, than whom none could have been better fitted for the task.

The introductory pages from the pen of the late Dr. Wm. Goodell, show the wide scope of his mental attainments, the breadth of his views, and the soundness of his teaching. The careful perusal of these pages is both a pleasure and a profit to those engaged in this special work.

Whilst advocating in the strongest terms the greatest amount of conservatism in surgery, he gives ample proof of the truest kind of courage where surgical interference is required. In commenting upon the removal of the ovaries, he states "that the unwelcome fact cannot be ignored, that mental disturbance may be traced directly to the ablation of the ovaries. He is disposed to think that such disturbance is due rather to the fact that the woman considers herself unsexed, than that the shock of operation could produce the unbalancing of the mind.

These pages, few in number, are probably amongst his last writings. They are helpful to the profession, and in many ways tend to define our art.

In a system written by different men, it is almost impossible to have perfect freedom from conflicting opinions, but we notice that in this work there are few personal hobbies, and that few opinions clash.

Chapter I.—Written by Wm. H. Baker and Francis H. Davenport, it treats in a careful way of "Gynæcological Examination." In doubtful cases the use of an anæsthetic for diagnostic purposes is advocated. Full directions are given for palpating the ureters, as well as for catheterization. Undue importance seems to be attached to the uterine sound. As uterine dilators, the hard rubber ones are mentioned as being "thoroughly satisfactory." Some prefer steel on account of its hardness and polish. The chapter is well worthy of careful perusal.

Chapter II.—"Gynæcological Technique," by Hunter Robb. This chapter, giving prominence to every detail of technique, goes far

towards establishing on a scientific basis the practical work of the surgeon. He describes and figures the principal micro-organisms which concern us in our work, and especially the progenic bacter

The practical details of sterilizing, both the field of operation instruments, dressings, etc., are clearly dealt with, and should be carefully considered by all. Aseptic sutures, ligatures and carriers are treated of in a masterly way. We cannot agree with his remark that "as a rule, it is better not to make a complete knot when employing silk-worm gut, but to use instead only the first stroke of the surgeon's knot." We have known such "first-stroke-only" knots to slip, producing disastrous results. There is so much of value in this whole chapter that it seems hard to find a fault.

Chapter III.—"Gynæcological Therapeutics." In this chapter Bach. McE. Emmett gives careful attention to the latest improvements in treatment, and his directions for massage, both pelvic and general, are clear, and the contra-indications are stated in a concise way.

Chapter IV.—Barton Cooke Hirst gives a good idea of the anomalies of development of the genital tract, with copious illustrations and full directions for the most modern treatment.

Dr. P. F. Mundé gives an excellent chapter on uterine displacements, though undue prominence seems to be given to the operation of shortening the round ligaments for the cure of retro displacement. This system, in common with others of the present day, bristles with operations named after the men who invented or brought them into prominence. It seems a pity that in a work so scientific and of such excellence, a more rational method of nomenclature had not been adopted.

In a short review it is impossible even to mention all the various authors and their work. The treatise gives evidence of care and thought by everyone who has been engaged upon it. The publishers have given us the benefit of good paper, clear type and profuse illustration. The editor has shown great discrimination and good judgment, which, coupled with his acknowledged ability, have produced a book which is easily of the foremost rank and indispensable to those engaged in the study of gynæcology. A. A. M.

Dr. John R. Stone, of Parry Sound, has been appointed an associate coroner for that district.

Correspondence

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

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—In looking over your issue for April two ideas attracted my attention: First, your editorial, "The Patrons and Medical Education;" and second, Dr. Sangster's letter. In the one, "Another attack to wreck vested rights;" and in the other, a fulsome excuse. For what? I ask this question, that your readers may answer according to the evidence.

You rightly, to my mind, give credit to Dr. Ryerson for his prompt action in notifying the profession generally, and in successfully repelling assault. Now, Mr. Editor, I ask you, and I ask the profession in general, Why did Mr. Haycock attack the Medical Act? Was it not simply that he wanted to do something? He wanted to pose as a redresser of grievances, and he thought the medical profession were a disorganized body. He had read the *Farmers' Sun;* he had read the imbecile twaddle of discontent. He in his innocence, thought it weak and disorganized, and coward-like attacked it. If this was not so, why did he not turn his artillery against the legal profession? The daily papers give flagrant instances of excessive charges. It was plainly shown that the poor client, even if he won a case, lost in legal expenses. It is about as expensive to win as to lose. This fact makes it of interest to every individual—every Patron. Why not attack the press? A paper is sent; you return it. It is sent again; you do not want it; yet, in the end you have to pay for it. Is this just? Is it right? As it affects the individual it affects the Patron. Why did not Mr. Haycock try to remedy this grievance? Yet he would pose as a saviour of citizens' interests. Is he really better than the agitator, the Anarchist?

Dr. Sangster, in his letter, does not thank Dr. Ryerson, although every thinking reading member of the profession will. Oh, no; he does not even censure Mr. Haycock. Why? I answer that he well knows Mr. Haycock's action was the natural logical result of the articles written by himself and his friends, and the lengthy articles in the *Farmers' Sun*, so freely distributed, and marked copies sent to the electorate at the time of the medical elections. I ask Dr. Sangster, Who were the writers of these articles, and in whose interest were they published? At that time I intimated in my letters that subjects interesting to the profession alone should be confined to the

columns of medical journals. My advice was unheeded. Why? Simply because it did not suit the peculiar mode of attack of those gentlemen on the Medical Council they were going to disrupt, disorganize, destroy. Have they succeeded? Where are they now? What have they gained? I reply, simply unenviable notoriety—nothing more, nothing less. It is true the Medical Defence have elected some representatives, but the good sense of the medical profession are in the lead. The *Farmers' Sun* shed its light—but to pale, fade, die. And Haycock! Ask at the doors of Parliament, Where is he? A tail-end of—what?

Mr. Editor, I ask now, as I did months ago, that, as a profession, we stand together. If we have dirty linen, let us wash it at home. The new Council are elected. Let us loyally support it; and, instead of personal bickering, let us, shoulder to shoulder, work in the common interest.

If the Medical Defence Association, as represented by Drs. Sangster, Armour, and Registrar McLaughlin, is still a live factor, why not in the Council, where principles may be advocated and strengthened by personal vote and influence, secure unity of elected members, and, in this way, override and control school influence? Why not see that moneys taken by older members of Council, by mistake, be returned? Why not work to make *all* members of the Council elective? The schools are represented. We do not question by what right or by what means. We do not question by what covert and ingenious arguments they secured power. Let the M.D.O. satisfy their professions and the deluded votes they received; let them correct anti-election abuses; let them be the power they promised; relieve the general profession from chicanery and fraud; and let them introduce an honest executive. All this they promised. Let them carry out the programme. And more than all, let these good men introduce such reforms as are in the best interests of the profession. First and foremost, "Intraprovincial Registration." Why not a uniform examination wherever the British flag flies? Is that not a part and parcel of a British degree? Why, then, not throughout the British Province? Why a separate examination in Quebec, Ontario, British Columbia? Is it not merely and only to give to certain cliques a bonus on each applicant for license? Is it not really legalized robbery of our graduates? Why perpetuate this fraud? Abolish lodge, society and contract work as degrading. Adopt an *increased* and *uniform* rate of fees all over the Province, and a stated fee for expert evidence in any court. These and a number of other matters are of first interest. Let the new members inaugurate an era of reform and

progr and if they were in the past too opportune, if too rash and carel we will forgive them if by humility of heart they seek forgiver and by advantages secured by honest contrition the whole pro on benefit.

In the meantime let us present the medal to Dr. Ryerson.

Yours truly,

Lindsay, Ont. P. PALMER BURROWS.

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

GENTLEMEN,—The Medical Defence Association was formed three years ago for the vindication of your rights and the furtherance of your interests, and it has already in that direction reached results to which it can point with honest pride. It has largely disabused the profession of the idea that the injustice and other manifold evils of the past *regime* were a fate to be meekly accepted without useless resistance. It has awakened the medical electorate to a saving sense of the degradation involved in a tame submission to indignity and wrong, and has nerved it to self-assertion and a strike for freedom. It has satisfied most of you—perhaps, indeed, all of you except those too apathetic to read and investigate, or too subject to extra-professional considerations to be open to conviction—that the Medical Council has, heretofore, been controlled, and is still liable to be greatly influenced, by a grasping and dominant clique, whose power therein needs not only to be strenuously opposed, but to be either abolished *in toto*, or very seriously curtailed, if your most vital interests are to be protected and advanced. It has prompted you to inquire why of all professions that of medicine should be the most overcrowded and the most notably hampered, with an increasingly large annual influx of new recruits; and to find the answer chiefly in the fact that the composition of the Council favors, and the easy subserviency of your elected representatives therein permits, the existence of the evil. It has created among you a widespread and a growing desire for clean and economical government, and it has animated you with an invincible determination to rest content, ultimately, with nothing short of professional independence. By the beneficial changes it has procured in the Ontario Medical Act, it has placed the future destinies of the profession chiefly in your own hands. It has, practically, given you the control of the Council, as soon as you shall have determined that no uncertain or weak-fibred candidate for election thereto shall receive your suffrages at the polls. It has ventured to remind you that

"eternal vigilance is the price of freedom," and that an apathetic, non-exigent electorate is certain to be served by careless, self-seeking or unfaithful representatives. And such being the case, it has urged you to ensure fidelity on the part of those you send to the Council by closely watching and intelligently criticising all their votes and contentions, so as to be able to call them to a strict account of their stewardship, when, three years hence, their day of reckoning comes around.

The Defence Association is very far from regarding its mission as closed. Much as it has accomplished in the past, it hopes to do yet more in the future. In the recent Council elections it has secured a coign of vantage from which it can henceforth act with tenfold greater effect, and it will never lay down its arms until professional autonomy is reached. Its immediate aim will be to bring about, through its elected members, such reforms in the Medical Council, next month, as can be effected in that body without further legislative assistance. You are earnestly requested to carefully watch the work then done or attempted, and to note the cause or causes of failure where our efforts are not crowned with success. Means will be found to place before you the yeas and nays of every important vote, together with a full record of the whole proceedings, and also to furnish you at the close with a running commentary on the principal arguments and forces brought into play. There may not be stalwarts enough in the new Council to carry every point in favor of the profession, but there will be quite a sufficient number to make the atmosphere of the Council chamber uncongenial to that school of cuckooism which has heretofore prevailed therein, and to expose, if they cannot prevent, infidelity on the part of your representatives. It is proposed to repeat these tactics next year, and the year following—at the same time using the professional press, to the extent of our opportunity, to mould and develop in our ranks a just and dignified *esprit de corps*—in the confident hope that the medical electorate, when next called upon to use the franchise, will have attained, practically, to a unanimity of sentiment. Whether, in the furtherance of the grand end we have in view, we shall feel impelled to approach the legislature next spring, or not until after next election, will very largely depend on the results of the coming session. If our reasonable claims on behalf of our constituents and our honest efforts at economy are then thwarted, mainly by the irresponsible elements in the Council, the profession will probably insist that decisive action shall not be delayed. In view of that contingency, it is most desirable that every medical man in Ontario who is in sympathy with our movement towards clean, econo-

mical and responsible government, shall join our brotherhood without delay. Our present membership of nearly 1,300 ought to reach 2,000 before the next Council elections, and as our influence with the government and the legislature will be in direct proportion to our numbers, we hope that our friends, throughout the province, will exert themselves in this behalf. Our Association owes nothing, the expenses of the past having been cheerfully borne by a few, and we anticipate no outlay in the future not easily within our means. We therefore levy no assessment on our members and ask for no contributions, so that membership in our Association will cost you nothing. It is your name and influence, and not your money, we want on behalf of the profession. Any members of the College who desire to identify themselves with us can secure enrolment by sending to my address a post-card (not a letter) expressing a wish to that effect, and properly dated and signed.

Our opponents have repeatedly tried to frighten us with the threat that, if we do not desist and leave the schools in undisturbed possession of their usurped privileges in the Council, they will break up the Ontario Medical Act. It is an idle threat, and they know it. Political charlatan Haycock's absurd fiasco in the House has served to show the immense power and reserve force which the profession can bring into play when roused to action, and has thus effectively exploded the idea that we have anything to fear in seeking such legislative relief as we may require. In this manner unquestioned good has accrued from a crazy attempt—instigated by malice, and, no doubt, largely promoted by a desire to cripple the Defence Association and the worst result of which was to excite a few emotional persons to the verge of hysterics. Happily, however, it has taught us that, unitedly, we can exert on the government and on the legislature an influence so powerful that neither schools, nor universities, nor Patrons, nor homœopaths, nor professional outcasts, nor all of them combined can prevent the final triumph of our reasonable and righteous claims. This knowledge is so important that we think it has been cheaply bought, and, although we dare not hope that sycophants and school parasites *et hoc genus omne* will altogether cease to use their servile pens in crying peace! peace! when there is no peace, their paltry efforts are, henceforth, harmless indeed. We do not, however, conceal from ourselves the fact that quite outside those who may be prompted by interest, or association, or flunkyism, or personal vanity, or disappointed ambition to thus carp at our methods or try to belittle our results, there are in the profession those who honestly think that having worsted our opponents in the recent elections, and

secured a controlling voice in the new Council, the hatchet should now be buried and peace proclaimed. Such persons know but little of the motives which still influence the irresponsible elements of the Council. If our opponents in that body were open to conviction on points where their financial interests are involved, and could be made, like the rest of us, to look at matters from a purely professional standpoint, there might be some reasonableness in this view. Their past actions and their present attitude, however, alike prove that they are to be beaten and not won into acquiescence—that, if we are to obtain from the medical schools and their satellites a profitable recognition of the rights of the profession, it must be, not by an exhibition of mistaken generosity, but at the point of the sword. That they still hug the delusion that they can continue the stupid concealment of the past and prevent us, in the Council, from exposing the extravagance and mismanagement of the last five years, is well shown by an incident which has just occurred. In blocking out the work to be attempted in the coming session it became necessary to apply to the Registrar for a return respecting the sums paid to the Council examiners, the number of papers read by each, the number of candidates presenting themselves at each fall examination who had not written the previous spring, etc. This information was asked for nearly three months ago. The request was forwarded by the Registrar to the President on the 8th of February, by him referred to the Executive Committee, and by it flatly refused. But all intimation that it was refused, was withheld till yesterday (the 12th inst.), lest, had we received it during the session of the legislature we should have obtained it—as in a previous case we were driven to do—by a motion of the House.

I shall probably more fully discuss this unworthy subterfuge in my next letter. Meantime I may remind you that the information sought was asked for in the interests of the profession, to be laid before the Council at its approaching session—that it involved no expense whatever, that it was within the prerogative of a member of the Council to seek and to obtain it, and that its refusal was either a piece of blundering incapacity or autocratic insolence. I may further ask you to remember that it was refused by an Executive Committee appointed by a moribund Council, at a stolen session, and composed of three persons—a University appointee, a president whose constituency publicly declared in the recent elections its want of confidence in him, and a homœopathic ex-president, discredited throughout the profession by his unblushing perversion of facts in his official address last June.

Yours, etc.,

Port Perry, April 13th, 1895. JOHN H. SANGSTER.

Obituary.

John Nash, M.D.

In the death of Dr. Nash, of Newmarket, which occurred March 19th, Ontario loses one of its oldest practitioners. Deceased was born near London, England, in 1799, and was educated at Oxford. After practising in London for some time he came, in 1836, to America, settling in Bridgeport, Connecticut, where he practised for a few years. He then came to Toronto, and shortly afterward settled in Newmarket, where he has resided ever since. Dr. Nash enjoyed the confidence of a large *clientèle*, and besides his skill as a practitioner he took a live interest in philanthropic work.

Kenneth Hugh L. Cameron, M.D.

Dr. K. H. L. Cameron, of Cayuga, died on the 8th of April, at the too early age of 40. He studied at the Toronto School of Medicine, and graduated from it and the Toronto University in 1875. He took a most active interest in politics, but did not allow it to interfere with his practice, in which he was highly successful.

Surgery is vastly overdone of late; . . . the modern shifting notions on pathology are largely responsible for the present state of things; the ever-haunting phantom of infection from simple lesions has led to the conclusion that local and radical measures are called for in the treatment of conditions which in the usual order are remediable through simple means with the aid of systematic therapy.—*Times and Register.*

Ovaritis.—

℞. Sulphate of soda ..... ℥iv.
Sulphur ..... ℥j.
Sugar ..... ℥v.
Essence of peppermint ..... q.s.

S. Teaspoonful at bedtime in a glass of water.

—*Winternitz.*

the difficulty of nomenclature is anyhow too great to lightly reject so expressive a word, which, as bacteriologists and morphologists all admit, does certainly most vividly express the primordial condition of which this is the physiological analogue. In its last analysis, after all, it is the molecular disturbance or change produced in the germ that deprives it of its toxic power. This we know will effect even chemical action. Upon this fermentative processes depend. Isomerism is another example of the effect of molecular arrangement or disarrangement. Where can you find two substances more distinctly different than sugar and gum arabic? And yet they are exactly the same in composition and in the proportion of elementary combination, the difference in arrangement of the molecules being sufficient to account for the difference in chemical and physical properties. With these examples before us—and I could, if time permitted, bring out many others equally as striking—it is very easy to see how the slightest disturbance of molecular arrangement in any germ will deprive it of its specific character, and by investing it with certain cellular elements, emasculate the most deadly of toxic bacilli and send them harmless through the blood currents of the organism. Having, therefore, found that it is within the leucocyte that all protozoic material is developed, that upon the proliferation of the leucocyte all assimilation depends, it is but a step further to establish the action of the leucocyte in resisting the effect of toxic germs, as well as divesting them directly of toxic power. It would perhaps be more accurate to define this action by the statement that they are capable in themselves of overcoming the pathological influences which are being continually introduced into that organism. To those whose daily experience brings them face to face with the awful side of human life, I think I can appeal with emphasis, when I state that there is scarcely a breath we breathe, or a drop we drink, or a morsel we eat, that is not charged with the germs of deadly disease, and if there were not in our organism a distinct provision made for the resistance of such germs, to use a Pauline expression, we should "die daily." When the tocsin of disease is sounded through the organism, it is the rushing of the leucocytes that constitutes the first physiological response—to directly resist a toxic agent, or supply the structure attacked with material for nutrition or repair in case of lesion. And yet there are still those among the ranks of intelligent practitioners who consider the increase of leucocytes as an element or phase of disease itself, instead of nature's effort to support her crumbling battlements. At this stage of my argument, I shall, upon the strength of what may be microscopically demonstrated to be the function of the nuclein-charged leucocyte,

make an assertion which I have no doubt will be considered somewhat arbitrary. It is, that whatever of so-called specific effect lies in the antitoxine obtained from the immunized animal, as opposed to the bacillus and the toxine of diphtheria, is accomplished by the excitement of leucocytosis, and after all the end is reached by the same physiological process.

The ultimate aim of all antitoxic agents must be the overwhelming of the toxic element of the germ, and this can only be accomplished by a great excess of physiological tissue-building material. Let us observe the process by which this antitoxic effect is brought about. In the first place, the physiological relation of protonuclein would of course preclude the idea of its action as a direct specific antidote to a specific poison, such as that observed between chemical agents, or even physiological antagonists, as for instance the hydrated sesquioxide of iron against arsenic, or atropia against morphia, or chloroform against strychnia. Were this the principle of the functional activity of protonuclein, its therapeutic range would be limited to such an antagonism, but. as I am prepared to show, by careful experimental records, its effect is first observed when the system has been thoroughly charged with it, thus preventing the expression of the toxic agent by a preoccupation of the nutritive field, and an investment of the attacking germ. I have often noticed a leucocyte, thoroughly charged with original nuclein, adhere to the cell of a sarcoma, and after bursting itself, send the round cell floating away in the field crenated and almost emptied of its contents. Such effects have been observed also upon the blood after days of treatment with protonuclein. This appears to me to be the very *ultima thule* of therapy; and the question will be—has been, very naturally asked after such developments: "If such be the power of a substance capable of investing, controlling, and overwhelming toxic agents, where is the limit of its action?" If I spoke the truth boldly, as it should be spoken, I should answer that, properly applied, I can see no limit of its resisting power. When side by side with my own experiments I have observed what I admit to be the wonderful effects of antitoxine in the organism on the bacillus and toxine of diphtheria, I have, nevertheless, felt that protonuclein was as far superior to it in pathological results as the whole realm of pathology is greater than a single disease.

And now we come to the question of practical interest to the general profession, "How is it possible to extract this delicate substance from the animal tissues?" and its corollary, "What are the methods used to preserve its cellular activity?"

There are three forms of nuclein material now before the profession.

1. Nuclein made from yeast.

2. Another preparation of nuclein taken from the animal organism by chemical methods.

3. The third form, protonuclein, is a product taken directly from the lymphoid tissues of the healthy animal, the thyroid and thymus glands, the brain substance—within the area in and about the corpora quadrigemina, the pituitary body and pineal gland—the pancreas, spleen and liver. No chemicals are used in this process, the methods of extraction being purely physical, and the protonuclein is kept active by an investment of gum benzoin and milk sugar, which preserves it indefinitely, just as the germ of a grain of corn is kept potentially active by its environment. The activity of the protonuclein may be easily shown by dissolving some of the powder in distilled water. After the sediment has settled, draw off the supernatant fluid and apply a drop of it to a drop of freshly-drawn blood. You will see a most beautiful physiological panorama, instantaneous photographs of which I have here for your inspection. Protonuclein is richer in nitrogen than the ordinary nuclein of the text-books. Its formula, as far as it is possible to be chemically accurate in quantitative analysis, is $C_{29}\ H_{49}\ N_{10}\ P_5\ O_{32}$, differing by about one equivalent of nitrogen. It will be noticed how rich in phosphorus this wonderful physiological agent is.

So much therefore for its preparation and extraction. The most important factor in the problem is the answer to the questions, "What will it do?" "What can it cure?" "What will it prevent?" in the great battle between science and death. Were I to give free range to my own confidence in the therapeutic power of protonuclein as observed from day to day for the last six months, under the most favorable circumstances and under the direction of experienced and authoritative clinicians, you would discredit even the demonstrations of this report. But if you will consider for a moment what a sweeping therapeutic power must belong to any agent which is the normal tissue-builder of the organism and the direct antagonist of its invading toxic germs, you will see how difficult it is to limit its indication as a therapeutic agent.

Its most pronounced results have been observed in tuberculosis, sarcoma, diphtheria, tonsillitis, and la grippe. In the hospitals in New York it has been used with general success in the following diseases, besides those already mentioned: Abscess, anæmia (pernicious), Bright's disease, carcinoma, colds, malaria, tuberculosis of bladder, ulcers, and many others.

As to dose and mode of administration, I subjoin to this paper full

directions, which have been carefully prepared from the closest clinical observations.

Nothing has been left undone to thoroughly test the practical truth of what has theoretically been claimed for protonuclein as a therapeutic power. I believe with others even more conservative and less sanguine than I, that it will mark an era in therapeutics. Such relationship between the pabulum and the individual tissue-cell of the various structures of the body, seems to be the very last analysis of function in the human organism. Indeed, it has been said by one who occupies a high position as a medical teacher: "I feel assured that protonuclein is to fill a most important place in the therapeutic resources—perhaps the most important."

Up to the time when therapy began to look to physiology for help, our whole system was a vast accumulation of clinical reports without one iota of determining philosophy—a vast labyrinth without an Ariadne thread to guide the returning footsteps of our reason. I doubt not that before the close of the nineteenth century our therapists will look back upon the thousands of agents vaunted in the cure of disease las the modern soldier gazes upon the spear and shield of ancient Greece and Rome. The simplification of physiological methods has been followed most naturally by the use of those physiological principles of therapy upon which the normal curative conditions of the organism depend, and without which no scientific system of therapeutics could ever be formed.

Tendon Grafting.—A new operation for deformities following infantile paralysis. At the meeting of the New York Medical Association, October 15th, 1895 (*Medical Record*, October 26th), Dr. Milliken presented a boy eleven years of age, upon whom twenty months before he had successfully grafted part of the extensor tendon of the great toe into the tendon of the tibialis anticus muscle, the latter having been paralyzed since the child was eighteen months old. The case which was presented showed the advantages of only taking part of the tendon of a healthy muscle, which was made to carry on the function of its paralyzed associate without in any way interfering with its own work. The brace which had been worn since two years of age was left off, the patient walked without a limp, the talipes valgus was entirely corrected and the boy had become quite an expert roller skater. Dr. Milliken predicts a great field for tendon grafting in these otherwise hopeless cases of infantile paralysis, who heretofore have been doomed to the wearing of braces all their lives.

THE

Canadian Medical Review.

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Original Communications.

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

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

Fellow of the American Gynæcological Society, Gynæcologist to the Montreal Dispensary, and Surgeon to the Women's Hospital, Montreal.

(CONTINUED FROM LAST ISSUE.)

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

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

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

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

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

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

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

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

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

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

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

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

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

* "Sutton's Surgical Diseases of the Ovaries and Fallopian Tubes," page 292.
† "*Des Suppurations Pelviennes chez le femme, Paris*," 1891.
‡ *Journal of the British Gynæcological Society*, Vol. II., page 264.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS.

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

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

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

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

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

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

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

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

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

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

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

Honorary Associate of the Order of the Hospital of St. John of Jerusalem in England; Honorary Member of the Association of Military Surgeons of the United States.

I. THE BRITISH ARMY MEDICAL STAFF.

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

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

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

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

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

(To be continued.)

Society Reports.

Toronto Medical Society.

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

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

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

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

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

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

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

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

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

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

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

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

A Case of Poisoning by Atropia.—Dr. OLDRIGHT said that practitioners who had used atropia and belladonna in the maximum doses would find they were too strong. In a patient suffering from neuralgia and excessive perspiration he had ordered gr. 1-25 of atropia in ℥iv. mixture doses. The patient telephoned him that the medicine did not agree with her, that she had a good deal of stiffness about the neck and jaws, and that her face became flushed. Upon inquiry, he found that the druggist had used ℥25 liquor atropiæ (gr. ¼), which was gr. 1-64 at a dose, almost the minimum B. P. dose.

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

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

Dr. MACDONALD seconded the motion, which duly carried.

The society then adjourned.

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

Toronto Clinical Society.

(MAY 8TH, 1895.)

President DR. RYERSON in the chair.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Editorials.

Electrical Progress.

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

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

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

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

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

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

Specialism Gone Mad.

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

The Diagnosis and Treatment of Abdominal Injuries and Hæmorrhages.

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

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

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

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

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

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

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

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

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

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

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

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

Ontario Medical Association.

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

DISCUSSIONS AND PAPERS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

common. It may arise from some condition injuring the general health, from improper food, from bad hygienic conditions. No matter from what cause, if the blood is insufficient in amount, or comes to any portion of the nervous system in insufficient supply, the nerve matter is not nourished, and it fails to do its work. 3. Active poisoning of the nervous matter. This may be from poisons formed within the body. These injurious waste products are circulating through the system in the blood, and affecting deleteriously the nerve elements. Or, in the second place, the nerve system may be poisoned from injurious articles taken into the system.

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

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

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

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

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

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

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

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

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

Dr. Bertram Spencer has been appointed an associate coroner for the city of Toronto.

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

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

Correspondence

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

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

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

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

Yours truly,

Port Perry, May 18th. JOHN H. SANGSTER.

Registration in Illinois.

To the Editor of the CANADIAN MEDICAL REVIEW.

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

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

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

Chicago, Ill. J. F. BURKHOLDER.

Miscellaneous.

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

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

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

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

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

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

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

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

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

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

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