THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Published monthly at Vancouver, B. C.

Nervous Breakdown
C. F. Barker

Acute Intestinal Obstruction

Ophthalmic Aspects of General Medicine

SEPTEMBER, 1925

Published by
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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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VANCOUVER MEDICAL ASSOCIATION.

Founded 1898. Incorporated 1906.

28th Annual Session

GENERAL MEETINGS will be held on the first Tuesday of the month at 8 p.m.

CLINICAL MEETINGS will be held on the third Tuesday of the month at 8 p.m.

Place of meeting will appear on Agenda.

GENERAL MEETINGS will conform to the following order:

8 p.m.—Business as per Agenda.

9 p.m.—Paper of Evening.

The regular work of this Session will commence on Tuesday, Oct. 6, 1925. Programmes to be announced later.

* * * *

CITY HEALTH DEPARTMENT

Vancouver, B. C.

STATISTICS — JULY, 1925

Total Population (estimated)		126,747
Asiatic Population (estimated)		9,960
		Rate per 1000 of Pop. per Annum
Total Deaths	111	10.3
Asiatic Deaths	10	11.8
Deaths—Residents only	70	6.5
Total Births—Male, 161 Female, 127	288	26.8
Stillbirths—not included in above	9	
Infantile Mortality—		
Deaths under 1 year of age	10	
Death Rate per 1000 Births	34.7	

Cases of Contagious Diseases Reported.

	June.		*July.*		*Aug. 1st to 15th.*	
	Cases.	Deaths.	Cases.	Deaths.	Cases.	Deaths.
Smallpox	10	0	8	0	3	0
Scarlet Fever	24	0	9	0	4	0
Diphtheria	11	1	11	1	5	2
Chicken-pox	12	0	6	0	4	0
Measles	3	0	0	0	0	0
Mumps	21	0	3	0	3	0
Erysipelas	1	0	5	2	3	0
Tuberculosis	2	8	9	8	5	0
Whooping-cough	28	1	24	1	4	0
Typhoid Fever	3	0	2	0	0	0
Ep. Cerebro-Spinal Meningitis	0	0	1	0	0	0
(Cases from Outside City included in above.)						
Diphtheria	3	1	4	0	1	1
Smallpox	0	0	0	0	3	0
Scarlet Fever	3	0	0	0	1	0
Typhoid Fever	0	0	2	0	0	0

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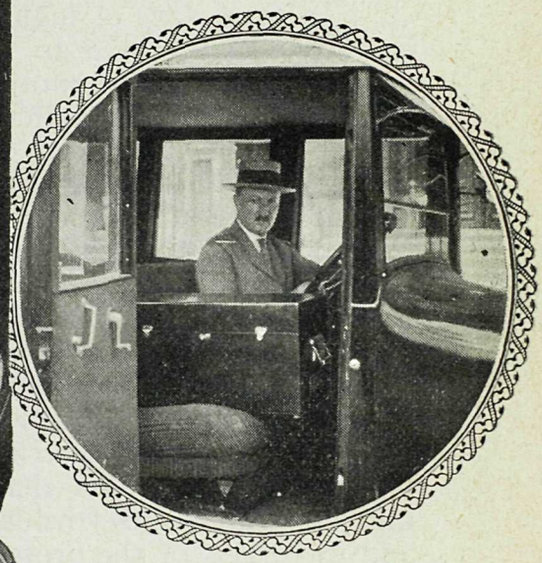

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EDITOR'S PAGE

The wise mariner, when his ship is labouring in a storm, shortens sail. If she labours still, he sometimes finds it necessary to lighten ship by jettisoning cargo. One supposes that, in doing this, he selects that which is least valuable to throw overboard. So the wise man, when he finds income insufficient to meet outgoings, when his financial ship is labouring, shortens sail and throws overboard unnecessary things, and luxuries which he can best spare.

In these days of high overhead cost of living, all of us occasionally feel the need to retrench. Whether we do this in the wisest way or not, is another question. The cause of these reflections is the discussion that has been rather frequently heard of late about membership in the various Medical Associations. To many it would appear this seems a luxury, a rather superfluous addition to one's burdens, and they adduce arguments for relinquishing it, if not in all, at least in one or two.

To such, indeed to all who need a little moral support for their belief that such membership is a necessity and not a luxury, we would heartily commend a careful reading of a great speech of Osler's, "On the Educational Value of the Medical Society," found in the collection of Essays known as "Aequanimitas." While he gives it this title, the speech points the way, in his inimitable style, to many other profits that accrue from associations of medical men. "Unity and friendship . . . are essential to the dignity and usefulness of the profession." It would be hard to put more truth into ten times as many words. The removal of misunderstandings—better yet, the prevention of them—encouragement in the day's work, renewal of enthusiasm and devotion, refreshment of mind and recreation—these are some of the blessings, apart from educational advantages, that Osler found in "a well-conducted society." Everyone of us must know this to be true; in fact, the history of our own Association proves its truth. Surely in the stress and strain of a busy medical life, perhaps even more to the men beginning their career, with their long periods, deadly dull, of waiting, and of discouragement, such boons as these are beyond price, are more than mere luxuries.

And then the Library—and one can imagine what Osler would say about this. From a mere dollars and cents point of view, this one thing alone repays the yearly subscription a dozen times a year. Especially is this true of such a Library as ours, with its admirable system of delivery of books, magazines, and so on.

There is another side to the picture—the necessity for organized action, for union, not merely unity. The medical man cannot be, at any rate he should not be, only a practitioner of medicine. He should be an apostle of public health, of sanitation, of good laws—he should be a citizen, and one of the moral police force of the country—and he can do this most effectually through association. Again, he has enemies, spoilers, exploiters of his good-nature and idealism—and for defence against these he

needs a shell of organization, of companionship *en masse* with his fellows. Here comes in the wider type of association, provincial and federal. Through these we may preserve intact our identity as a profession, may carry weight in the councils of the nation, may find insurance against the perils that do so easily beset us. And as insurance, it is very cheap.

Not to do one's share in this, argues a rather small spirit. For the work must be done, and is done, and everyone benefits by it. The least each one can do is to pay his share, or he is accepting charity from those of his fellows who have a better appreciation of their responsibilities.

Moreover, it gives one the valuable right of every free-born citizen, that of finding fault with one's administration. You may do this justly, if you have paid your tax and cast your vote, but the man who won't pay his taxes, and neglects to exercise his franchise, has no right whatever to complain of the government of his country.

And so with us. If the Association, whichever one it may be, is not up to your ideas of what an Association should be, you have your remedy—join it, work in it and for it, and give it the benefit of your own personality. Both of you will gain immensely, yourself perhaps most of all. The cost is trifling, in fact it is an investment, and not an expenditure, but to get the most out of your investment you must look after it yourself.

* * * *

NEWS AND NOTES

It is with great regret that we hear that Dr. Alison Cumming is still very seriously ill, and has gone back to Montreal for treatment. A large section of the public will join us in our wishes for his speedy recovery.

Dr. R. A. Seymour, of the Vancouver General Hospital, is being congratulated on the arrival of a daughter. Mrs. Seymour and the new citizeness are doing well.

Our worthy President, Dr. J. A. Gillespie, has returned from California, where he has been with his family for a month's holiday, in the form of a motoring trip.

Dr. E. H. Funk is the latest addition to the Benedicts' Association. He has our congratulations.

The little island of Savary is gradually becoming a very popular resort for medical men, many of whom have summer cottages there, and whose purest delight it is to introduce their friends to the charms of the island. Latest converts, we understand, are Dr. F. N. Robertson, who has built there this summer; Dr. T. H. Lennie, who reports favourably on the place; Dr. W. D. Keith, Dr. H. H. Milburn, each of whom have taken cottages there for the summer, and others, who have made visits of more or less length. It is an ideal spot from a doctor's standpoint, quiet, and far from telephones and automobiles. To many of us, the fact that there is no golf, also gives a feeling of change and rest.

It is with great pleasure that we record the return of Dr. A. S. Monro to his usual occupations. We can assure him that the corridors of the V. G. H. have seemed unusually quiet and untenanted, without the daily, almost hourly, vision of his white-sheeted form flitting about them.

Dr. A. W. Bagnall has left for Boston and New York to do post-graduate work in medicine.

Dr. F. P. Patterson leaves soon for the East to visit orthopaedic clinics.

In view of the ever-growing interest in physiotherapy, members will be glad to hear that Dr. H. A. Barrett (Medical Arts Bldg.) has offered to give a short course of practical instruction in this subject to all who care to take it. No charge will be made, and out-of-town physicians are especially welcome. The course will be held in the evenings, and any who are interested are requested to communicate with Dr. Barrett at once.

Members are again reminded that fees for the current year are now due and payable. The work of the Executive is greatly impeded by the tardiness of a good many of our members in this respect.

We would again call attention to the obligation we are under of supporting the firms who advertise in THE BULLETIN. When doing so, please apprise such advertisers of the fact that you read their advertisement in THE BULLETIN.

Dr. Geo. Lildon, member of the Dominion Medical Council, left for the East on the 27th August, and expects to be away about a month.

* * * *

LIBRARY NOTES

(*The Library is situated in* 529-531, *Birks Building, Granville Street, Vancouver. Librarian*: *Miss Firmin. Hours*: 10 *to* 1, 2 *to* 6.)

REVIEWS OF BOOKS

International Clinics, Vol. 1. Thirty-fifth Series, 1925. J. B. Lippincott Co. $2.00.

The international character of the work is maintained in this volume by contributions from Scotland, Switzerland, and France, though by far the greater part of the material had its origin in America. Two articles by Prof. L. F. Barker—on Staphylococcus Septicaemia and Treatment of Neuroses, respectively—will be of special interest to members of this Association at this time. The prominence of functional disorders in present day medical thought is attested by the fact that three other writers discuss some aspect of the psychoneuroses, the articles by Dr. Alfred Gordon, of Philadelphia, on "Psychoneuroses in Relation to General Medicine," being especially interesting and suggestive.

Some of the problems of urological diseases are comprehen-

sively dealt with in two articles from the Dorsey Clinic of St. Louis. Other surgical subjects considered are diseases of Meckel's diverticulum, mastoid diseases, malformations of the rectum and anus, acute osteomyelitis and intranasal lesions. Dr. Max Thorek, of Chicago, describes what he styles "A New and Effective Method of Treatment of Clinic Suppurations, Especially of Bones," which consists in the application of an aluminum-potassium nitrate solution in a compress of sterilized rolled oats. The claim of the effectiveness of the method is supported by a tabulated report of 116 cases so treated by the writer and others.

Commencing with a sketch of the regime of Cornaro, a Venetian, born in 1467, who attained the age of 105, Charles Greene Camston, in his article on Macrobiosis, gives an interesting account of some of the methods that have been advocated for prolonging life, and makes some deductions applicable to our own time.

A summary of Medical Progress in 1924 concludes the volume.

W. F. M.

* * * *

ADDRESS BY DR. BARKER ON "NERVOUS BREAKDOWN"

Dr. Lewellys F. Barker, of Johns Hopkins, addressed a large audience of members of the Vancouver Medical Association in the University Auditorium on the evening of Wednesday, July 29th. Dr. A. W. Hunter, Vice-President of the Association, occupied the chair and introduced the speaker. Dr. Barker took as the subject of his address "The Nature, Causes and Prevention of Nervous Breakdown."

Dr. Barker said that the nervous individual often lacks the sympathy to which he is entitled. He cannot think right and act right because he is ill, and it does great harm to tell him that his symptoms are imaginary. These symptoms are just as real and as genuine as those produced by definite organic ailments. As to the varieties of nervous breakdown their name is legion. The neurasthenic and hysterical patient we all recognize. The hypochondriacal patient who tries to interpret his own symptoms in terms of organic disease; the psychasthenic, who is full of fears —fears of himself, fears of place, and fears of people—are also familiar to us.

Of the psychoses proper the manic depressive group is one of the most important. This cyclic, or circular insanity, is one which in some form or other is quite widespread. In this condition the patient for a period of time may be greatly depressed, claims everything appears "blue," and is decidedly melancholic. After a year or two he may begin to see daylight again. The gloominess and depression wear off and things may take on a more roseate appearance. He feels happy and ecstatic, tends to talk rapidly, and is in a rather exalted state of mind. The trouble is he is

often *too* exalted and may become erratic or even maniacal. The first stage is the depressive and the second the maniacal stage of this malady. We must recognize, too, that there are incomplete forms of this disease during which the patient may be only mildly depressed and correspondingly mildly elated. The depression grows, and the disease is quite unaffected by treatment, and the physician in charge of the case may lose or gain credit according to the time at which he sees the patient. If at the beginning of his depression it has been said no treatment is of use—if at the end, the patient will lose his depression with any or no treatment. In patients with manic depressive psychoses there is no loss of mental power.

Another variety is the dementia praecox group. These lamentable cases occur in young people. They begin to think their friends are not treating them rightly, they have grievances, they are misunderstood, and in general take on the aspect of misfits. They may get paranoid symptoms. The prognosis in this group is much worse than in the manic depressive group. Systematized paranoid delusional cases are rare.

Of the organic psychoses there are many. For example, those of the toxic infections, as in typhoid fever. Lately a great many instances have resulted from the infection of encephalitis lethargica, which produces very characteristic symptoms. While it is probable that some cases entirely recover, it must be recognized that most have residual symptoms. About 25% or more of cases will show that variety of sequela known as Parkinson's syndrome. This syndrome may occur early in the disease (in which case recovery seems to be possible), but usually six months or even a year elapses before its onset, and the outlook is then correspondingly bad. This syndrome is well recognized, very closely simulating paralysis agitans, except that the tremor is usually absent.

Syphilis may be the cause of another form of organic psychosis, either in the form of definite lesions of the brain or meninges, or as one of the parasyphilitic affections producing general paresis. Then there are the organic psychoses associated with severe attacks of multiple neuritis, as may occur in arsenical poisoning, known as Korsakoff's syndrome.

Finally we come to the arterio-sclerotic dementia, which in greater or less degree affects us all if we only live long enough for it to do so. Unfortunately this condition may at times be presenile in character, that is, the customary arterial changes associated with advancing years occur (possibly for reasons of heredity) in early life, and symptoms, such as unusual forgetfulness, begin to manifest themselves at this age.

Psychopathic personalities are distorted personalities. Among them we find a degree of feeblemindedness. These are the people who are unusually quarrelsome. They are the litigious variety of persons. They constitute a large element of those who appear in the divorce courts. Rightly considered the circumstances leading to divorce mean mal-adjustment, and it is very curious that divorce proceedings often run in families. They also con-

stitute the derelicts of society, the ne'er-do-wells, tramps, drug addicts, etc. All these have bad nervous systems and tend to be antisocial. Rightly regarded all crime and delinquencies are due to mal-adjustments, and are the result of bad nervous systems. Society is apt in these cases, for its own protection, to take revenge upon these people when, doubtless, the proper way would be to try and reclaim them, if possible.

The nervous system is the great organ of integration, and in all forms of nervous breakdown there is evident a lack of adjustment to surroundings. The laity recognize this in their very familiar expressions of the condition. They say of such a person that he is "all gone to pieces," or disintegrated, or is "all broken up," and, conversely, when he recovers they will say he has "pulled himself together."

The borderline between health and disease is very narrow, and it is somewhat difficult to give a definition of what one understands by these terms. The best definition, the lecturer said, which he had been able to arrive at was that health represented an adequacy of response to environment. What are the conditions leading to inadequacy of response? In these cases we must look for causes to what has gone before. We must consider, for instance, the germ cells, two in number, which contain all the potentialities of the individual, and these potentialities cannot in any instance be transcended. Whether they shall be allowed full development depends upon the environment in which the individual is placed, and this development is the forerunner of all that comes afterwards.

Heredity and environment constitute two important causes in the conditions under consideration. Heredity is probably the more important of the two, and certain conditions, such as longevity and predisposition to disease, are undoubtedly hereditary in character. Identical twins is the name given to foetuses produced in the same egg-cell by a single fertilization in contradistinction to twins produced from different egg-cells. These latter may be of different sex, but identical twins are always of the same. They are exceedingly alike, and it is very hard to tell them apart, especially when young, even their parents may have difficulty in doing so. Curiously enough, so strong is the part that heredity plays, twins of this nature are apt to sicken of the same disease in later life, although they may be living in entirely different parts of the country.

Dr. Barker went on to illustrate his point by a reference to the classical case where, as the result of illicit intercourse of an individual with a feebleminded woman, a child was born from whom there have been a great many descendants also feebleminded and many of criminal tendencies. Later the man married, and most of his legitimate descendants have turned out extremely well, many occupying high positions in various professions and in political life. Dr. Barker thought that as a result of the work being done by various societies interested in the problems of eugenics, genealogical histories might some day be available for medical consider-

ation and for use in the treatment of individual patients.

It is probably true that hereditary dispositions may be modified by environment. Nevertheless, hereditary possibilities must be carefully considered, and especially in the adoption of children the history of the antecedents should be fully investigated.

It follows, then, that in the prevention of nervous breakdown there are two prime necessary requirements: (1) the individual shall be well-born, and (2) his environment shall be of a suitable character. Dr. Barker's opinion was that in the long run more will be accomplished by applying eugenic principles than by modification of environment. He considered heredity was extremely important. As to the best way of introducing and applying the principles of eugenics, he had grave doubts as to the wisdom of legislation except so far as such legislation represented the settled conviction of the majority of the people. The proper way is by means of education. Especially should this be applied to young people, who should be taught things concerning the beginnings of life, biological principles particularly. He considered that Mrs. Grundy was a very important factor in the case. If young people realized that it was not the thing to become engaged to an individual because of feeblemindedness or insanity in the family, they would soon learn to nip early manifestations of love in the bud. The immigration problem has also to be faced. In the United States they allowed all and sundry to come in without let or hindrance until they found that it seemed likely the native Anglo-Saxon stock would be overwhelmed by the influx of peoples of less vigorous race, and they had come to the conclusion that in future more careful selection should be made.

Concerning environment, we must realize that while, as a rule, the germ cells were well protected, nevertheless they might be affected by certain poisons. In lead workers, for instance, it has been found that defects may occur with a good deal of regularity in the offspring as the result of the toxic effects of this mineral. Regarding alcoholism, the question was quite open. Dr. Pearl, of Johns Hopkins, was of the opinion that alcohol tended to kill off the poor germ cells and leave the good ones. Then there was the question of pre-natal care and the hygiene of the expectant mother. The hygiene of infancy was of great importance, care, food, nursing, and so on. The pre-school age is the important formative period of life, both from the physical and mental side. At this age the child is taught obedience, the proper performance of tasks, the bearing of small annoyances. The habits of parents and the home surroundings are of immense importance at this stage in the formation of character, and great differences may result according as to whether such influences are good or bad. School age is important. The school physician of the future should be able to examine and estimate mental, as well as physical traits, being thus able to indicate the style of education which is suitable to the individual child. If a child of inferior nervous or mental development is placed in a class with more normal children and its inability to carry on the work in competition with them is

made the subject of remark or scorn, an inferiority complex may develop which the child may never overcome. As maturity is reached, vocational guidance is of great importance. Life work of an interesting character is one of the greatest safeguards we possess against the likelihood of nervous breakdown. Putting people into a position where all their legitimate needs and requirements, such as need for healthy parenthood, economic security, and proper social relationships can be satisfied, is another of the defences against nervous breakdown.

* * *

THE IMPORTANCE *of* OPHTHALMIC ASPECTS *of* GENERAL MEDICINE

By DR. EDWARD JACKSON, Denver, Col.

Abstract of an Address delivered before the Vancouver meeting of the Pacific Coast Oto Ophthalmological Society, June, 1925.

The situation and constitution of the eye are peculiarly favourable for exact observation of what occurs in it during life. We can see with the ophthalmoscope the first reaction along the retinal vessels to the tubercle bacillus, or we can watch the appearance of a choroidal tubercle and its passage through the different phases of its progress. Tuberculosis with its lesions now recognized in every tissue of the eye is open to continued microscopic study throughout its course. Syphilis has been more studied and is better understood in the eye than in any other organ of the body. All vascular diseases known by their gross effects or recognized after death are to be studied in the eye from incipiency to resolution or to functional or organic destruction of the parts involved. The relations of the eye to the central nervous system are such that this organ might be termed "the bulletin board for diseases of the brain and spinal cord." Of the twelve cerebral nerves six are distributed in whole or in part to the eye and its appendages. The four cranial and the sympathetic motor nerves distributed to the intra and extra ocular muscles bring their controlling impulses from the cortical motor centres. We can think of this elaborate division of the nervous system as of a telegraph or telephone system capable of bringing information from all parts through which it passes, as well as from its more distant terminals. The intelligence thus furnished is published by the symptoms manifest in the eye. To change the metaphor, the ophthalmic physician from his point of vantage watching the eye and interpreting the signals it gives, as the forest observer would interpret a distant column of smoke, has command of a great territory of disease.

It is time that those who study diseases of the eye should understand their position of advantage and accept the responsibility it entails in the general struggle of the medical profession with the forces of disease, disintegration and death. Lesions occurring in the eye are most favourably situated for the observation and demonstration of the course of such lesions. Pathology has a new

meaning for all physicians when it is demonstrated and studied in the living body. Its ophthalmic aspects constitute a whole department of modern scientific medicine. In a few directions these are already somewhat known, but in all directions the boundaries of our knowledge show unexplored regions to be studied that stretch out beyond the extending horizon of science.

The common methods of examining the eye offer a field for the acquirement of a great deal of knowledge, experience and skill. It is important that all physicians should know something of these methods of investigation. They should be regarded as part of the fundamentals of medicine. But the special advances in modern medicine that enable us to render our most important services to the community and entitle us to the greater part of the compensation for our services, are only mastered by years of observation, and study and application of what has been learned in the conscientious management of cases.

He who would qualify for the function of an ophthalmic physician or a consultant in the best sense, must have both the broad outlook on disease in general and the sense of proportion obtained by thinking on its general problems, and an exact practical acquaintance with modern methods. He should be able to test visual acuity in different ways and under all sorts of circumstances. He must know that vision of 20/20 may be vision markedly below the normal for a particular person; that visual acuity above standard and entirely normal for the individual patient, is possible along with marked papilledema; or great narrowing of the visual field, hemianopsia or scotomata, of various forms and locations and significance. He must have in mind the possible causes of sudden variations in visual acuity; circulatory disturbances with brain tumour, or pituitary disease, toxic amblyopia, spasm or paresis of accommodation. The effect of floaters in the vitreous, the variations due to posture and adaptation in detached retina; besides the ups and downs of glaucoma; or the changes in visual acuity with changes in the size of the pupil, in ametropia or partial opacity of the crystalline lens. He should know the meaning of each change in the form of the field of vision; the enlargement of the blind spot from disease of parts adjoining the optic nerve, the toxic causes of central scotoma, the peripheral boundaries of the field for different test objects, different illuminations, different states of adptation, the significance of ring scotoma, islands of retained vision, relative sensitivity to light and colors. The changes of field and visual acuity that characterize tobacco, amblyopia or the effects of methyl alcohol poisoning, or quinine amaurosis. How the recovering brain cortex may perceive movement in the visual field, before form or moderate changes of illumination are able to impress consciousness.

The ophthalmic consultant must be familiar with all the forms of pain referred to or about the eye, and with the language in which they are described and referred to by different patients. He should know that the significance or lack of significance to be attached to all kinds of pain, depends as much on the psychology,

physical condition and desires of the patient as upon the organic conditions with which it is associated. The various forms of dysthesia, dryness of the eye ball, "stiffness" of the lids, tics that are not evident to inspection, sensations of heat or cold. All these occur in an organ most delicately sensitive, the sensations in which are most sure to be thought about, and talked about, and watched for, and to furnish supposed cause for alarm, of any portion of the body.

The visual sensations to be classed as dysthesias are numerous and important, and the patient's story of them often puzzling. Scintillating scotoma and the sudden disturbances of the visual field that belong with it, are always alarming when they first occur, and more often depend on other than ovular disturbances. Muscae volitantes cause more annoyance, unjustified disquiet and alarm, than almost any other symptom we are asked about. The various interferences with vision, due to after images, usually entirely a mystery to the patient, are often confusing to the physician. He who would interpret their effects must be familiar with them, in both health and disease; must be on the lookout for them when testing visual acuity, or mapping fields, or considering apparent improvement or deterioration in acuteness of vision.

So much for the subjective evidences of general function. But the ophthalmic aspects of disease are of greater importance because they are so largely objective. Let us recall the breadth of their significance by consideration of a very few. The ophthalmoscope opened the modern era in ophthalmology. The power it gave of pushing our investigations to the depths of the eye, was not greater than the power it gave of discrimination as to the character, origin and outcome of conditions heretofore thought of as identical. We no longer deal with "inflammation of the uveal tract"; we have to consider the inflammatory reactions to syphilis, tuberculosis, focal infections of the uveal tract, or involvement of the uveal tract by the attacks of pyogenic bacteria, its invasion from adjoining parts or by metastasis through blood channels. The influence of innervation in the causation and modification of uveal disease still challenges our ability for original research. Through symptoms of herpes zoster, and acute glaucoma we know it may be extremely important.

Not only has the ophthalmoscope made us acquainted with atrophy of the optic nerve during life. Not only has it enabled us to discriminate between inflammation and atrophy, between primary and secondary, beginning and advanced atrophies: it has placed upon us the burden of correlating the visible changes in appearance of the nerve head, with the nature of the pathogenic agent, the progress of the disease process, the possibilities for recovery, the influence of therapeutic agents in checking disease and in bringing about recovery. Not only has the ophthalmoscope revealed the existence and course of optic nerve oedema and optic nerve inflammation. Not only have physicians like Allbutt, Hughlings, Jackson, and Gowers, and surgeons like Jonathan Hutchinson and Victor Horsley, demonstrated the flood of light it throws

on diseases of the central nervous system, making diagnosis certain, prognosis probable and therapeutics more definite. Swiftly accumulating observations of many workers in ophthalmoscopy show the very wide range of conditions, ocular and extra-ocular, in which this method of examination is giving new light on the character and presence of general disease. It is a modest inference, going little, if any, beyond what individuals have already achieved, to claim that the ophthalmoscopic examination of the optic nerve will, in the very near future, play as important a part in the observation of general disease as the feeling of the pulse did up to 70 years ago.

With reference to the circulation of the blood, it might be said in all soberness and restraint of enthusiasm that the use of the ophthalmoscope has doubled the clinical value of Harvey's great discovery. The changes in the color of retinal vessels in conditions of anaemia, polycythemia, altered haemoglobin or lipaemia retinalis, should all be recognized by the ophthalmoscopist. The widening of veins by collapse, or by distension; the irregular calibre of the blood stream due to spasm, or to endarteritis; the change of color or hiding of veins crossing behind them, due to changes in the arterial walls, should be familiar ophthalmic aspects of general disease. The exudates and haemorrhages of various forms have a wide range of significance, in connection with circulatory conditions. That significance can only be discovered by the skilled ophthalmoscopist. He should have the knowledge of pathology, the interest in different possible causations to interpret their significance. These are refinements of observation and judgment that can only be expected of the experienced ophthalmic physician.

The recognition of early departures from health in the small retinal vessels is more definite, more significant than any observations on the blood pressure. The warning it should convey would be of the highest value to a large proportion of people who have reached middle age. If such information were at the disposal of every patient for whom a physician prescribed correcting lenses, how many intelligent, well-to-do people would go to the non-medical optometrist for relief from presbyopia? If members of the general medical profession understood these things, how many of them would send their patients to the optometrist for glasses?

Microscopy of the living eye is likely to be as fruitful of important facts as ophthalmoscopy, and it is waiting for students to explore and map out its most important domain. Koeppe, Vogt, and their followers, have observed and pointed out many things, that are to be seen by this means; but their significant relations to general conditions of the body and their clinical value in diagnosis, prognosis and indications for treatment, are still to be worked out. It is quite likely that in another generation biomicroscopy will be found more fruitful and more important than ophthalmoscopy.

There are other methods of examination that promise results of great interest in general medicine. The study of epithelial

parasitism in the eye by Lindner, Graef, Gifford, McKee, Howard and others, opens up a field of great promise in bacteriology and pathology, and for this, as for other things, the eye is the peculiarly favourable portion of the body for clinical experiment and observation. Here the various anaphylactic reactions are best studied locally: and such studies must help to fix their general practical importance.

The staining of living tissue in the eye and the effects of such staining, are worthy of our most careful attention. In our search for corneal ulcers and foreign bodies we have been using a method that can throw light on many questions of cell physiology, normal and morbid and pharmacology.

* * *

ACUTE INTESTINAL OBSTRUCTION

Abstract of Address delivered by Sir Henry M. W. Gray before the Vancouver Medical Association Summer School.

After referring to the lessening incidence of obstruction following abdominal operations due to improvements in technique and to the variation in symptoms produced by obstruction, the lecturer proceeded to consider the etiology of the condition. In infants and young children intussusception is by far the most frequent cause. Beginning possibly as the result of excessive peristalsis, as the process develops the bowel becomes more and more infolded, with the result that congestion, swelling, occlusion of gut and vessels, traction on nerves, haemorrhage and shock assert themselves. Needless to say in such cases symptoms are severe and persistent unless and until their severity is marked by the exhaustion of the bowel and of the patient. Intussusception in older children and in adults is usually due to some pathological condition, most frequently a polypus, more rarely a stricture. At this age, however, the most usual causes of intestinal obstruction are fibrous bands, internal hernia, Meckel's diverticulum, volvulus, impaction of concretions, sudden blockage of a chronic stenosis brought on by tubercle, cancer or pressure from a tumour outside the bowel, and old or recent adhesions causing acute angulation of the bowel. Finally we must remember the so-called adynamic or paralytic ileus, which may possibly occur after any abdominal operation, but especially where the bowel has required much handling or where over-distension has existed previous to operation. The most frequent and serious form is that caused by peritonitis, which may affect both small and large bowels. Hence Sampson Handley's name of "ileus duplex." In this connection one may mention the acute toxaemia which occurs especially when the obstruction is situated high in the small intestine. It would appear that the poisons absorbed from the upper jejunum and especially from the duodenum, exert profound metabolic changes which can be easily appreciated in the blood. These are evidenced by great diminution in the chloride content, increase in blood urea, and in

the capacity of the blood for carrying carbon dioxide. In the later stages this toxaemia exerts an evil effect on the kidneys, producing an acute inflammation with changes in the tubular epithelium or a more diffuse nephritis.

The clinical symptoms of obstruction vary according to the site and cause, but there are certain phenomena common to all varieties. In some cases there are premonitory symptoms in the form of recurrent colicky pains usually in the same part of the abdomen. If a loop of bowel becomes suddenly strangled, very severe pain, with manifestations of shock, occurs. After this preliminary storm may come a more or less pronounced calm, though considerable steady pain usually persists. This, when the small intestine is the seat of trouble, is usually referred to the umbilical region, and to the hypogastric area when the lower bowel is affected. In some cases the respite may be so definite that the patient drops off to sleep. Very soon, however, the characteristic turmoil begins. The persistent pain becomes more intense. It is accompanied by spasms of colic, more frequent and more intense when the small intestine is affected. Vomiting soon sets in. At first remnants of food are evacuated, then bile, followed by more or less clear watery material as the contents of the small intestine regurgitate into the stomach. Finally as congestion and decomposition increases, the vomitus becomes brownish; it is described as being faeculent in character. The higher the obstruction, the more severe usually is the persistent pain, the more frequent the colics and the earlier the onset of vomiting. In some cases localized bulging of the abdominal wall, accompanied by the sensation of a tumour mass on palpation, may develop quite early and before general distension occurs.

One can frequently make out a succussion splash in the distended coils above the point of strangulation which sometimes give clear indication of the site of obstruction. This is also at times indicated by an area of greater tenderness.

While general distension occurs fairly regularly if the lower part of the small intestine is affected, it may not occur in strangulation of the upper part. It is stated that distension occurs much later in obstruction of the lower part of the colon or rectum.

Obstruction in the small intestine has been shown to render the bowel more permeable so that imperfectly digested proteins, etc., gain entrance to the blood, which may explain the excess urea found therein. Constipation is a very prominent feature in these cases, and should always be impressive, because when colic occurs without obstruction it is always accompanied, sooner or later, by the passage of gas or faeces. But here, after the bowel has become emptied of its contents below the site of obstruction, constipation becomes absolute, neither flatus nor faeces being passed.

If the obstruction is not relieved the muscular coats of the bowel become exhausted, and on that account pain may be relieved to some extent. At this stage the nervous mechanism of the bowel is liable to become poisoned by toxins manufactured in the stagnating contents. This may result in paralysis or at least paresis

of the bowel. Very soon one finds that organisms penetrate the walls of the bowel at or above the obstruction, and cause peritonitis.

The picture presented by the patient at this time is a very miserable one. Some describe it as a condition of secondary shock. In large part the symptoms are due to loss of fluid, from persistent vomiting and sweating, but it is really also a condition of profound toxaemia. The face is drawn and pale, often dusky, the eyes are sunken, the skin is cold with clammy sweat. The nose, ears and fingers may be mottled and blue, with stagnating capillary circulation. The pulse is feeble, thready, rapid; respiration is rapid, often sighing, and temperature is subnormal. There is persistent, insatiable thirst. There is only occasional colicky pain. Vomiting becomes of an overflow character. The patient may be unusually alert mentally. He often does not realize the seriousness of his condition. The end may come quite rapidly.

Treatment

There is usually so great urgency in many of these cases that I think one does the patient an injustice if one waits for results of special laboratory examinations. Please do not think that I do not appreciate the value of these findings. The abnormal conditions of the urine and blood may give most valuable indications for both operative and post-operative treatment. But the questions, whether blood urea is or is not present in large excess, and whether chlorides have or have not largely disappeared from the blood, does not, or ought not, to influence the operative procedure.

There are certain necessary procedures which are accessory to operation, and which become increasingly important as the case develops in intensity.

First, it is necessary, if the patient has been vomiting at all, to wash out the stomach, especially before giving a general anaesthetic, otherwise he runs the risk of being drowned by his own vomit, or of inhaling vomited material and bringing on septic pneumonia. Spinal or even local anaesthesia does not entirely obviate these risks. I remember many years ago being called to a remote village to find the patient, a large, heavy man, in a very pitiable and distressed state owing to neglected chronic obstruction which had suddenly become acute. In my innocence of those days I thought that while he would not stand a general anesthetic, he would be able to control his vomiting so that it would not choke him, if we gave him a spinal anaesthetic. I wanted to avoid for him the further distress of having his stomach washed out. He was very nervous and had a bad heart. I neglected to tell him that his legs might become paralyzed temporarily. When the spinal anaesthetic took effect, he suddenly realized that he could not move his legs. He took fright, became greatly excited, fainted, vomited profusely and really drowned himself, although his enfeebled heart failed him also.

In some cases where vomiting had persisted and was tending to become overflow in character, I have left the stomach tube in

situ during the operation, or if the stomach and upper intestine were found distended when the abdomen was opened, have had it passed again.

The next big indication is to restore as far as possible the depleted body fluids which have been extracted from the tissues everywhere. Recent investigations have shown that, as the case develops, the chlorides of the blood become increasingly diminished, and this fact has apparently a great deal to do with the recuperative powers of the patient. We must make up for the loss of these chlorides by supplying him with more, but not in overwhelming amounts. Therefore give, according to the size of the patient, the state of his heart, and the effect on his pulse and general condition, intravenous, subcutaneous and rectal infusions of saline solution. His tissues will tend to drink it up rapidly, so encourage absorption by making the solution isotonic.

I think it is better not to give active aperients after operation until the bowel has had time to recover its tone. Such a stimulus may, I believe, have the opposite effect to what is desired and make the debilitated bowel "throw up the sponge." I prefer to give enemata to empty the bowel from below so that less strain is required to push on what may come along from above, and at the same time I try to coax back vitality and vigour and co-ordinate movements in the injured part by such simple remedies as belladonna by the mouth, or, if sickness threatens, atropine or eserine hypodermically in small doses. The first enema is usually given on the day after operation. When evidence of activity becomes manifest, by spontaneous passage of flatus or faeces or even by desire to go to stool, then I give, for example, small repeated doses of cascara or even a dose of castor oil and laudanum. As soon as the patient feels desire for it, I give him ordinary food so as to stimulate peristalsis and prevent noxious adhesions. The part of the bowel which has been strangled tends to form adhesions. On more than one occasion I have had to open the abdomen again on account of fresh obstruction from this cause. Sometimes, if the bowel has been severely congested and dilated, although it may recover its colour quickly at operation it may require several weeks before it works properly. In these cases one finds the pulse remains abnormally rapid. In such cases both feeding and the exhibition of medicinal intestinal stimulants may have to be carefully regulated.

In discussing actual operative measures I wish first to lay stress upon the situation and manner of the incision. I almost invariably make a long, at least 6-inch paracentral incision on the right side a good inch from the midline, and displace the rectus outwards. I like to infiltrate the area of incision with ½% novocaine solution so that I may, if necessary, carry the making of the incision under local anaesthesia alone, at least as far as the peritoneum and at the end of the operation be able to close the abdomen without more general anaesthetic than may have been required for intra-abdominal manipulation. This reduces the length and strain of general anaesthesia very greatly, and it is a much

more simple business than making, for example, paravertebral injections. A short gas and oxygen anaesthesia will not harm the patient unless his condition is absolutely desperate. I think that the long incision, by permitting easier examination and handling, more than makes up for the extra time expended on it. When sutured in layers, post operative hernia is avoided more by this than by any other method of making a long incision.

Having opened the abdomen, the hand is inserted into the lowest part of the pelvis and pulls up any collapsed coils there. The bowel is then followed upwards until the point of obstruction is reached. If no collapsed bowel is found in the pelvis, the caecum is examined. If the caecum is collapsed the obstruction must be above it, if distended, then the obstruction is below it, so the sigmoid is next inspected. If it is collapsed the obstruction lies between caecum and sigmoid. If there is much difficulty in arriving at a diagnosis of the site of obstruction, I do not scruple to allow the distended coils of bowel to come out of the abdomen. I cover them carefully with warm dry towels and gauze strips to prevent undue cooling. I prefer dry material to moist material. The latter by its evaporation fosters the cooling process of the bowel. If warm lotion is continuously poured over it, in order obviate cooling, there results a sloppy mess, besides introduction of extra risk otherwise. I do not think that evil results follow the use of dry material so much as when moistened packs are used.

When the obstruction has been located the character of the causative factor and the condition of the bowel decides further proceedings. These vary from the mere snipping of a band to difficult and tedious separation of adhesions or actual excision of a gangrenous loop, followed by entero-anastomosis. In the last case I prefer to make end to end anastomosis whenever possible. If the patient is in very bad shape, it may be compulsory, after dealing with the cause of the obstruction, simply to bring the gangrenous loop well out of the abdomen, fix the viable proximal and distal parts of the bowel to the edges of the wound and open the loop. One or more enterostomies should be made above the affected loop through separate small wounds. Multiple enterostomies, reserved for the worst cases procure the advantage of draining different parts of the bowel and at the same time permitting the introduction of saline solution. Every surgeon of experience knows how inert the bowel may become, and though drainage effectively empties one loop, adjacent loops may remain distended. The bowel kinks very readily in such circumstances. The saline solution must be introduced at very low pressure—over-distension prevents recovery of tone, besides tending to cause kinking. I believe that the performance of enterostomy gives better results than emptying the proximal bowel during operation. The latter procedure demands too much handling of the bowel and tends to increase shock. The same remark applies of course to wide excision of bowel.

It is sometimes difficult to decide when to make enterostomy

as already indicated. I feel that if strong, colicky pains have persisted right up time of operation, and if, at operation, the bowel responds by local contraction to local stimulation, e. g., by pinching, it will likely recover without enterostomy. If, however, the colicky pains have become feebler, if general distension of the abdomen is present, and if, at operation, the coils are found to be flaccid and floppy, and do not respond to local stimulus, enterostomy is compulsory. In cases of doubt, rather make an enterostomy than not. If the obstruction has been in the large intestine, I like to make a caecostomy as well as an enterostomy.

I think a Pezzier's catheter is quite a suitable tube to use, and of a medium size, but an ordinary catheter does equally well, and is easier to remove. The latter has to be fixed by suture. Only exceptionally are there solid particles in the small intestine, so that the contents drain through comparatively small tubes. I like, when multiple enterostomy is done, to remove one tube at a time, the upper before the lower, so as to try to obviate distension which is liable to occur from adhesive kinking. I have an impression that the higher the enterostomy the longer it takes to heal. The tubes may be removed and the stomata allowed to close, as soon as the patient is established in convalescence, that is, really, when vomiting has stopped and the bowels have "moved' satisfactorily. A simple application for preventing excoriation of the skin round an enterostomy is ethereal rubber cement solution (1 in 4). This is applied several times a day. The ether evaporates and leaves a thin film of rubber over the skin.

It is sometimes almost impossible to tell, from the appearance of the bowel alone, whether the colour and swelling is due to intense congestion and subperitoneal or interstitial haemorrhage alone, or whether gangrene has actually occurred. The presence of the haemorrhagic effusion constitutes the difficulty. The purple colour of mere congestion soon gives way to more normal appearance when strangulation is relieved, but effused dark blood does not dissipate and there may be no change of colour, or only in patches. Of course, the flaccid, inert and often brittle state of the really gangrenous bowel is easy enough to distinguish—but there are all gradations. One must remember also that interstitial extravasation of blood has probably taken place before gangrene occurred. I have never found the following test to fail, and I have used it for very many years. I incise, with a sharp knife, the peritoneum and very superficial fibres of the muscular coat of the suspected part of intestine. If circulation be intact, definite bleeding, although possibly in small amount, will occur. One finds then that each time a clean piece of gauze is pressed lightly on the incised part, it will be stained with fresh blood. Still more certain can one be of the viability of the bowel if blood can be seen oozing out steadily from the cut. If gangrene has occurred the first or second piece of gauze may be definitely stained, but not more. There is practically never any doubt in actual experience. If the gut is viable, the small incision is closed by a mattress suture of fine linen or catgut.

Dr. Wm. T. Kergin, of Prince Rupert, has returned home from his European trip, having been away three months.

Dr. Graydon Hume, of London, England, was a visitor in Vancouver for a few days, in the early part of July. He was greatly impressed with our wonderful scenery, well equipped hospitals, and last, but not least, the work of the B. C. Medical Association.

The holiday season is in full swing, weather perfect, and many doctors, being very human, are taking advantage of the business office of the B. C. Medical Association to obtain *locum tenens*, so that they may get away for a well earned rest.

Dr. J. W. Lang, late of Hutton, B. C., and Mrs. Lang are to be congratulated on the birth of a daughter.

Dr. D. J. Barclay, who quickly recovered from his recent automobile accident, was able to resume his holiday, which, with Mrs. Barclay, was spent on the coast, where they renewed many old friendships.

At a recent meeting of the B. C. Medical Association, the following doctors were appointed Chairmen of Standing Committees for the coming year:—

Legislative—Dr. M. J. Keys, Victoria.
Industrial Service—Dr. T. H. Lennie, Vancouver.
Publicity and Educational—Dr. Neil M. McNeill, Vancouver.
Ethics and Discipline—Dr. I. Glen Campbell, Vancouver.
Credentials and Constitution—Dr. A. W. Bagnall, Vancouver.

Dr. A. A. King, of Ladner, returned to his practice on August 1st, after doing six weeks' strenuous post-graduate work in eastern cities.

Dr. D. G. Morse, of Port Haney, is taking a month's holiday from August 8th. His practice will be taken care of by Dr. H. C. MacKenzie.

Dr. E. W. Ewart has relinquished his practice at Terrace, B. C., and is now acting as assistant to Dr. Moffat, of Vancouver.

Interesting communications are received from time to time by the B. C. Medical Association, from Dr. Carl M. Eaton, of Atlin, B. C., who has now been isolated in this most northern town in the province, for nearly three years. His many friends in Vancouver will be glad to see Dr. Eaton, when he passes through this city in the fall, on his way east to take post-graduate work.

Dr. Lewellys F. Barker passed through Vancouver towards the end of July, and the members of the Vancouver Medical Association turned out in force to hear an address by him on the

"Nature, Causes and Prevention of Nervous Breakdown." In his address Dr. Barker touched on some of the burning topics of the day, such as the community's responsibility to criminals and delinquents, the teaching and application of the principles of Eugenics, and the need for departments of mental hygiene in the public schools and colleges.

Miss Johns, Professor of Nursing at the University of British Columbia, has resigned that position to take up work for the Rockefeller Institute in the organization of nursing in Czecho-Slovakia. Miss Johns will be very much missed in nursing circles in Vancouver.

The University of British Columbia, at the close of the holidays, will open its doors in the new (temporary) buildings at Point Grey. The only permanent building completed at present is the Science Building, which will house the Library. The temporary buildings erected are of stucco and will probably be in use for some years. The old University buildings, in Fairview, will be taken over by the Vancouver General Hospital to meet the need for increased accommodation.

On July 27th the Victoria Medical Society met in the Library room to hear a most interesting and instructive address by Dr. David McKenzie, of McGill University and the Royal Victoria Hospital, Montreal. Dr. McKenzie dealt with "Tumours of the Bladder." Again the Victoria profession found itself enjoying instruction from a teacher from one of the educational centres, even though it was necessary to encroach on Dr. McKenzie's well earned vacation, from which he so graciously spared an evening.

The Victoria members are pleased indeed to note that arrangements are being made for a programme of post-graduate courses under the Canadian Medical Association.

At the meeting of the Victoria Medical Society, held on July 27th, Dr. Raynor gave a short but interesting resume of the proceedings of the Canadian Medical Association annual meeting at Regina. This was well received, as the members of the Victoria profession feel that they must be fully informed of the exact nature of the details to which they must attend, to ensure the comfort and success of the meeting at Victoria next year. Dr. Forrest Leeder, President-elect of the Canadian Medical Association, was present, and a meeting will be held in the near future to commence active planning for the 1926 meeting. If Victoria can duplicate the weather of this and past years, we can safely promise those who attend a very busy time enjoying a full programme under temperate weather conditions.

Dr. Gordon C. Kenning is holidaying with his family at Chemainus, where the big salmon have been running.

Dr. J. W. Lennox and family are again at Parksville, on Vancouver Island. Dr. Lennox, who is the popular Vice-President of the Victoria Medical Society, returned to Victoria with his complexion ruined by sunburn. He reports the bathing as good.

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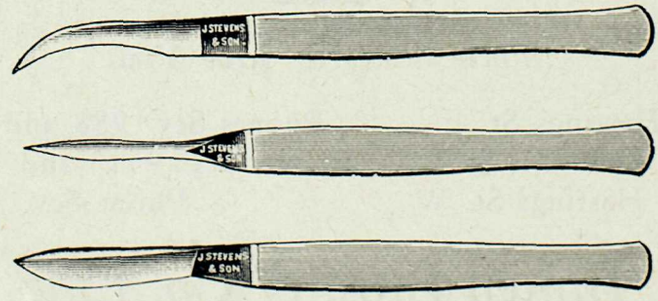

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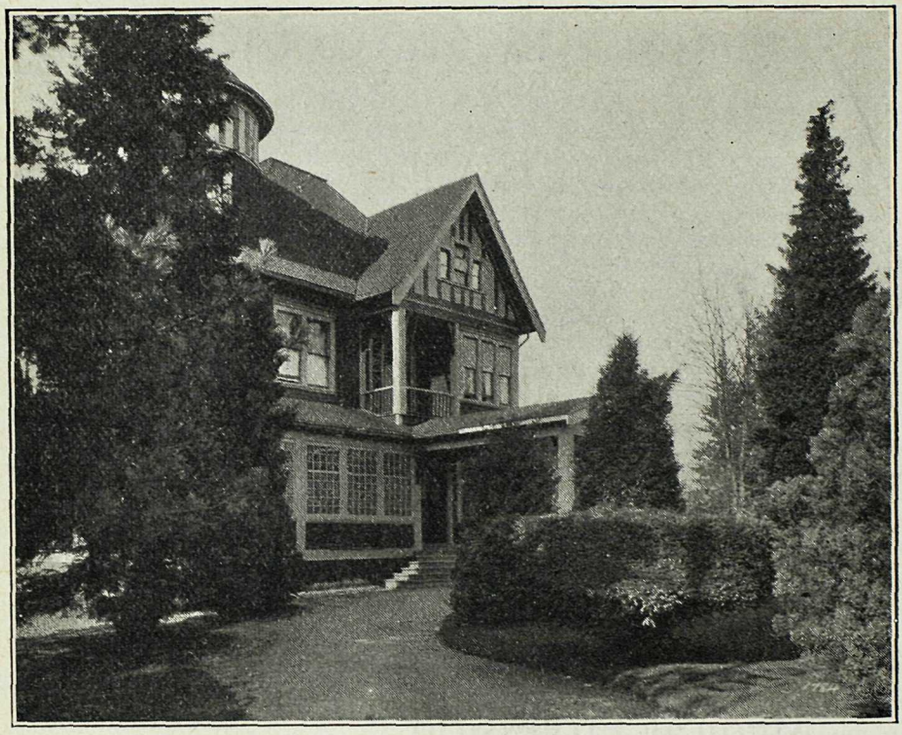

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