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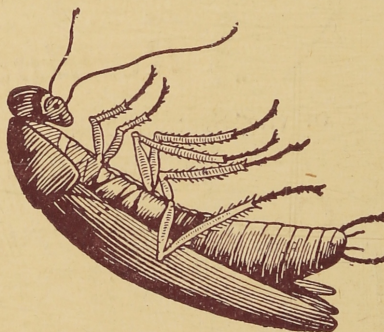
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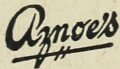
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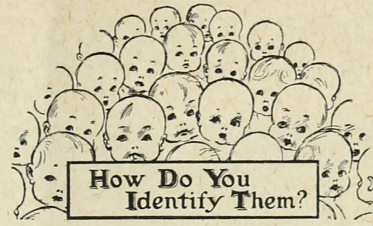


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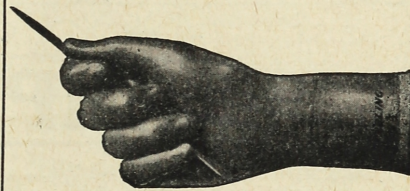
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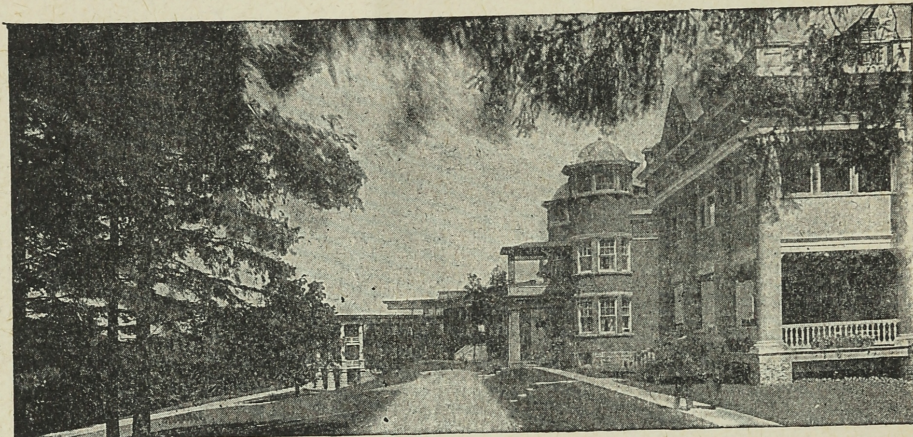
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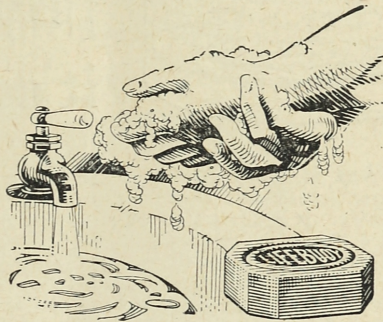
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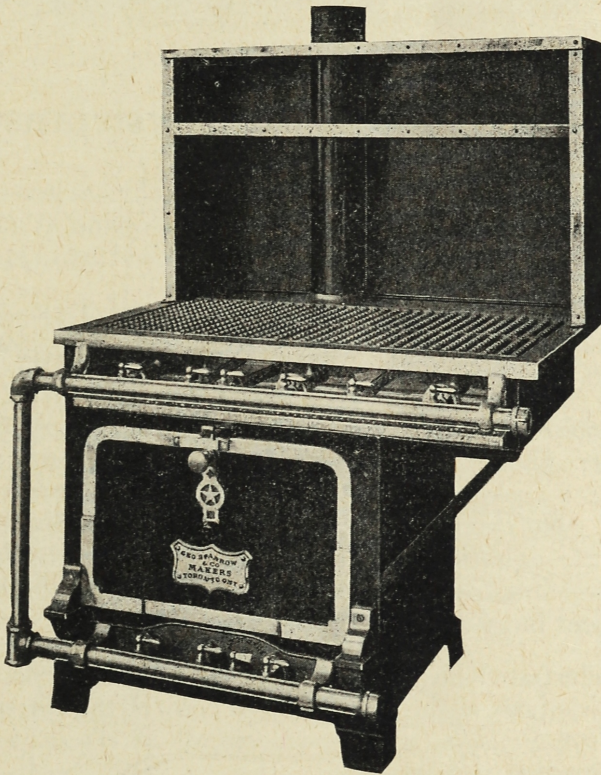
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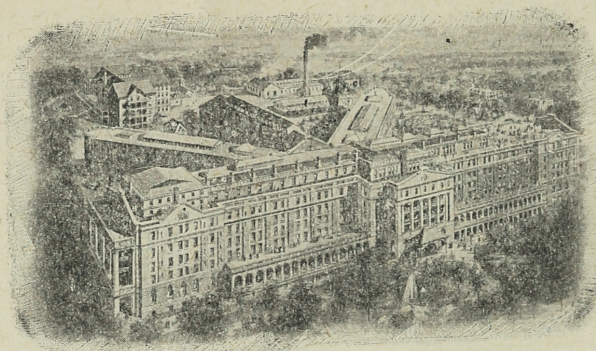
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Editorial

Verse and Worse

The social service departments of many hospitals are teaching the convalescing patients to do things; few of them have attempted to teach the convalescents to make verses. We are pleased to know that in some hospitals, they do allow patients to make verses instead of mats or wicker baskets. The following is a contribution from semi-private ward 3 of the Toronto Orthopedic Hospital by a patient poetically inclined:

Miss Mabel Dulcibella, she
Was fine a lass as you could see
Until one day (and 'twas no fake)
She got an *awful* tummy ache.
The cops flew in and turned about
And hustled Mabel Dulcie out,
And rushed her, tummy ache and all
To the Orthopedic Hospital.
And then they dosed her like a rummy,
And did research work in that tummy;
And sewed her up with fancy stitches
And hoped-to-peace there'd be no hitches.

Now all her kinfolks, friends and such
They wept her sore and loved her much.
They came and prayed and brought bouquets
And sympathized in many ways;
And Mabel Dulcibella, she
Grew pale and lank and sad to see,
Until one day into the ward
Entered a dame with heart so hard
That first go-off she cracked a joke
And Mabel Dulcibell awoke.
The yarns so funny made her blush
Until the nurses bade her hush.
She opened Mabel's sweet blue eyes
To many funny revelries.
They talked and laughed from morn till night:
Her cheeks grew pink, her eyes grew bright.

To such a pitch did Mabel come
That when at last she sailed for home
They stuffed their ears and veiled their eyes
For fear she would demoralize!

Now which is best for sickly folks
The pious prayers or wicked jokes?

Records Department

A writer in the *Modern Hospital* stresses the importance of the record department in hospitals. It should be one of the major departments, he maintains, since it contains an account of the work done by the hospital. This department must be organized along lines that are sound, simple, sensible and scientific. The records should be truthful, without evasion, omission or prevarication.

The system must not be complicated. The various reports from the laboratories, anæsthetist, surgeon, etc., should harmonize and dovetail into one another so that the whole may easily be comprehended. The formulated plans should be the embodiment of common sense, without fads, frills, air pockets, cross currents or enigmas. The history should be traceable from the entrance of the patient

into the hospital, through the physical and laboratory findings, operating rooms, post-operative care to ultimate outcome, whether the patient is sent home or autopsied; and the system should contain the elements of an up-to-date medical synopsis so that the records may be adjusted scientifically.

The writer, Dr. J. Wesley Long, adds that the records must be made immediately accessible.

Psychic Treatment of the Tuberculous

"To prevent the possible development of a psychosis or psychoneurosis in a tuberculous patient, the physician should receive him in a cheerful, well-ventilated room, scrupulously clean, and with fresh reading matter on the table. If at all possible, tuberculous patients should be received by special appointment. A reception-room full of coughing patients, some not over-careful when coughing, spraying the air with infectious droplets, may be enough to lay the foundation for a psychosis. In the history taking too much stress should not be laid on the family history, but emphasis should be laid on the fact that the loss of one near relative by tuberculosis does not mean that the rest of the family is doomed. The patient should be told that if a hæmoptysis has occurred or will occur, it is one of the phases of the disease which by no means lessens the chances for recovery.

"Concerning the sputum, he should be assured that if he takes care of it there is not the slightest danger of his giving the disease to anybody else, and his relatives and friends who may be with him should be warned against developing phthisisophobia. Nothing will make the tuberculous patient more miserable and despondent than to be treated like a leper."

The wisdom contained in the above two paragraphs which appear in a recent number of the *New York Medical Journal and Record* from the pen of Knopf will be acknowledged by all our readers as sound. Knopf, continuing, says that the prognosis should always be guarded, but expressed in hopeful terms, and no fixed time for recovery should be set. He advises that the patient should be impressed with the fact that the more carefully he carries out his instructions the sooner he may look for an arrest of

the disease. The famous St. Clair Thomson remained silent one year, which, no doubt, contributed very materially to his recovery from a tuberculous laryngitis with some lung involvement.

The patient, says Knopf, should be asked directly if he has any mental anxiety, and if it is within the power of the physician to remove it, he should do so. If he worries on account of financial matters, the relatives should be informed of it so that steps for relief may be taken. The patient who worries will not eat well, and his recovery will inevitably be retarded thereby. Worry and anxiety are among the greatest obstacles to the successful treatment of tuberculosis, particularly among the poor, when the patient is the breadwinner of the family. Doomed to temporary inactivity, as otherwise he cannot be restored to health, he usually broods over his fate and worries about those who are dependent upon him.

The wonderful results of Pratt, of Boston, are pointed out by Knopf, who says that they are attributable to the fact that with the aid of funds placed at his disposal by the Emmanuel Church he was enabled not only to take the very best care of a large number of tuberculous poor by instituting sanitarium treatment in their homes, but he could investigate the financial resources of all the patients under his care, and when there was want, the good men and women of the church supplied food, clothing and other necessities of life for the family so that the patient could feel absolutely sure that those who were dependent on him were amply provided for.

Knopf says that to appreciate this phase of psychology in the treatment of the consumptive, one must have observed the psychological change in the

patient who was suddenly relieved from anxiety concerning his loved ones by the assurance that all was well at home and that there was no suffering or want. It is not, he says, to be wondered at that Pratt obtained results equalled, and in some instances surpassed, by those obtained in the sanitarium for the consumptive poor located in almost ideal climatic regions!

Health Insurance

The trend of lay opinion, as represented by organized labor, is toward health insurance. At present conditions are far from satisfactory, when sickness invades the home of the poor and of the middle class. The poor, when stricken with an acute serious illness are hustled to the public hospitals and looked after at the public expense. The middle-class individual under like circumstances is admitted either to a public ward where he may pay a part of his maintenance or, if he can pay more, to a semi-private ward where he may afford the cost of his maintenance.

Now if some one would get in touch with these classes and insure them against sickness by providing hospital nursing and medical care, it would be a great accomplishment both for the sick folk themselves, the hospitals and the doctors. The sick man, having paid his premiums, would feel he had a perfect right to enjoy hospital nursing and medical care, instead of, as he is now, entering on a pauper or semi-pauper basis; the doctors would get pay for their work, which now very often they do not get from many such individuals, and hospitals might expect at least the cost of maintenance of all insured sick admitted to their wards.

To accomplish this much-to-be-desired health insurance project, who will take the initiative?

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Original Contribution

EMPLOYMENT FOR ARRESTED CASES OF TUBERCULOSIS *

W. J. DOBBIE, M.D., Toronto.

In considering employment for arrested cases of tuberculosis, it is advisable, at the outset, to mention certain prevalent misconceptions. There are three of these that are very commonly held.

The first is, that the best thing for the patient to do is to "get a job in the open air." Nearly always this is bad advice to give, because (1) such jobs are not easily secured, (2) they usually require the person to do a kind of work to which he has not been accustomed, and (3) such jobs always require that the worker be exposed to undue fatigue and inclement weather.

The second misconception is that a change of climate is essential if a patient is to keep well. This is usually not so, and it is a very serious mistake to advise a tuberculous person to change his place of residence on account of climate alone.

The third is, that an arrested case of tuberculosis is a menace to other workers in a workshop or factory. This is not true. Adults do not often contract tuberculosis because of contact with other adults. The infection is usually contracted in childhood—the disease is a development from that infection and most frequently comes into prominence in early adult life.

In undertaking to give advice there are two essentials that should be kept in mind in each particular case: (1) What demands, physical and mental, do the jobs actually make upon the worker? (2) Does the applicant present the physical and mental capacity necessary for the successful performance of the job under consideration?

In considering these essentials in a particular case it is well to have in mind the fact that tuberculous persons usually present an altered mental attitude, acquire frequently a dread

*Read at a Stated Meeting of the Academy of Medicine, Toronto.

of assuming responsibility, and exhibit a certain emotional instability, all of which have a direct bearing on capacity for work, especially if it is of a kind which brings the individual into competition with normal persons.

Moreover, although a person in whom tuberculosis has become arrested may appear to be well and strong, there is always a degree of disability, much greater than is at once apparent to the inexperienced observer. This disability must always be kept in mind when any individual case is being considered.

In a general way it may be said that among the best informed, there are certain principles with regard to employment of the tuberculous on which there is substantial agreement. But in order that these principles may be applied certain definite information is needed in each particular case, and this may be very well summarized as including: (1) previous occupations, with some information as to the degree of skill attained while at them, as well as the earning capacity of the individual at each of these occupations. (2) The general education and special experience or training of the individual—this may include education acquired by experience, association, or study, as well as the ability to speak, read and write English. (3) The individual's preferences as to occupation. With this information at hand it may be said that, generally speaking, the tuberculous adult should be advised to seek employment in which he can capitalize the knowledge and skill gained through his previous life and employment experience. A complete change of occupation is only to be recommended when there exist hazards known to be dangerous to the tuberculous.

When considering occupations, what are known as "health factors" should be carefully considered. (These have been outlined by Dr. G. M. Price in his "The Modern Factory" P. 32, 33). Among other things emphasis is placed on:

1. Factors due to the personality of the individual, such as his health, nutrition, personal hygiene, temperament, education, sex, age, etc.

2. Factors due to the conditions of work, such as: (a) attitude and position; (b) duration and pauses; (c) fatigue, tension, responsibility; (d) extremes of climate, temperature, humidity, etc.

3. Factors due to materials and processes such as: (a) dusts; (b) poisons; (c) gases and fumes; (d) infectious material; (e) dangerous machinery and appliances.

4. Factors due to the place of work, such as: (a) outdoor or indoor; (b) type of workplace; (c) location of work-

place; (d) natural light and illumination; (e) air and ventilation; (f) sanitary conveniences.

It will be seen that there are many considerations to be weighed before suitable advice can be given.

However, to summarize and put in concrete form some suggestions for guidance, it may be said that arrested cases may be advised as follows:

1. *In the case of children.* These may be advised to continue at school—with perhaps a more limited curriculum and one constructed with a view to fitting them for future occupation, having in mind that they are already handicapped by loss of time as well as physical disability. They may also be allowed a reasonable amount of suitable play, the periods being shortened to permit of a greater amount of rest being obtained than is necessary with normal children.

2. *In the case of women,* there are usually two classes:

- (a) Those who have the responsibility of domestic duties.
- (b) Those who have their time free for remunerative employment.

The former may continue their usual household duties, being advised to omit those of the most arduous nature, so that a daily period of rest may be obtained.

Those of the second class should be recommended to engage in the kind of work to which they are accustomed, at which they can perform with the least expenditure of energy, and from which they can obtain the greatest return, always provided of course that it is such as has not undue hazards to themselves or others, and does not require the expenditure of too much energy, either in the work itself or in the distance to be travelled in going to and coming from the place of employment.

3. *In the case of men,* there are again two large classes:

(a) Those whose previous occupation is suitable. These should be advised to resume the occupation with which they are already familiar.

(b) Those who have been following an occupation in which the conditions are palpably unsuitable. For these a change is necessary, and some measure of re-education or training may be desirable. Unfortunately, the facilities for obtaining these are not always readily available, and there may be difficulties which cannot easily be overcome.

In all cases, however, the arrested cases should have it impressed upon them that their working hours comprise only about one-third of each day, and the care they take to use ad-

vantageously the sixteen hours when they are not at work will have a most important bearing on the success they will have in keeping well while "carrying on." Persons with arrested tuberculous disease should learn early that it is disastrous to attempt to work and play too. In the words of a well known advertisement, you may have either but not both. It is not at best, however, an easy matter to give advice on this subject if the advice is to be of any real value, or indeed more than the personal opinion of the adviser. It is a matter in which there is much need for special knowledge, and the exercise of sane judgment and good common sense.

THE TREND OF THE PRESENT ANTI-TUBERCULOSIS CAMPAIGN *

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I am reminded of two small books in my office, "The A.B.C. of Exhibits" and "The Work of a Secretary." I cannot recall either author anticipating the present predicament of a secretary speaking for his president. In looking over the programme and noting the subjects being contributed by six other speakers, you will sympathize with me when I say I had difficulty in trying to avoid overlapping their material. I hope my effort in this particular phase will prove acceptable to you.

The trend of the work of our cause is along two separate channels aimed at the "Bovine" source of infection, and the "Human."

BOVINE

Eradication of this disease has been pressed for years in the animal kingdom with most generous financial backing from many governments. The ox has been the principal animal assailed, on account of the meat and milk being food factors for us humans. The hog has been carefully watched at slaughterhouses, but losses from detection of the disease in the hog have been principally borne by a special levy upon the producer up to two per cent. of the value of all porkers sold—varying in different areas according to the prevalence of the disease in the respective localities. Ontario has three distinct zones according to prevalence, and the prevalence is influenced by the cattle industry of the district veering to beef production, butter production or the production of cheese; cheesemaking predominating, I think, in the most favorable

*Read at a Stated Meeting of the Academy of Medicine, Toronto.

area, or that having the lowest incidence of tuberculosis among the hogs. Two schemes have been advanced in Canada:

1. The eradication of the disease in restricted areas by repeated tuberculin testing and removal of positive reactors, either for slaughter, following condemnation with necessary reimbursement to the owner, or for quarantine under the Bang system.

This practice has produced an area in Manitoba where cattle are certified free of tuberculosis. The owners are now organizing to demand special prices for the beef on hoof because no loss at slaughterhouses can occur, and better prices for their pork because the hogs should not be infected from negative reacting cattle.

The latest fly in the ointment is that avian tuberculosis bacilli have been proven to infect just as seriously the hog population.

2. Tuberculin testing of all cattle supplying milk to municipalities for human consumption, the owners of positive reactors condemned for slaughter, being compensated for their loss. More than \$84,000 was spent last year in the city of Ottawa for this scheme. All the milk is pasteurized as well. Winslow produces figures in the October issue of *The American Review of Tuberculosis* for twenty-two large cities, covering twenty years, having pasteurization of ninety per cent. of supply for varying periods. He concludes:

1. Pasteurization has no influence on tuberculosis deaths in the first year. Maternal nursing and child hygiene education accounts for the splendid reduction in deaths recorded. Infection is almost entirely from contact with human cases.

2. Bovine infection would seem to-day to be of negligible importance among infants in large cities where the infant welfare campaign has been vigorously advanced.

3. From one to four years variations in non-pulmonary tuberculosis are strikingly correlated with the extent of commercial pasteurization.

4. It would appear probable that the death-rate from non-pulmonary tuberculosis of children between one and four years of age in cities which have a thoroughly pasteurized milk supply is about seventy-five per 100,000 population, as against a pulmonary rate of about twenty-five per 100,000. In cities which have not effectively pasteurized their milk supplies, the pulmonary rate is about the same, but the non-pulmonary rate rises to about 100 per 100,000. *An excess of twenty-five deaths per 100,000 indicates the approximate danger from bovine tuberculosis at this age period.*

We may infer therefore from Winslow that non-pulmonary tuberculosis deaths in cities having perfect pasteurization, are practically all caused by the human tuberculosis bacillus and that they form three-quarters of the total tuberculosis deaths, all forms, for the age group one to four; twenty-five per cent. of the tuberculosis deaths, all forms, being pulmonary type. In city populations not enjoying ample pasteurization of milk, the bovine strain becomes evident in an increase of the non-pulmonary deaths, amounting to one-fifth of the total for the age group one to four years all forms. We are interested in this high mortality rate that Winslow reports, namely, 100 per 100,000 in cities with ample pasteurization and 125 per 100,000 in cities not having ample pasteurization, these rates being for the age group one to four. Canada's one to four age group in the 1921 census, was one-tenth of the total population and in 1923 this one-tenth of our population had a death rate from tuberculosis, all forms, of 43.4 per 100,000.

HUMAN

May I hurriedly review the agencies which we think are the most useful factors requiring pressure in executing to-day, in so far as the human-infection channel is concerned:

1. Education and more education in general health habits.
2. Improvement of general health conditions.
3. Case finding efforts as extensive as possible, conveying all the scientific facilities we have to the aid of medical practitioners.
4. Institutional care of cases in the less fortunate families.
5. Removal of child contacts, immediately after birth, where cases are being treated in the home.
6. Minimum delay in admission of cases for institutional treatment—improved opinion of municipal and provincial treasury departments to facilitate quicker and more generous aid to needy cases. The British Health Ministry's suggestion, which is paramount to an order, because they can stop their substantial contributions of cash to any local authority not conducting their work to the satisfaction of the Ministry, is as follows: "In considering whether a patient is in a position to contribute towards the cost of treatment, the local authority should have regard in each case to the question whether a charge could be made without detriment to the patient's ability to provide proper and adequate maintenance for himself and his dependants, and that no charges should be made unless they are satisfied on this point." This is an

honest, sane effort to look after the tuberculous and not a practice which will increase the number of qualified and needy indigents.

7. Rehabilitation schemes for the arrested cases of tuberculosis. Placement of such cases in going industries under constant medical supervision as to the amount of effort possible by the patient and its resulting effect. Employment in the open is proven unfavorable on the whole. Teaching of new trades or arts requiring more than thirty days' period of instruction does not suit the mentality of most of these cases. Colonies or villages are too costly to provide and maintain, and it is almost inconceivable to anticipate accommodation being provided for all the cases warranting such provision. Their number will exceed the total discharges of arrested cases from sanatoria and they would require such village accommodation not for one or two years, but for life.

Research efforts are on the increase as to centres working, the quality of work being done, and the elimination of duplication of fields being explored. Our Association is working through a special committee in this particular branch.

THE PRESENT STATUS OF RADIUM IN THE TREATMENT OF NON-MALIGNANT GYNECOLOGICAL CONDITIONS*

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The title of this paper in the programme is a misprint and instead of "The Present Status of Radiation" should read "The Present Status of Radium in the Treatment of Non-malignant Gynecological Conditions." I do not propose to deal with the status of radiation in general, but only with that of radium.

Although various conditions are referred to in the bibliography on this subject, as being successfully treated by radium, there are, in the last analysis, only two non-malignant gynecological conditions of sufficient frequency and importance to warrant our consideration. These are endocervicitis and uterine hemorrhage. In the first condition, radium is used with success in a dilettantish way by a few men. Arthur H. Curtis, of Chicago, has written most fully upon the treatment

*Read at Section of Obstetrics and Gynecology, Academy of Medicine.

of chronic leucorrhœa by radium. He describes his method in *Surgery, Gynecology and Obstetrics*, November, 1923. He uses two 25-milligram tubes of radium in tandem, screened by a rubber-covered gold capsule .5 millimeters in thickness, placed in the cervical canal. He states that the immediate result of radium treatment is increased discharge which persists for many weeks. This stage is often followed by a stationary period of a month or even two months; meantime the cervix should be dilated occasionally at office to prevent stenosis. Gradual improvement is the rule; recovery after a single application is frequent, but a considerable number require a second radiation to effect a thorough cure. This is preferably postponed for several months, first, because one treatment may eventually prove to be sufficient, second, because it is desired to ascertain with certainty that radiation has not interfered with the menstrual function. He also says that it is always advisable to state that the curative effect of the radium may not be manifested until nine months or one year has elapsed. He reports 104 cases, with recovery from chronic leucorrhœa in eighty-seven per cent.

The status of any therapeutic agent depends upon the value of that agent as proven by end results, and although in arriving at conclusions I have necessarily considered the opinions of others expressed in public discussions and in articles published in the medical journals, I feel that experience is really the best and safest teacher, and my conclusions are drawn in great measure from my own end results. Personally, I see no justification for the use of radium in endocervicitis. It is a very roundabout way of reaching one's objective and would remind one of a traveller who wishes to go from Toronto to New York, taking his passage via Chicago, San Francisco, New Orleans and Philadelphia. He would probably arrive, but at a loss of time, energy and money. I have used radium in a few cases of endocervicitis, but have discarded the method as being uncertain, tedious and expensive.

Endocervicitis is a low-grade inflammation of the compound racemose glands situated near the external os and is usually accompanied by a hyper-secretion from these mucous glands. If the endocervicitis is excessive, it is accompanied by simple erosion, cystic degeneration and, if there has been a slight laceration of the cervix, frequently by eversion. The glands and tissues are diseased and a cure can only be effected by the removal of all this diseased tissue. The most effective way of removing this tissue is by the cautery. From the gross appearance of the cervix, one can see exactly the tissue that is diseased

and exactly how much cauterization should be done. Radium will also destroy this tissue but its action is more uncertain than the cautery and more destruction may be caused than is necessary. Lailey, in *The Canadian Practitioner*, February, 1924, states that "radium causes atrophy and obliteration of the cervical glands, gradual improvement usually follows, occasionally a second application of radium is necessary."

In my records I find I have case histories of 964 patients, showing a greater or lesser degree of endocervicitis, where I have cauterized the cervix. Considering those which I did before keeping records, I know I have cauterized the cervix well over 1,000 times. I have not sent out questionnaires, but I have seen many hundreds of these cases afterwards and I have yet to see an unsatisfactory result; moreover I have never had a patient return to me complaining of a return of leucorrhœal discharge; and as these cases date back over fifteen years, I think it is fair to conclude that the result has been permanent. The same criticism which I here make of treating these cases by radium, applies to the use of diathermy and X-ray. Cure by use of the cautery results from one treatment and is accomplished in from four to eight weeks, according to the amount of cauterization necessary; simple cases may be treated without an anesthetic in the office but if there is extensive erosion or cystic degeneration, an anesthetic is necessary. With the use of the cautery there is no disturbance of menstruation.

The use of radium in the treatment of uterine hemorrhage of non-malignant type is quite another story. Radium has here established itself upon a firm, sure foundation and is endorsed by the large clinical experience and careful study of numerous observers. The reports published by Clark and Keene, of Philadelphia, Gellhorn of St. Louis, Polak of Brooklyn, Stacy of Rochester, Minn., Miller of New Orleans, Weiss of Pittsburg and many others of equal standing all over the world cannot be controverted. The skepticism shown for many years has disappeared and prejudice should not stand in the way of the employment of this method in proper cases.

My opinion on the use of radium in treating uterine hemorrhage has changed very little since I stated my views in a paper published in the *Canadian Medical Association Journal*, in November, 1923, but I am more convinced than ever that radium is the method of choice in many of these cases, perhaps in a larger percentage than I have previously stated. I made a lengthy classification for the purpose of eliminating all gynecological conditions to which radium was not applicable, and will not weary you with repetition. Briefly,

for our purpose here, they are pedunculated, sub-serous or sub-mucous leiomyomata, those showing any form of degenerating change and those complicated by ovarian tumors or old inflammatory lesions of the adnexa. As a rule, leiomyomata larger than a 3½-months pregnant uterus and those producing marked pressure symptoms are unsuitable for radiation. If there is even a suspicion of these complications, the case should be treated surgically. I repeat, extreme care is required in differentiating which cases of leiomyomata should be treated by radium and which should be dealt with surgically. It must be remembered that a certain percentage of these leiomyomata present no symptoms and therefore require no treatment but should be kept under observation. A considerable number of those requiring treatment have either some form of degeneration of the tumor or an associated malignancy. In the majority of cases where malignancy is associated with leiomyomata, the malignancy is found in the body and not in the cervix. I have, therefore, made it an absolute rule that I will not treat any case of uterine hemorrhage without a preliminary diagnostic curettage. I have proved for myself the advisability of this for in my last 100 cases in which diagnosis was doubtful, I have found carcinoma of the body five times, and it is now almost universally admitted that hysterectomy is preferable to radiation in carcinoma of the body. Again many of the leiomyomata are complicated by old inflammatory disease of the adnexa. There are also the cases where a myomectomy is more suitable than either hysterectomy or radiation. If hemorrhage does recur after myomectomy, it can then be checked by radium and one is sure of one's ground. If there is any pathological condition present or there is degeneration of the fibroid, the whole uterus and other diseased tissue should be removed surgically. I repeat, when there is any doubt as to the choice of treatment in a leiomyomata, it should be treated surgically rather than by radium. Extreme care in diagnosis is required, and do not let us forget that the most experienced surgeons and gynecologists sometimes make mistakes in the diagnosis of a pelvic lesion.

There is still, however, quite a large field for radium in treating uncomplicated cases of fibrosis uteri, hyperplastic granular endometritis, the bleeding at or near the menopause and in some cases of so-called idiopathic hemorrhage and in patients who are especially bad surgical risks. Fibrosis uteri is a clinical term rather than a pathological entity. The majority of these cases are of the sub-involution type with both the muscular and fibrous tissue increased. The blood vessels

are thick-walled and there is considerable perivascular infiltration and increase in elastic tissue. The histological findings in cases of fibrosis uteri are not of paramount importance but the most constant is glandular hyperplasia. Although this type of uterus may be met with at nearly any age, it is the type usually found in women who suffer from menorrhagia when nearing the menopause. These are ideal cases for the use of radium, and if the patient is over forty, one usually gives sufficient radiation to produce an artificial menopause. This does not necessarily have to be done, and with a smaller dose, after menstruation has ceased for some months, it may be re-established. The cases of uterine bleeding in younger women, which are often called idiopathic hemorrhage, are also suitable for radium. These are the cases which are theoretically explained as being caused by some disorder of the function of the endocrine glands. If this be true, one might theoretically hope for benefit from the administration of the extract of various glands, but although I have tried this treatment many times, it has been perfectly useless in my experience. These are the cases which have taxed the skill of gynecologists for many years and the unsuccessful treatment has led in some cases to hysterectomy and even to death. Even if hysterectomy is successful, these unfortunate young women are usually very unhappy as a result of being deprived of the possibility of motherhood. The careful and conservative use of radium in these cases is a great boon.

My technique has not changed since I described it in the article referred to above. I have now been using radium myself for over three years and continue to use it with greater confidence as time goes on. I have never had a mortality from its use and in only one case have I had a rise of temperature and this was due to a mild pelvic cellulitis. In this case the cellulitis subsided in about two weeks and the patient made a perfect recovery with no permanent effects from this trouble. I have never had a case of troublesome leucorrhea following radiation. I always screen the radium needles with a brass container of one millimeter thickness and then in heavy, black or grey rubber tubing. If radium can be used at all, it should be preferred because of its safety. There is an economic saving in less loss of time to the patient, lower hospital charges and no special nurses; the patient is also relieved of mental and physical suffering which cannot be entirely eliminated after a surgical operation. There is no long period of convalescence which follows a hysterectomy. I have seen very little so-called radium nausea, and in cases where it has occurred, it

is usually relieved by the administration of sodium chloride. Radium must not be looked upon as competing with surgery or surgery with radium; this would be perfectly absurd, for every surgeon and gynecologist should be as familiar with radium and as able to use it as he is a scalpel or a cautery.

In the past three years I have had 175 cases in which a decision had to be made as to treatment by surgery or radium. Seventy-five were surgical, one hundred were radiated. Of the seventy-five cases myomectomy was possible in only seven. Sixty-eight required either pan or sub-total hysterectomy—these were the cases of leiomyomata belonging to the classes I enumerated above as being unsuitable for radium application; of the 100 radiated thirty-five were leiomyomata; so that approximately thirty-five per cent. of leiomyomata requiring treatment were radiated and over sixty-five per cent. were treated surgically. Fifty-five cases were radiated for fibrosis uteri—all being cases in which the uterus was grossly, uniformly enlarged, and in which no fibroid nodule could be felt by manual examination under anesthesia. There were ten cases of so-called idiopathic hemorrhage. In these no gross enlargement of the uterus could be felt.

In leiomyomata and fibrosis cases, the dosage varied from 900 mg. hrs. to 1,800 mg. hrs., according to the size of the uterus and age of the patient. In no case has a second radiation been required, although in four patients normal menstruation was re-established after amenorrhea for about one year in each case.

1st case	age 40	1300 mg. hrs.
2nd “	“ 37	1250 “ “
3rd “	“ 32	1500 “ “
4th “	“ 34	1150 “ “

I should mention, however, that one woman, age 44, with very slight enlargement of the uterus, suffering from menorrhagia and who wished particularly not to have menstruation stopped, was given only 225 mg. hrs. and has never menstruated since.

In the idiopathic cases the dosage was from 120 to 600 mg. hrs. and in one case 900 mg. hrs. In seven cases after amenorrhea from one to three months, menstruation has been normally re-established. One case received 400 mg. hrs. radiation without appreciable effect, and has since refused further radiation. In another young woman, receiving 500 mg. hrs., there was no amenorrhea but the flow has been satisfactorily lessened. The tenth case was a young woman, 25 years old, who had been bleeding freely and was very anemic; it was

thought wise to stop her periods completely for a number of months and she was given 900 mg. hrs. on November 19th, 1924. There has been amenorrhea since treatment but it is too soon to expect the flow to be re-established.

End results are so satisfactory in those cases where radium may replace surgery, that I am thoroughly convinced that every gynecologist should be armed with radium as he is with knife or cautery; he should either have radium of his own or facilities to obtain it, and should familiarize himself with its use so that he may feel as confident in treating a case with radium as he would surgically. The amount of energy given off by a fixed quantity of radium is accurately known and the effect is dependent upon the amount used, the screening, the time and the distance. The technique is not complicated, and a gynecologist should no more need to refer a non-malignant case of uterine hemorrhage to a radiologist for treatment than he should need to refer a case for hysterectomy to a general surgeon.

I make this statement in speaking to the Section of Obstetricians and Gynecologists, and if I were speaking to radiologists, I would say that a radiologist should familiarize himself with the diagnosis of gynecological conditions sufficiently to know that a case he is treating is not more suitable for a surgeon than for radiation. But I think it is infinitely easier for a gynecologist to learn the use of radium than it is for a radiologist to learn gynecological diagnosis. The point I wish to emphasize is that no mistake be made in the selection of method. One must lament ultra specialization, even while one admits its necessity and admires its achievements in this complex age of medicine. Let us be constantly on guard against developing what John F. Baldwin calls a "single track mind."

TEACHING ABOUT TUBERCULOSIS

DOCTOR DAVID ALEXANDER STEWART, Ninette, Man.
Medical Superintendent, Manitoba Sanatorium.

Fire which consumes our houses and lays waste our substance may be fairly compared with tuberculosis, which consumes our bodies and lays waste human lives. The red plague of houses we deal with so loosely that smoking piles and blackened ruins are to be found in every community. And tuberculosis still destroys one life in twelve and more or less wrecks tens of thousands besides.

We suffer from both away beyond what is necessary. If we could but spread abroad widely what we know of both;

if we *would* but apply fully what we know, and be vigilant always, their ravages would be almost at an end.

We apply our knowledge better to the fighting of fire than to the fighting of tuberculosis. We fireproof some buildings, get apparatus, exhort one another against carelessness, arrange fire drills, train fire brigades against a day of mischance, watch closely the latent fires in furnaces and grates and all combustible substances. Tuberculosis, which lies latent in our bodies, ready to break into harmful flame if vigilance be relaxed or unfavorable conditions prevail, we do not keep so well in hand or so well in mind.

At the very worst, when the least sign or symptom or smell of fire is detected, the least little wisp of smoke where smoke should not be, we take extreme measures, raise the alarm and send for the fire brigade. If the alarm is needless, if we find we have made a mistake, that there is after all no danger, we are praised for our keen sense of the terrible possibilities of fire—the acute disease of houses. We are strengthened in our judgment and resolve that in similar circumstances we should again raise the alarm.

With disease that threatens life we act differently. The first signs and symptoms we ignore, go about our work and indeed about our play, as usual. Even when signs and symptoms increase we refuse to become alarmed. Only when gross symptoms have appeared, when the roof, so to speak, is falling in, do we realize our danger and send for the fire brigade. Then we expect the completest recovery in the shortest time with the smallest upsetting of our habits and the least curbing of our inclinations. We expect the brigade summoned when the house was enveloped in flames to restore it to us safe and without damage. Fire insurance companies could not long keep their heads above water in communities where house plagues and house dangers were dealt with as we commonly deal with body plagues and body dangers.

Unfortunately, tuberculosis is insidious in its onset, passes almost insensibly from bad to worse. Its symptoms are confused with the symptoms of more common and less dangerous diseases. And unfortunately, also, the prevailing policy is the policy of the ostrich. We refuse to be alarmed. We are blind because we will not see. There is a conspiracy of silence. Tuberculosis must scarcely be mentioned in well-regulated households. It has never been in the family on either side of the house. Everything possible or impossible must be thought of to explain symptoms rather than a disease which lies latent in all of us, becomes a definite illness

in one in six and kills one in twelve among us. This disease must not be thought of.

So it comes that we who treat tuberculosis, seldom see an early case. One of my assistants after eight months said he had not yet seen what he came to see, a real incipient case of tuberculosis. Three out of four patients admitted to the Manitoba Sanatorium have gross, far-advanced disease, one of them already hopeless, and only one in four can be classed when he comes in as having even moderately advanced disease or less. They come often for treatment, with large hopes for recovery, not when they have begun to be ill, but when they have begun to die. They seek the Sanatorium scarcely as a hospital but as a refuge and shelter when they have become a nuisance to themselves and others, a menace to their friends and families.

It is true that a stocktaking in any well-regulated community, would give much ground for encouragement. In most civilized countries the tuberculosis death rate was cut in two in the fifty years before say, 1912. In some of the more careful communities it has been almost cut in two once more since 1912. The more general decline doubtless had to do chiefly with improvements in living, housing, and working conditions, in habits and hygiene and with better diagnosis and treatment of all diseases. The more rapid and more recent decline in special communities undoubtedly is in large measure a result of a definite well-thought-out campaign against tuberculosis, a campaign of legislation, segregation, better diagnosis, more treatment, but, above all else, of more general education. We are getting advantage from special effort directed against tuberculosis and from all general efforts as well for the amelioration of social conditions. Everything that makes for better and more wholesome living makes for a lower tuberculosis death rate. We have one death only from tuberculosis where in our fathers' day there were two, and in our grandfathers' day, three. There is much to encourage.

But yet infection is as widespread as before. Saskatchewan, with the lowest death rate in Canada, and one of the lowest in the world, has more than four in ten of its children infected at six years, six in ten at fourteen years, and nearly eight in ten of its youth and maidens at eighteen years. More normal school students have had proved tuberculosis infection than have had proved measles infection. With all that is known and taught about the care of the body, say the care of the mouth, about cleanliness and good living, the con-

ditions of disease, defect and dirt in which some of our fellow-citizens drag from a neglected childhood, through neglectful adult years, into neglecting parentage, and premature old age, is wasteful in the extreme, sometimes even horrible.

And alongside of this gross tenth century ignorance there is a fairly ample supply of twentieth century science. Alongside of stupendous fire losses there is a vast amount of expert knowledge available for the prevention of fires. Alongside of crops that waste a tithe or two tithes with noxious weeds, there is ample knowledge in agricultural colleges and in Government departments to clear all farms of weeds. Alongside of crime and moral corruption, stands moral teaching, example and stimulus within the reach of all. Alongside of unnecessary disease, health loss, loss of life, there is knowledge in medical schools and health departments, in hospitals and laboratories, enough to cut all death rates in two and add at least a decade to the length of our days. Alongside of death and maiming from tuberculosis there is a knowledge of prevention, diagnosis and treatment which would make tuberculosis a negligible disease, and in time banish it from our race.

Why this contrast; why these bad conditions; why the slow improvement, so that our civilization seems like a stalled car on a crossing, making no move in spite of all the whistling? Perhaps a proportion of our people are really tenth century people—in their health thoughts and habits anyway—and indeed in other ways as well—some sixteenth, seventeenth, and eighteenth century people and a few only of the twentieth.

The fact is that people are hard to raise to higher standards, to inoculate with new ideas. Outward and insignificant fashions, like the length of skirts, or the shape of hats, gasoline engines or electric lights, moving pictures or the latest slang, are acquired easily. But fundamental thoughts, personal habits, home ways, change slowly.

Individuals are easier; but people in general are hard to teach. In nearly two thousand years the Christian gospel has not spread either widely or deeply over the world. After all that is spoken and written about high tariff or low, free trade or protection, taxation direct or indirect, ownership public or private, how many average citizens could pass a fair examination upon either side of any of these questions? With all the gentle influences of art and literature and religion playing upon us, how little have they left with the man in the street beyond a few catch words or trite phrases, or a prejudice likely inherited?

When people break laws we are inclined to blame the law makers. When they lapse in morals, we cast reflections on those who instruct in morals. And when they suffer from preventable disease we are inclined to hold the physicians responsible. For the tragedies of tuberculosis the doctor is indeed sometimes to blame, and very deeply; but not always, perhaps not usually. He does sometimes so fail to realize the significance of early signs, and indeed of later signs and symptoms, that life is lost which might have been spared. But much more often at fault is the ignorance of people in general, and the sad story of symptoms put up with and signs overlooked or explained away for months and even years before the doctor has been called.

And, strange to say, in our system of dealing with disease the burden of diagnosis falls first of all upon the sick man himself. The presumption is that a man knows when he is ill, that the point at which he goes to the doctor, asks for diagnosis and treatment, is exactly the point at which diagnosis and treatment should be asked for; but this is an assumption usually unjustified. Real obstacles such as natural reluctance, fear, and even cost, have to be overcome. And people in general do not know about symptoms or about disease, do not know when diagnosis and treatment should be asked for. Indeed a man may be hopelessly ill and not know it, and he has usually passed through the stages most amenable to treatment before he admits illness. It has been said that in a large measure all the disease a doctor sees is advanced disease, that pretty much all the disease treated in hospitals is advanced disease, that we do not often get a chance even to study early disease. Largely that is true. The curse of cancer is that it is brought for cure when it is already beyond cure. The curse of tuberculosis is that though strength may fail, cough may rack and symptoms go from bad to worse, relief will not unlikely be sought only at the very last, when relief is well nigh impossible. The doctor is called, not when the man begins to be sick, but when he has begun to despair of getting well. When he has got to the end of his own resources, beyond even the kind but blundering suggestions of his kinsfolk and acquaintances, the doctor may be a court of last appeal. He begins to exercise his function when disease is already well established.

If disease has to be let go until unexpert, untrained, ignorant, backward, reluctant, remote, scared, wrong-headed people come to a point at which they stand it no longer, then not much can be done in the way of cure of tuberculosis. If we are to get

disease under treatment at a stage amenable to treatment and with any prospect of cure, we must go and hunt for it. If we go no farther than the office door or the hospital door to receive what the general public in its ignorance casts down there for us, lives will continue to be lost that might have been saved and bodies maimed and crippled that might have been made whole.

The time has come when the better instruction of people in general, out to the remotest townships, in matters of health and disease is a responsibility upon the state, upon public health officials, federal, provincial and municipal, upon the organized medical profession and indeed upon all more intelligent citizens. The true substitutes for the wrong notions people have are right ideas. The only ammunition we can properly use against charlatanism and quackery is the ammunition of established fact and it is the best of all ammunition. Light dispels darkness; truth alone can drive out error. We have waited much too long before deliberately setting ourselves to teach people in general what we can tell them and what they should know about disease. Enough medical science is in existence, sure and established, to banish half the diseases people suffer from. But knowledge is of little use until it is spread abroad.

Who are to be the teachers? Naturally those who know something that is worth teaching, and who have life to give as well as logic. They must be enthusiasts. Torches are not lighted at icebergs. Teachers must not only possess truth; they must be possessed by it. With equal inspiration Moses taught a religion of health for the body and a religion of health for the soul.

Every tuberculosis organization should teach about tuberculosis, every health department, every visiting nurse, every clinic, every intelligent citizen. But pre-eminently the teaching centre should be the sanatorium. It should be the university for tuberculosis in the community it serves, a place for research, for study, for instruction. What it has learned of diagnosis or treatment, of the course of the disease or its prevention, is not for itself alone but should belong to doctors and students, to nurses and patients, and indeed by extension lectures, to people in general throughout its whole sphere of influence.

Most sanatoriums grew up with the idea that their one function was to treat the sick, perhaps improve them, sometimes even cure them. But so many applied at the very end of their disease that diagnosis soon came to be considered

an even more urgent duty. And since the root of all tuberculosis evil after all is ignorance, teaching might easily come to be considered, indeed has already by many come to be considered, as the primary and principal function. To diagnose is good but to teach diagnosis is better. To treat and to cure are good, but still better is it to teach the principles of treatment and of cure. To check disease in a few earlier cases is good; but to spread widely abroad a knowledge of prevention of disease and of laws of health—that is better.

And who are to be taught? Naturally those first and most who are in turn to be teachers of others, that truth may be scattered widely abroad. Among these are students of medicine. The best way to teach the doctor is to teach the student. The *genus homo* should be caught young if he is to be taught new tricks. A century ago when the student was an apprentice and rode the forest trails with his preceptor, he learned as much about tuberculosis as about other diseases—or as little. At least he met it often; but when medical education became a college function and training about disease was given in a general hospital only, from which tuberculosis was excluded, how were students to learn about it?

There were groups of medical professors—and they were called faculties—who, without pangs of conscience and with withers all unwrung, taught and trained young doctors up to graduation and licence, yet giving them no teaching, training or experience in a disease practically universal in its spread and so a background through life for all other weaknesses and diseases; a disease that still kills at least one in eight or ten the world over. There is no difficulty that is insuperable in the way of teaching a medical student in a sanatorium. Distance from the medical school is not a disadvantage but an advantage. Students have to come into residence, to live the life of the place, to become apprentices in its work. They are cut off from distractions and think, read, and work with tuberculosis intensively. The Manitoba Sanatorium, one hundred and fifty miles from a medical school, has in the past ten years given such an apprenticeship to nearly three hundred students. For every fourteen patients admitted for treatment one student enters for study. The Saskatchewan Sanatorium, three hundred miles from a medical school, is doing a similar work. This work of teaching students is one of the best things the Manitoba Sanatorium has done, perhaps the very best. It is one of the best things any sanatorium can do, perhaps the very best. From a selfish point of view, having in mind the good of the sanatorium, it is one of the best things that can

be done. It is a constant stimulus to the more permanent staff. A teaching hospital is tuned up to good and better things as a non-teaching hospital can never be. Teaching is as blessed to give as to receive. It casts bread upon the waters that returns after many days. After thirteen or more years of sanatorium effort I would rather lose and forget what has been done in healing than what has been done in teaching.

What has a student to show for a month of sanatorium apprenticeship? At the very least he has learned what two or three hundred tuberculous people look like, and what they do not look like. He has joined in an examination of perhaps one hundred and twenty patients and in a review of many more; has written a few histories and discussed many; has helped the staff to meet a month's complications, tuberculous and non-tuberculous, in two or three hundred patients; has learned a little of X-ray evidences of disease in chest and abdomen; followed pneumothorax treatment in thirty or more patients, become somewhat accustomed to fluoroscopy; has learned something of the evidence of tuberculosis in the intestines, in bones and joints, in kidneys and larynx, perhaps in meninges. He has learned something of the course and the recurrences of tuberculosis and of its meaning in the community. In short, he has had the real share of a resident in a month's complex sanatorium activities. If this has not given worthwhile opportunities for betterment in general medicine and in the tuberculosis phase of medicine in particular, there must be something wrong either with the student or the sanatorium.

Just think of what it would mean in the welfare of the community if every young doctor could enter practice with an intelligent interest in the problems of tuberculosis; with a fair idea of diagnosis and the principles of treatment; with an appreciation of tuberculosis lying latent almost universally as a background in all illnesses and at all times of lowered resistance; an understanding of its many modes of attack in the various organs of the body and its many recurrences; and some clear sense of the social import of a disease which bankrupts, leaves young widows and young children, strikes down the young man before he has arrived, while cancer strikes the older man after he has arrived. All these things are common knowledge to specialists. What if every practising physician were a real focus of such knowledge, and such interest? Why should he not be such a focus?

Much can be done to increase the interest of the man already in practice. He should be impressed more by the helpfulness of the sanatorium near him than by its criticism.

He should be free to drop in at almost any time, hang up his hat, take out his stethoscope, check up his methods and results and better his knowledge of tuberculosis. He should learn from every patient he sends. As soon as possible after a patient comes in the doctor should be written very fully about the sanatorium impression of history, physical findings, classification type, treatment and prognosis. For some time, in addition to such a letter, I have been sending for a look over, one or both of the X-ray films of the chest. These sanatorium findings do not by any means always agree with the doctor's or with the opinion he has given to the patient and his friends, and herein lies a difficulty in the way of pleasant and helpful relations. Tact will help, but one burden the sanatorium cannot and must not bear is the burden of this discrepancy. Widespread, far-advanced, long-neglected disease, needing years of treatment, and with a bad prognosis must not, to please doctor or patient or anybody else, be smoothed over as a mere touch of early disease which a month or two will completely and permanently cure. The sanatorium cannot say it has received five thousand dollars in assets when it has received but fifty. No good to anyone in the long run will be accomplished by giving a false receipt. A little tact will usually hold the doctor's co-operation and next time there will be a smaller discrepancy and a less dogmatic opinion.

No medical convention should be held without a presentation of some phase of tuberculosis. No medical society should carry through a season's programme without some set discussion on tuberculosis. A sanatorium should, whenever possible, act host to a medical convention.

When the general public goes to school for instruction in health matters the public health nurse is often the teacher—and a good teacher too; but she must have special teaching and experience. Her ordinary hospital training does not give her the messages about disease and health she needs to give to the people. The authority of her uniform must be given only to right teaching, not to notions she inherited from her grandmother. The more charm she may have, the more harm she will do if her message is a wrong message. Certainly, without special training and experience she is not competent to tell about tuberculosis, especially to give counsel to tuberculous patients. A little more or less activity, a little less or more rest, a little more or less indulgence seem small matters; but may mean the difference between life and death. The tuberculous man

is a convert to a new religion. He is in a world of temptations. A nurse to help him must know, indeed must have within herself, something of his religion of health. She must know sympathetically his pitfalls and temptations, his need of self-denial if she is to keep him in his straight and narrow way. Better no visiting nurse for the tuberculous than one untaught and inexperienced in tuberculosis.

Even for her ordinary care of the ordinary sick a nurse should have a background knowledge of tuberculosis and the principles of its treatment. As the sanatorium should teach medical students, so the sanatorium should receive into residence and teach under-graduates or graduates of the regular nursing schools throughout its sphere influence. This should not be a matter of convenience, but as much a part of its work as the care of the sick.

Tuberculosis is a community disease, and community leaders of all sorts, teachers, women's institutes, farmers' associations, men's and women's clubs, normal school students, all should be taught. The various luncheon clubs at which members may snatch a sandwich, a cup of tea and an idea occasionally should not be overlooked.

And we can teach the fathers and mothers, the teachers and leaders of the next generation, by teaching the children of this generation. Doubtless enough campaigns and studies have been unloaded already upon the long-suffering children; but many of the elemental things necessary to health, both in childhood and through adult years, must be learned in childhood or not at all. It is these general things at the basis of all good health and not the badness of any particular bacillus that should be subject matter of teaching to children.

How shall we teach? Perhaps we must learn the art of advertising or broadcasting. This is a new art not much older than our generation. Barnum has been called the father of publicity. A very great benefactor to his race will be the man who by super-advertising, by novel or by play, by picture or paragraph, through fear or through humor, will get into the minds of all the people the essential facts about health and disease. At any rate teaching is the thing. The body that has been healed, at very best cannot last for ever, but must sooner or later be swept away by the ruthless on-rush of time. Teaching is more permanent than healing. Ideas live. Seeds of truth sown in the minds of men pass from seedtime to harvest, and seedtime to harvest, through successive tilths, year after year, generation after generation, and will as long as our race may endure.

Afternoon

Left free for demonstrations.

The Programme Committee of the Ontario Hospital Association met at 410 Sherbourne Street, at 2.30 p.m., on Wednesday, June 17th, 1925.

Present: Dr. W. J. Dobbie, Chairman; Dr. J. N. E. Brown; Miss Dickson; Dr. Routley.

It was decided to hold the next annual convention on the 15th and 16th of October in the Academy of Medicine, Toronto.

Also the results of the questionnaire regarding the programme were taken up and a tentative programme mapped out, this programme to be submitted to the Chairman, Dr. Dobbie, for revision.

THE PROGRESS OF THE INTERNATIONAL CATHOLIC GUILD OF NURSES

The first of January, 1925, saw the International Catholic Guild of Nurses, which was formerly established at its first convention at Spring Bank, last June, moving forward rapidly in its membership. Not counting the number who have signified their intention to become members of the Guild, but have so far failed to send in their annual dues, the paid-up members of the Guild numbered 378 on January 1st, 1925.

It is interesting to remark the distribution of the members and to notice how representative a body they are as regards geographical location. The 378 actual members come from 134 cities in the United States, nine cities of Canada, and one place in Europe. The States of the Union which have the largest representation are Illinois and Missouri, each with 44 members. After these come Wisconsin, with 35, New Jersey with 32, Pennsylvania, 21, Kentucky, 19, New York, 19, Ohio, 17, Maryland, 13, Iowa, 11, Minnesota, 11, and Michigan and Texas, each 10.

The honor roll of the cities, which is constantly growing, now includes the following, which have ten or more members in the guild: Kansas City, Mo., leads the list with 26 members. Trenton, N.J., comes next with 19. Toledo, Ohio, is next in order with 18. Louisville, Ky., follows with 17. Then comes Jamesville, Wis., with 15; Chicago, Ill., 13; New York City, N.Y., 13; Baltimore, M.D., 12; and Houston, Texas, 10.

It would be interesting to observe the honor roll of the states and cities from month to month, and note how each pro-

gresses in membership. There shall be inscribed on the honor roll, all those cities and states which have ten or more members to their credit. It is easy to see that those cities which have many members owe this distinction to the fact that one or more zealous promoters of the Guild have been busy there, encouraging the nurses to become members and sending their applications and annual dues to the international headquarters. Some of those who attended the first convention last year have distinguished themselves in this way.

The total number of members in the United States, it may be interesting to know, is 365. Twelve members reside in Canada, while one of the memberships comes from Edinburgh, Scotland. The Guild is in correspondence with guilds of nurses in England and Ireland, as well as Scotland, and trusts soon to receive applications for membership from these countries also.

Not all the members have given full data as to their religious affiliations, but 123 have marked themselves down as Catholic, and thirteen as non-Catholic. If this proportion is borne out in the rest of the membership, as is quite probable, it would seem that about one-tenth of the Guild members are non-Catholics; that is to say, about thirty-five or forty of the entire number.

Frequent communications have been sent to the members of the Guild by Father Garesche, S.J., spiritual director, and Miss Kathryn McGovern, R.N., president of the Guild. All the members are invited to send in at any time their suggestions and ideas concerning its activities.

Among the plans that have been offered is that of endeavoring to found one or more scholarships for Catholic lay nurses, at the new College of Hospital Administration at Marquette University. Ideas are also being developed for some Guild applications of a nature to be very helpful to its members and to nurses in general.

Entertainments in aid of the international fund have been held at various places, notably in Blue Island, Illinois, and Minneapolis, Minnesota. Some of the committees, through the activity of their chairmen, have done good work. At the annual convention which will be held again this year at Spring Bank, Okauchee, Wisconsin, a report will be given of all these various departments of the work.

The individual members are earnestly requested to redouble their efforts during what remains of the first year of the

Guild's history. By taking a personal interest in the work and reducing as many as possible to co-operate in it, it should be possible by June to have a thousand members. Attention is called also to the various grades of membership to be found in the Guild. To some of these, other than nurses are eligible. Thus, for example, the sustaining members who pay \$10.00 a year in aid of the Guild, may be recruited from any class of persons and need not be nurses. The same may be said of the contributors, who give \$100.00 or more as a donation. The nurses are very earnestly encouraged to try, individually, to get at least a small group of sustaining members and contributors. In this way the financial status of the Guild will be greatly aided.

Though Father Garesche has until this time been carrying on much of the promotion work of the Guild, he looks forward confidently to seeing the nurses assume more and more of its activities. The coming Convention in June should be a very interesting one. At this time, the work will be further systematized, and plans developed for the second year of the Guild's existence.

Book Review

Diabetes. Its Treatment by Insulin and Diet. A handbook for the patient, by Orlando H. Petty, A.M., M.D., F.A.C.P., and William H. Stoner, A.M., M.D., F.A.C.P. Second edition, with illustrations and tables. F. A. Davis Co., publishers, Philadelphia. 1925. Price, \$1.50.

An excellent compendium of all points in which the unfortunate sufferer from diabetes requires instruction for the adequate following out of his physician's directions. Most practitioners will agree that the temperament of the patient must be borne in mind in placing such a work, excellent as it is, in his hands. Many such patients cannot "see the woods for trees," and in those of defective education, or intelligence, or of neurotic self-centred type, peace of mind may be much disturbed. The well-deserved laudation of Dr. F. G. Banting might better have contained some indication that he is not an American either by birth or by training.

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I. C. Brill and Harold B. Myers, Portland, Ore. (*Journal A.M.A.*, March 21, 1925), report the results of an investigation into the bactericidal efficiency of mercurochrome and gentian violet, administered by the intravenous route. Mercurochrome and gentian violet, in freshly prepared solutions, were employed in doses of from five to seven mg. per kilogram of body weight in three cases of septicemia and in two cases of local gonococcal infections. The results were not such as lead one to believe that this therapy is effective. Furthermore, the results in these few cases are characteristic of the results obtained in eight additional cases known to the authors, but which were not under their immediate management. Each of the additional cases terminated fatally, apparently uninfluenced by intensive intravenous treatment with one or the other of these dyes. Further evidence of the inadequacy of mercurochrome and gentian violet as intravenous bactericides is furnished by the report of an experimental study of the direct action of these dyes *in vitro*. Experiments on the effect of dilutions of mercurochrome and of gentian violet on the growth of staphylococcus, streptococcus and *B. coli* *in vitro* seem to indicate that there was no direct bactericidal action on those organisms from three hours' exposure to mercurochrome and gentian violet in concentrations of 1:10,000, representing the maximal advisable concentration of these dyes in the circulation.

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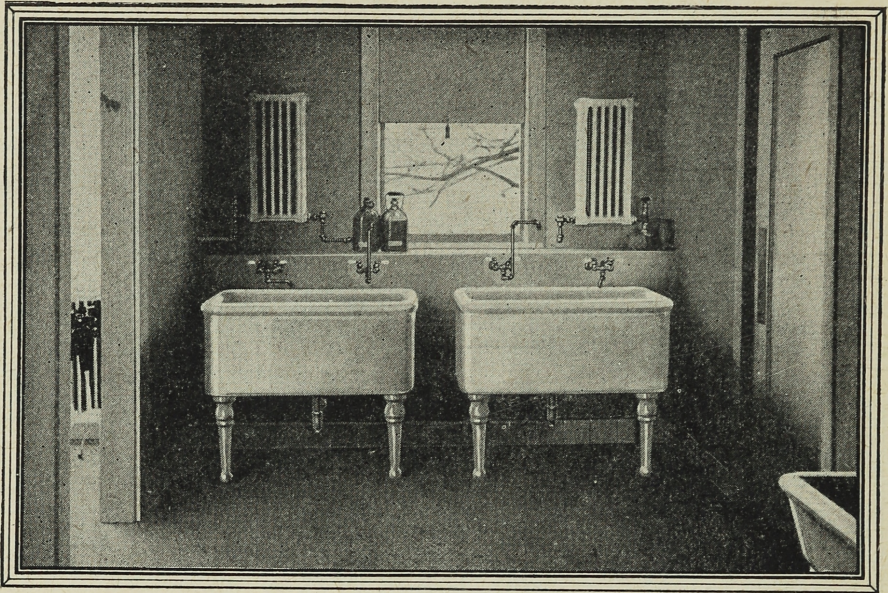
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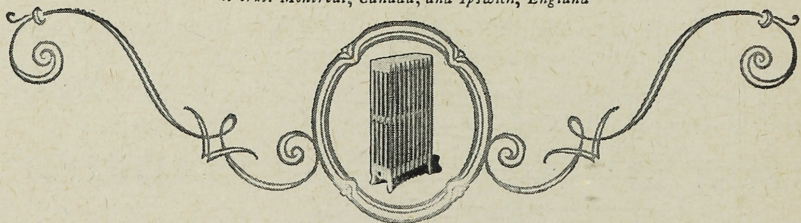
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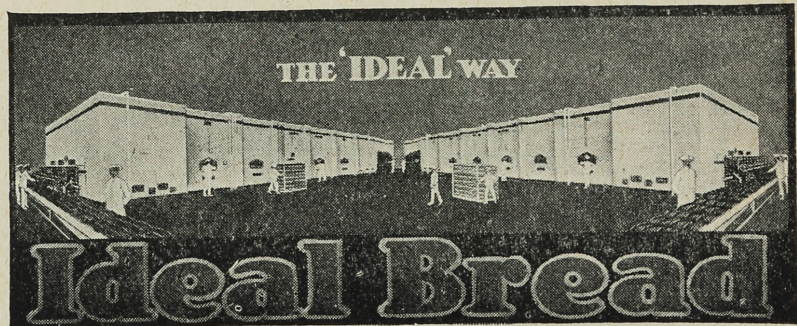
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Kastor Jems

**PURE TASTELESS CASTOR OIL
In Delicious CHOCOLATE Candies**

PRINCESS PAT PRODUCTS LIMITED TORONTO

OUR GUARANTEE:--

FIRST:—Kastor Jems contain the purest of castor oil in sufficient quantity to act on the bowels with absolute certainty, the dose being two for an adult, and one for a child.

SECOND:—Kastor Jems contain no other drug but castor oil. They do not contain Phenolphthalein, or any other coal-tar derivative, calomel or other mercurial.

THIRD:—People will say they cannot contain enough castor oil to have any real effect. You may say so yourself, but the reason why Kastor Jems are so effective lies in the fact that by a special process the activity of the oil is greatly increased, and the dose contained in a single Kastor Jem is as active as a tablespoonful of pure castor oil.

FOURTH:—Kastor Jems do not have the least taste of castor oil, for when placed in a candy dish together with other chocolate-covered after-dinner mints, they cannot be recognized by either taste, smell or appearance.

FIFTH:—The only other ingredients in Kastor Jems are sugar, peppermint flavoring, and chocolate coating.

When you prescribe Castor Oil, give Kastor Jems, and be a real friend to the kiddies.

Princess Pat Products

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