who claims, if not a specific for the disease itself, at least one for its sequel.

In the Medical Annual 1893 he is quoted as follows: “Having regard to the essential state of a severe attack of influenza, I conceived I would get the most effective antagonism to greatly increased alkalinity—and the bicarbonate of potash, was the first agent I thought of... I give liberal doses 30 grains in half a tea cup of milk, every two or three hours. I add a few drops of tincture of capsicum, but this is not essential.” In the Lancet, Feb. 3, 1891, he says that this treatment used early will prevent debility and obviate sequel, and further states, that under such treatment the acute symptoms and fever disappear in from 4 to 6 hours. He does not mention what he considers the essential state of influenza, evidently regarding other people as equally clever with himself, and disposes of those who have not had the same happy results with “his treatment” as himself, by saying that they have not given it as directed. I have had no personal experience in the matter, but have about the same confidence in soda bicarb. for influenza, as in mint water for acute rheumatism.

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THE IMPORTANCE OF EARLY OPERATION FOR CANCER.

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(Read before Nova Scotia Branch, British Medical Association.)

I will not trespass on your time to any extent in the few thoughts I will submit on this subject. I will make a very short paper and deal only with its subject-matter, from a practical standpoint.

Malignant growths are common in Nova Scotia. So far as our death rate is recorded it will be found that Cancerous Diseases stand high in the list of “Causes of Death.”

Let us ask ourselves then what progress have we made of late years towards a more hopeful prognosis in this most fatal of diseases? Is there any gleam of hope to the cancer patient in the rapid onward march of surgical science that we have observed with such pride of late years? I can safely answer yes, to these questions. We have made some progress; very little it is true, but a little gain is a great one in so formidable and fatal a disease. The smallest hope is a great gain over “no hope.” Recurrence after removal is almost as certain as anything in surgery, says Paget, in the great majority of cases. This means hopelessness in almost every case.

The result of the recent study of the etiology and pathology of cancers makes it almost certain that cancer begins as a local infection, and there is little doubt that it belongs to the germ diseases. It is believed that the source of infection is a micro-organism of a different order from those which produce fevers and other infective diseases, and that its attack on the system in the beginning is limited to the first point of infection and from that point the general infection is produced. In other words, it is a local disease at the outset and a distinct period of time elapses before the general system is brought under its influence a period of time, longer or shorter according to circumstances, we do not yet understand, probably such as the variety of the infection, as well as the different resisting power of various systems and various tissues to the invasion of the micro-organism. If this be true how instructive it is! What a lesson it teaches us! How important is it that the general practitioner should learn the tremendous value to the patient of that period of time, the time between the first indication of cancerous growth, and that when the whole system is brought under its influence. That period of time is a patient’s only hope. Once it has passed by death is inevitable. The
disease will run on to a fatal issue in one or two years as a rule. There is not the faintest chance of cure.

What care then can we take in our daily practise to take advantage of recent additions to our knowledge of cancer

Our first care should be to make an *early diagnosis*. This is of the greatest importance. Every case of small ulcer which shows no tendency to heal, especially if there is some infiltration of the tissues at its base, should be looked upon with suspicion. Every persistent abrasion or fissure about the mucous inlets or outlets of the body that remain open for a time, make a slight effort to heal and then open again usually mean the onset of epithelioma after a time.

Every nodule no matter how small that gives us three characteristics—pain; an increase in growth; and a tendency to acquire adhesions or infiltrate into neighboring tissues should challenge our closest attention.

Let us as early as possible after we see the case ask ourselves the question, is it malignant? and endeavor to answer the question definitely yes! or no! It may be said that we cannot always do so: that is true, but we should always aim to make a definite diagnosis as early as possible. On that depends in almost every case, the safety of the patient. Is there a member of this society who cannot call to mind cases that have gone on to a fatal result on account of a careless and slovenly diagnosis in their earlier stages?

How often do we find cases such as I have mentioned treated with ointments, washes, mild caustics and other applications of various kinds until many drift along towards the hopeless stage of general infection.

Our next care should be, if malignancy is diagnosticated, to advise an early and radical operation for the removal of the disease. Almost every text-book and every teacher of surgery for the past quarter of a century has strongly urged the necessity of early operation. There has been a consensus of opinion among the authorities in medicine and surgery that removal in the early stage offers the only faint hope of safety for the cancer patient; still we must acknowledge that that view while it is held and taught does not seem to mould the opinion of the profession even today.

Recent advances in our knowledge teach us that this view is more certain, I would say: *most certain*, for in the past our sad experience had taught us that even the so called were not cured.

I believe the most favorable cases will give us better results in the future than they have in the past, but it will depend upon what we would call “a most favorable case.” A most favorable case is one in which an early diagnosis is made, removal of the disease undertaken at its very inception; at the time its malignancy is decided on, and when the operation is full and complete that is, when every tissue that is likely to be infected is removed.

Why is an early operation often neglected? It is sometimes the fault of the practitioner, and sometimes the fault of the patient. It is too often the fault of the medical adviser, who, even though he is almost certain the case is malignant, waits and temporizes, he hesitates to decide positively in regard to medical treatment. It is a fatal error, and one that we should learn to avoid.

It is very often again the fault of the patient. In many cases the patient hides from the world the fact that cancer exists, so that it often goes beyond hope before it is seen by a medical man. There is also such a dread of a surgical operation in the minds of some, that they are willing too often to try plans of treatment of their own or the suggestions of friends. Patent medicines and advertised “cures” are given a trial, but all have but one result. They bring about the only real
danger in the surgery of cancer, delay! The radical operation is sought for them when it is often too late to do good. We can do much to remove this dislike and fear of a surgical operation. In the first place, we should impress patients with the fact, that any reasonable operation can be done, and we expect it to be done without pain or suffering of any kind, without fever, inflammation or any complications likely to involve either danger or distress. There is one other way in which we can calm the sensitive heart of those who shrink from an operation. By being able to point to a number of favorable cases. There is much to excuse the patient who resorts to quackery for the cure of cancer. He is able to say that the regular profession can offer little hope of cure even with the knife. The record of unfavorable cases is unfortunately too well known both to surgeon and patient. The bad record of surgery in cancer, can be improved also by avoiding the too common practice of operating on cases in which the system has already been infected. Cases in which the involvement of glands and infiltrations of surrounding tissues, make it apparent an operation is wholly useless. There may be cases that yet appear to be only on the border line of general cancerous infection, in which an operation may be done, but it should never be strongly advised, and only should be recommended by the surgeon, even under circumstances which justify him; with the fullest understanding with the patient and patient's friends that there is little hope of ultimate cure. But we should lay it down as an absolute rule, that any case which the best judgment of the surgeon declares a notoriously hopeless one should not be operated on.

One of the most instructive lessons of the past few years of study of malignant disease has taught us that cancerous infection spreads rapidly in the organ that is first attacked, and that the outlines of the growth do not represent the extent of the disease, that the infective elements of cancers permeate the apparently healthy tissue around the growth and invade neighboring lymphatic glands even before they give any evidence of infection. This belief is having a marked effect on recent operations for cancer. It is now believed, that in an operation for the removal of cancer, to be effective or hopeful of cure, the surgeon must cut wide of the growth and include a considerable portion of apparently healthy tissue around the tumor and that the neighboring lymphatic glands should be removed. I fully believe we will soon be able to point to better results in the operative surgery of cancer. When we observe more closely the two cardinal rules— an early operation and a full and complete removal of the growth.

Peter Bradley
vs.
Frank Rossin.

I have now to dispose of the merits.

In the first place, it was proved from the evidence for the prosecution and admitted by the defendant's attorney that defendant was not a person licensed or registered under the present act to practice medicine, surgery or midwifery.

Now the question comes, did he practise medicine, surgery or midwifery? and if so, was it for hire, gain or hope of reward? Let us see. Mrs. —— swears, "that she was ill, that defendant called to see her and visited her more than a dozen of times. She told him her symptoms and he told her what was the matter with her. He prescribed medicine for her and gave her medicine, two or three bottles, and gave directions how to use it. It time he came she told him how she was feeling and consulted with him about her symptoms, and she swears he also