Tennyson's In Memoriam

The wish, that of the living whole
  No life may fail beyond the grave,
  Derives it not from what we have
The likest God within the soul?

Are God and Nature then at strife,
  That Nature lends such evil dreams?
  So careful of the type she seems,
So careless of the single life,

That I, considering everywhere
  Her secret meaning in her deeds,
  And finding that of fifty seeds
She often brings but one to bear,

I falter where I firmly trod
  And falling with my weight of cares
  Upon the great world's altar-stairs
That slope thro' darkness up to God.

MEDICAL SOCIETY OF NOVA SCOTIA

ANNUAL MEETING, JULY 1927, AT SYDNEY

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Reminiscences

YARMOUTH DOCTORS OF THE 1870's

Read at the regular fall meeting of the Western Nova Scotia Medical Association, Yarmouth, Nov. 29th, 1926.

Dr. C. A. Webster, Yarmouth, N. S.

WHEN a man is asked to give his reminiscences, the furrows of time and the hoary signs of age are evident to his fellows and, no matter how juvenal he may feel, or how agile his movements, or how active the working of his brain, the request conveys the fact that he is soon to be placed on the shelf along with other antiquities.

Age is relative however, and to a child, the person of 30 represents an old person; to the new settler, the pioneer (no matter what his age in years) is an old timer.

Being born in Yarmouth, I have lived longer here than any other Doctor in the community, and next to Dr. Perrin, have practiced medicine here, longest. Dr. Perrin has promised to give us some account of his experiences during his long practice, and, I trust, we may soon have the pleasure of hearing them.

Dr. Fox has also given us a few pen pictures of some of the earlier Doctors of our County, and I hope that he may be induced to pen a few more, to enrich our literature, and plant historical data of our community in our archives.

Naturally, personal memories include only the child's own limited environment, his home, his family, and his neighborhood, and these appear larger and more important to him, so that the relative importance of his circle may be distorted by nearness, and assume too prominent a position in the larger setting of the whole town or community. Time, distance, and comparison correct this, and finally the historians place the personalities and events in proper order.

The child's view, is always more intimate, as far as it goes, than the historian's, and frequently more interesting. My whole life has been spent in a medical atmosphere, and in close contact with a great many of the older practitioners of Yarmouth, as my father, my two grandfathers, and two uncles of my mother, were general medical practitioners in Yarmouth.

My earliest recollections of things medical, and of medical personalities in Yarmouth, must have been in the early 1870's. At that time, Church Hill was losing, or actually had lost, its former importance as the center of business, and as the best location for a Doctor; but three of the old Doctors had their offices there, and remained as landmarks of its former activity. Dr. B. V. Harley was on the corner

of McConnell and Crescent Streets. He was a rather large, sedate, bearded, elderly man, carrying a cane, and a frequent caller at the office of Dr. Geddes, where the two medical men talked of things above my childish head, and of which I now have no remembrance whatever. No doubt some of it may have been connected with a certain motion made on March 11th, 1871, at a meeting of the Yarmouth Medical Society, "that the charge brought by Dr. G. J. Farish, against Dr. B. V. Harley, for a breach of the 22nd rule, be laid on the table." Looking up rule 22, I find, "The duty of members shall be to observe professional etiquette, to treat every member with courtesy and respect, and to endeavor by all possible means, to promote harmony in the profession." As to the nature of the breach, nothing will ever be known, and the principals appeared before a higher tribunal, not many years later. During this decade, Dr. Harley moved to Carleton, Yarmouth Co., where he practised until his death.

On the crest of Church Hill, on the western side of the road, at the corner of Geddes Lane, stood the office, and residence of Dr. Thomas O. Geddes. He was born in Scotland, and had come to Halifax, in 1817, when about ten or twelve years of age, along with his father and mother and the rest of the family. He was put to school to Dr. Twining, and later was apprenticed to an apothecary, and finally, studied medicine under Dr. Sterling. He became a Licentiate of Medicine when nineteen years old, and settled in Shelburne County, where he practised medicine at Barrington Head for thirty-four years. He moved to Yarmouth in 1857, and practised here until his death in 1886, at the age of eighty-one years, having practised medicine over a period of sixty-two years. He was a typical Scotchman, with a pleasant, kind manner, and cheery smile; while in repose, his expression was rather severe. He was erect, spare and rawboned, and resembled very much in looks Sir John A. MacDonald, the celebrated Canadian statesman. He was a great reader, reading English or Latin books with equal avidity and ease. He was much given to theological works, so that his library was the driest in the Town. He was religious, holding family prayers regularly, to which all the household was summoned. As is the general custom to this day, his office was in his residence. It was the rear room of the house, with the door on the Lane. There was a bay window looking on the same Lane, in which stood two large glass jars, in three superimposed sections, containing red, blue, and yellow liquids, the signs of an apothecary's shop. As all the Doctors at that date had their offices in their homes, a description of this office, which would be typical of most of the offices, might be interesting. As one stepped into the office, a bell, suspended over the door, rang as the door was opened, and it was the custom to enter without knocking. The office floor was bare, and painted. About two-thirds of the office was used as a waiting, and consulting room. Along one wall, was

a wooden bench, and wooden chairs stood about this space. Here also, was the stove, always lighted in cold weather. On one side was a counter covered with parcels of medicine, made up and addressed to various patients, two or three scales, large and small, some graduates for measuring medicine; a day book, with ink and pens and pencils, and such things as would likely be laid there temporarily. Behind the counter the wall was shelved to the ceiling, and the shelves were filled with dispensing bottles and jars of all sizes and shapes, containing liquids, pills, and ointments, with large gay colored labels in Latin, to distinquish the various medicines. Below the shelves, the space was occupied by drawers of different sizes, holding herbs of all kinds, and these drawers were also decorated with the same gay, colored labels. His office was always a warm, bright, cheerful place, redolent with the smell of medicine, often heightened by the odours brought in by the waiting people—some smoking, some from fishing vessels, and from all sorts of occupations and habitations. Much talk took place, and news and gossip were exchanged as they wiled away the time, awaiting the return of the Doctor. There was a small inner office, containing a large library and desk, and two chairs, but it was seldom used. Those were the days, when a horse was both telephone and automobile. In sickness, someone must drive to the Doctor's office. The Doctor's wife was the office boy. She had an intimate personal acquaintance with all the Doctor's patients, and with their complaints. Mrs. Geddes was wise and discreet, with an abounding sympathy and genuine goodness of heart. She could dispense medicine for a cold or a cough, or a toothache, or fever, to tide along until the Doctor could see the case himself; or, in case of an accident, could meet the emergency to clean and bandage a wound, or splint a broken bone. It was very common then, for people who had driven a distance, say ten to twenty-five miles, to wait for hours. With such occurrences, the Doctor's table had to be a long one, and the Doctor's wife had to be prepared for unexpected visitors. His house was a hospitable place, full of bustle and activity. There was always the proverbial servant maid, a smart, clean, healthy, country girl; and a man, generally a middle-aged married man, to look after the horses, cow and garden. The Doctor generally kept two horses, but as he grew older and became less active, fell back to one. In the two-horse stage, he was a busy man, always on the road, practically day and night, and only at home to change horses, one might say. Dr. Geddes for years rode in the saddle, but after coming to Yarmouth used the carriage. Though constantly in the saddle, he was an awkward looking equestrian, I am told.

Dr. Geddes excelled as a medical man, and from his training, was a skilled dispenser. He was no surgeon. He had his nose always in a book, and was not apt with his hands. There was one accomplishment, however, that he had acquired, that he excelled in. He could shoe his own horse, and I have often seen him put a shoe on it, in

the stable. I have never known another medical man with this accomplishment.

It might be interesting before closing the sketch of Dr. Geddes, for you to know what he was earning. The January 1876 earnings as shown by his day-book, with total charges and cash, were $110.80.

Total earnings for 1876, were	$1,123.15
" " " 1877 "	1,358.00
" " " 1878 "	1,210.00

There are many charges of 12½c. seemingly for consultation and medicine.

In the 70's, the roads were good except somewhat rutty from hauling ship-timber, and all the Doctors travelled in open carriages. The covered buggy did not seem to have yet arrived, or at least, been adopted by the medical fraternity, and they seemed to do their work, fully exposed to the fury of the elements. Neither had they yet begun to wear the fur coat, but wore from one to three cloth top-coats and mufflers. They wore the cloth and rubber overshoe, and used buffalo rugs in the carriage. Woolen mits, oilskins, rubber coats and "souwesters" were in general use.

On the eastern side of Church Hill opposite Dr. Geddes, was the house of Dr. Frederick A. Webster. As I remember him, he was an old lame man, very tall and erect, with heavy bushy grey hair and beard, and walked with two canes. While he had been an exceedingly active and able man in his younger days arthritis deformans had severely crippled him in his later years. He was born at Kentville, N. S., where his father, Dr. Isaac, and his brother, Dr. William, practised medicine. For four years, 1829-30-31 and 32, he had studied medicine in Scotland, and had graduated from both Edinburgh and Glasgow Universities. He settled in Yarmouth in 1833, and practised here until his death, in 1879, a period of forty-seven years. Dr. Webster had the reputation of being one of the ablest medical men in Western Nova Scotia. He was very ingenious, and exceedingly dexterous, being ambidexterous. He made many of his own instruments, and was never at a loss to meet emergencies.

While I have no names or dates, I have been told (by my own father) that Dr. Webster was expelled from college for amputating a man's leg while still an undergraduate in Scotland. The man made a good recovery notwithstanding, and he was later reinstated. It may be that the reason he graduated from two universities was due to this event. While he was living in Kentville, a negro was hanged there, and buried. The Kentville doctors and students, Dr. Webster among them, at night, took the body and used it for dissecting purposes and study, and then carried the skeleton into the woods among some ant-hills covered it with brush and left it to be cleaned and bleached. It was discovered next year, and the bones fell into the hands of a Wolfville doctor, Dr. Shaw, I think. Some time later, Dr. Webster rode to Wolfville, wearing a long cloak, on the inside of which he had

made deep pockets, and called at the Doctor's, who was out, placed the bones inside the cloak, and rode away with the skeleton. These bones are now in my possession. While attending to a very large practice, he built a wood-working factory, called the "Mallikoff," it being built during the Crimean war, at the foot of Lonergan Lane, near the Harbor, and ran it for a time, but it proved a financial failure. He also ran a large farm and always raised his own horses. He had his own breed from start to finish, and the breed died with him. They were always mares, "Peg" and "Trace," "Trace and "Peg." mother and daughter, in perpetuity and continuity. They were always exactly alike, red roans with ewe necks, and long tails and manes. As I see them now, they had good withers and quarters and legs, with low true action, and the foundation must have been thoroughbred blood. They were about 1,000 pound horses. He never allowed them to walk, and they swung along with a low, easy gait of eight to ten miles an hour, uphill and down never varying until the journey's end.

They all had villainous tempers, and I doubt if their equal in kicking, biting and crowding, can be found in these days, although with him, they were as mild and gentle as lambs. As a boy I have stood and seen the man try to harness "Peg" or "Trace." There would be much noise of shouting by the man, and squealing by the horse, punctuated with kicks on the side of the stall, and flashes of hoofs in the air. Soon a small crowd of on-lookers would collect to see the fun. With ears laid back, whites of the eyes showing, and skinned teeth, kicking, crowding, and fighting every attempt to put the harness on; it frequently meant considerable delay, and the old six footer himself sometimes hove in sight before the process was even started. He would slowly approach hobbling along with a cane to "starboard" and one to "port" and jocularly or angrily, as the mood was upon him, in stentorian tones, demand the cause of the delay. At the sound of his voice, and a "love tap" or two from his starboard cane, there would arise a great calm, and the fickle jade, would obey like a lady should in public. Then he would roll away in his four wheeled chariot, through the "Nor'west Passage" to gain the road. This chariot, like the horse, was a home product, and was fearfully and wonderfully made, and was the one and only ever built on that pattern. It had small front wheels to turn under, while the bottom of the floor was as close to the ground as it could be, to clear the ruts and stones. This enabled the crippled Doctor to get in and out more easily. This rig was very familiar throughout the town and country, and could hardly escape the observation of a stranger.

Dr. Webster himself, (like his horses) was of somewhat uncertain temper, and was never backward in expressing his opinion in forcible and, frequently, in lurid language. Nevertheless he was a gentleman, educated, cultured, polished.

Dr. Webster's office was the biggest curiosity shop in Nova Scotia. It was crowded from the front door through the back office, to the end of the workshop, with everything imaginable—from stuffed birds and reptiles, to a cuttle-fish mould, for casting gold rings. Splints, machinery, instruments, tools, harness, and drugs, were all elbowing each other, for room. He was so busy with his large practice, and various business interests and fads, that he neglected the financial end of his business altogether, and many years before his death, had given up keeping any account books whatever.

The next Doctor in order, was Dr. G. J. Farish, on the corner of Cumberland Street. His dwelling was a very artistic building, of English design, with lawn and garden to the south, and a old cannon buried at the corner, to prevent teams encroaching on the lawn. With an ell along the street on the north for an office and porticoes over the front and office doors, and flowers and lawn, it was a most attractive home.

Dr. Joseph, as he was called, was a native, and well known throughout the County. He was a burly stout man, of over average height, with white hair and beard. He had a heavy voice, and in visiting the schools, as School Inspector, his gruff voice and brusque manner, rather over-awed us children. I infer that his duties as Inspector of Schools, must have prevented his attending to a general practice, and evidently he must have ceased to practise medicine about this time. He, like his brothers, had graduated from the University of Pennsylvania.

At this period, Dr. Perrin was the most gay and dashing of the medicos of Yarmouth. As he is still with us, and our oldest practitioner, I need not say very much about him. He wore clothes pronounced in style and a special brand of hat and drove a fiery horse in a gay gig. He was a member of the Fire Brigade, the Militia, and the Tug-of-War. He led every procession on his fiery horse, wearing a big Mexican saddle, that still heads our cavalry when the Truckmen of Yarmouth go on the ninth of June celebration. While extremely busy professionally, he found time to take an active part in politics, and in many Societies. He was a many sided man, with a vast fund of information, and with all, an excellent practitioner. He is still held in high esteem by his many patients, and tries by means of a gruff manner, to hide a tender heart.

Dr. E. K. Kelley was a native of Yarmouth. He was rather tall and high shouldered, erect, and spare, with a merry twinkle in his blue eyes. He was always dressed in a long black, frock coat. He was a rather quiet man, and very witty. At the beginning of my practice, I assisted him to remove the leg, for gangrene, of an old woman, an inmate of the County Poor House. When the leg came off, he said, "This old lady will die in the Poorhouse, but she will leave a *leg-I-see.*" On another occasion, he remarked how dangerous a bed was, as he had noticed that almost all of his fatal cases, had

died in bed. He had a large county practice, taking in a large section of the county about Chebogue, Little River, Pinkney Point, Comeau Hill, Plymouth, and Tusket Wedge and Islands. He graduated from the College of Physicians and Surgeons of New York, and practised here until he died of apoplexy. He was a wise man, and a good general practitioner, and went the even tenor of his way, making no enemies, and living a blameless life. His office was on Cliff Street, on the south side, two doors from Main Street.

Dr. George Bell, was located near the mouth of Parade Street, over Wyman's furniture store on Main Street. He was a very gentlemanly looking man, well dressed and neat, over the average height, with a profuse crop of white hair, a good complexion, and wearing gold rimmed spectacles, giving him a handsome distinguished appearance. He was a bachelor, and lived alone. His practice was largely office, as he did not keep a horse, and consequently, was not known very well throughout the County. Later, he moved to Digby County, and died there.

Continuing north along Main Street, we came to Starr's Road corner, where the office of Dr. John Webster was situated. Dr. John, as he was always called, to distinguish him from his father, Dr. Fred, who was at the opposite end of the Town, was a large, fine looking man. He was tall and large, weighing two hundred and ten pounds, ordinarily. He was born at Yarmouth in 1835, graduated from the College of Physicians and Surgeons of New York, in 1858, and died in 1885. His was a strenuous life, entirely devoted to the medical relief of the people of the community. In weather fair or foul, at all hours day or night, in summer sun, or winter snow, to people rich or poor, he went his constant round, literally sacrificing his life for the people, until at the early age of fifty years, he was suddenly stricken, and ceased forever, from his busy labors. The celebrated painting by the English artist, Luke Fildes, showing the doctor watching the sick child, is almost a portrait of Dr. John, so striking is the resemblance, and this has often been remarked upon by those who knew him. He was a most sane man and had a great amount of common sense. Dr. John was the only doctor in Yarmouth who kept an office man. For many years James Hilton was a feature in the office. He came at eight o'clock and left at six, and did all the office work. The front office was much like a drug shop. Hilton made all the tinctures, mixtures, pills and ointments. He put up the medicines for the patients, as ordered by the doctor. He pulled teeth and vaccinated the children that came to the office for that purpose, and, in case of an accident, did temporary dressings. He kept the books and did the collecting, and made annual calls about the county to effect settlements of accounts. I should here like to offer my tribute of respect to the memory of a most worthy gentleman.

Dr. Webster had several students studying with him at various times. The above James Hilton was one, although he never attended

college. Dr. George Butler, who practised in London, England, Dr. Joseph Messenger, who settled in New York, Dr. Edward Kelley, Dr. Simpson Lathern and myself, all studied under his tuition. Bones and specimens, medical books, colored anatomy plates, the microscope, were always lying about the study. Dr. Butler and Dr. Messenger were studying at the same time James Hilton was working in the office, and for two or three summers I remember the office as a lively spot.

As Dr. Messenger married a daughter of our next door neighbor shortly afterwards, there must have been some diversion after the study hours, during the long summer days. The office comprised a front shop with a wooden bench and chairs, a counter, shelves of bottles, and desk; a back office contained a sofa, big chairs, library, etc. From this back office a stairway ascended to a front room over the shop, and this upstairs room was assigned to the students as a study, which left the offices below clear for the Doctor himself.

Dr. Webster kept three horses, and having an extremely large practice, was generally on the road. The family being large, he ran a considerable establishment. Besides three horses, two cows were kept for milk, and country produce was constantly being brought in as payment for medical services, so that the house was "a house-of-plenty." In the autumn, loads of hay would be brought in by the farmers, and put into the barn, and later, sacks of oats. Then bags of potatoes, barrels of apples, other vegetables and loads of turnips would be placed in the cellar, and preparations made for the long winter. Later still, as the ground became frozen, quarters of pork and beef arrived, and were cut up, and salted in casks in the cellar. Along the cellar wall in a row, with the barrels of meat, was a barrel of cider, a cask of kerosene oil, a barrel of molasses, and a cask of alcohol, these laid on their side, broached and tapped, ready for draining the contents as required. In those days, when all the Doctors were poor, the poorest certainly lived in abundance. At this date, twenty-five cents was a common charge in the office for advice and medicine. A call anywhere in Town, was fifty cents.

Of the many horses driven by Dr. John only one was outstanding. "Bill" was a gentleman among horses and would have won at any show and in any company. The Hon. Staley Brown had imported him and his groom was brought along. Owing to Bill's perfect symmetry and proud and prancing ways he was greatly admired by everybody. Shortly the groom left and then it was seen that something was wrong; nobody could harness Bill. Bill lived in idleness a long time and many men by many methods tried to harness the horse but none succeeded. Then it was decided that Bill must be sold, but his reputation had gone abroad and no one cared to buy. Finally Dr. John bought him at a low price and, having noticed the peculiar way that Bill took the bit when his groom was harnessing, never had any difficulty. Bill did his master's work for a great many years and, finally,

when 27 years old, and he was becoming quite stiff, a merciful rifle bullet gave him a painless entrance to the horse Paradise. If I were to write his epitaph, I could truthfully engrave,—"Here lies the perfect horse." He was a coal black, 16 hand horse, of the perfect hunter type, with a high head and arched crest.

Continuing north we reach the office of Dr. W. A. C. Randall one door south of Milton Corner. Dr. Randall was a newcomer about this time although his wife was born at Yarmouth. He was a man of average height, somewhat stooped, with a bald head, bushy eyebrows and a long flowing dark beard. He was born in the Annapolis Valley and had practised at Bridgewater before coming here. He was an active temperance worker but indulged in chewing tobacco to an appreciable extent. With the loss of teeth and the whitening of the beard this became more noticeable, owing to the greater range of the jaw and the tell-tale stains at the angle of the mouth. Dr. Randall was always interested in racing horses and could tell about Messenger, Rysdaks, Hambletonian and the Belfounder mare. He drove a very fine trotting mare in his practice for many years, even until he himself had grown old. Then he bought a rapid pacer and drove a road cart, and attended all the races at the Victoria Driving Park, where he related many wonderful horse stories sitting on the sunny seats of the grandstand. He confined his practice to medical work, wisely leaving surgery to those having more taste for it. Before the days of anti-toxin he was very successful in dealing with diphtheria, and had a wide reputation throughout the county in such cases. At this period no swabs were taken. He boasted of his success in Obstetrics, but I imagine he must have struck an occasional snag. He outlived most of the other doctors of this decade reaching a ripe old age and died leaving only pleasant memories.

Next door to Dr. Randall at Milton corner, was the office of Dr. James Farish, another veteran of the Town, and brother of Dr. Joseph, already mentioned. The first names of these men of medical families, had to be used to distinguish them. The surname did not identify.

Dr. James, was a man of five foot, six inches in height, very erect and spare, with a grave, kind, serious countenance, grey hair, and side whiskers. I knew him well. He was pleasant and kind, but reserved, and somewhat austere. He had a strong personality, and was very methodical as far as his profession allowed, with calls at all hours. He kept one horse, which he attended himself always. During my recollection they were chestnuts or Morgans. He continued to use the saddle to some extent until over seventy, and he was the last of the doctors to use the old fashioned high 2 wheeled single seated gig.

The last occasion he rode horseback was on a windy, muddy night, when he rode to see a patient three miles in the country. The horse was tied to the fence, and naturally, grew restless. When

the Doctor tried to mount, the horse would circle, and could not be induced to stand for him to get into the saddle, and as he had lost the agility of his youth, he was finally forced, after much effort, and much against his will, to abandon his attempts and to walk the entire way home. Dr. James was exceedingly frugal, and his expenses in running his home, and office, were at the minimum. He had no fire in his office, but it was always warm in the grocery stores opposite. He has told me that, in his early practice, obstetrics was largely in the hands of midwives, and that the doctors had agreed to attend confinements for $2.50 each. He said that the many fatalities occurring in the hands of the midwives had induced the doctors to take this action. It resulted in the rapid displacement of these women. During the 1870's the fee had arisen to $5.00. Dr. James was the Croesus of the medical profession, and left an estate, I am told, of $20,000.00, the largest up to that date left by a doctor in Yarmouth County.

Now we have reached all the doctors in rotation and I must cease, making no mention of the country doctors. Changes were going on in this decade. Dr. Fred Webster and Dr. G. J. Farish must have died during this period, and Dr. Harley went to Carleton. Dr. Henry Kelley had come in and settled on the corner of Main and Albert St. There had been a marked wave in favor of Homeopathy and we had a number of irregular practitioners; but all these things would make another story.

Treating Baby Rough.

Pickup from the New York Times.

Bottles, a trade paper, calls attention to a nursing bottle advertisement which concludes with these instructions:

"When the baby is done drinking, it should be unscrewed and laid in a cool place under a tap. If the baby does not thrive on fresh milk, it should be boiled."

An apparently bold physician challenges us to print the following:

Dottie: "Come in and see our new baby."

Teacher: "Thank you, but I will wait until your mother is better."

Dottie: "You needn't be afraid. It's not catching, teacher."

Tubal Infections*

By L. M. Morton, M.D., C.M., Yarmouth, N. S.

OF the many problems which we continually have to contend with, and which stimulate our diagnostic ability to its greatest activity, there are none which present a greater variety of symptoms, and a more complicated differential diagnosis, than the problem of infections of the female pelvis.

Every medical practitioner is daily confronted with some phase of pelvic pathology, due to present or past infection; in fact, were it not for the ills of the "Female of the species," the Doctor's income would be seriously handicapped. Pelvic infection covers too large a field for discussion in a short paper, so therefore, I propose to confine my remarks more especially to infections of the Fallopian tubes or Salpingitis.

Regarding the Anatomy, the Fallopian Tubes or Oviducts are two small muscular tubes which extend outwards from the fundus uteri in the upper part of the broad ligament. The tubes vary in length from 3 to 5 inches and in shape somewhat resemble a shepherd's crook, partly surrounding the ovary. The lumen of the tubes is very narrow in the interstitial or uterine portion, and varies from about the diameter of a slate pencil in the isthmus, or portion extending from the uterus to the beginning of the curve, to the diameter of a lead pencil at the outer dilated portion or ampulla. Each tube has a small central cavity communicating at the inner end with the uterus, and at the outer or fimbriated extremity with the peritoneal cavity. Thus we have a direct channel of communication through the vagina, uterus and tubes into the great peritoneal sac. The narrowest portion of this channel from the vulva to the ovary being the Fallopian tube, it is, therefore, the natural place for the lodgment of infection.

The tube when once attacked by disease throws it off with difficulty and then only after permanent damage has been done. Infections of the tubes are more frequent, and more often undiagnosed, and less readily respond to timely treatment, than the same infections in other parts of the genital tract. Inflammatory invasion of the oviduct may terminate in one of four ways:

(1) By complete resolution; (2) By the production of adhesions; (3) By suppuration; (4) Or by fibrosis.

*Paper read before the Fall Meeting of the Western Nova Scotia Medical Association at Yarmouth.

On the invasion of the tube by organisms, the mucus membrane becomes swollen with oedema and the muscular wall with its connective tissue becomes very much engorged, due to dilatation of the blood vessels. As the tube is of smaller calibre at the uterine portion, and at the distal end of the ampulla, this initial swelling mechanically closes these portions and pus is forced out by pressure which begins to distend the tube. As the infection goes on, there is poured out by the vessels of the submucosa a plastic exudate. This plastic exudate increases the distension in the larger part of the tube, and at the same time increases the pressure at the constricted ends. Soon the Epithelium of these constricted portions, already devitalized by cloudy swelling, begins to disintegrate and the two surfaces covered with plastic exudate come intimately in contact. This exudate is soon invaded by new blood vessels, granulation tissue is formed, and later fibroblasts appear and the process of permanent closure is well under way. As this process is going on at the proximal and distal extremities of the tube, greater and greater pressure is required to force through the inflammatory products, and greater becomes the distention, until eventually none will pass out and we find ourselves with a most interesting pathological condition, a canal normally open at both ends, becoming a closed distended sac full of pus.

The micro-organisms chiefly concerned in tubal infection in order of frequency are the gonnococcus, streptococcus, staphylococcus, the bacillus tuberculosis and the pneumococcus. Not infrequently there is a mixed infection of two or more different organisms in the same diseased tube. What is the fate of these organisms as their environment changes from a rich well-nourished one, to an environment where they must live under pressure, an environment in which the physiological flow is ever outward, and no new sources of nourishment are available? Living at such a disadvantage with sources of nourishment steadily getting more and more restricted, the organisms lose their virulence and if they do not die at least become incapable of activity. One authority states that at least 70% of advanced pus-tubes are free from infective bacteria.

If the abdominal end of the tube is closed and the uterine end open, it is possible for the tubal contents to escape by way of the uterus. This condition is exemplified in those cases with which we are all familiar. The patient otherwise in apparent good health, complains of periodic attacks of pelvic pain, more or less severe. This pain is followed by a vaginal discharge of pus, sometimes mixed with blood, and the symptoms immediately clear up.

When both openings are sealed and the pyosalpinx develops, it may go on to further damage unless relieved, e.g., extension into the broad ligaments and pelvic cellular tissues, formation of a tubo-ovarian abscess, and in rare instances sudden rupture into the abdominal cavity. The length of time for infection getting in at the cervix to reach full bloom in the tube is variable and uncertain. It may be a few weeks or many months.

Puerperal or Gonnorrheal infection are the two outstanding causes of Salpingitis. In Puerperal cases the infection spreads by the Lymphatics so rapidly that the infection becomes as a rule, a general Pelvic one. Later, the Peritonitis and Cellulitis gradually subside and leave behind the inflammed, distorted, and enlarged Tubes of Chronic Pyosalpinx or the Sclerosed Tubes and Ovaries of Salpingo-oophoritis. As regards acute Gonnorrheal infection it is invariably an extension along the Mucous Membrane from uterus to tubes.

The rate of extension is slower and usually less virulent than Puerperal Infection. In grave cases of Gonnorrheal origin it is the superimposed Streptococci, Staphylococci or B. Coli which do the mischief. The Gonnococci pave the way much the same as Saphrophitic organisms do in Puerperal Infections. Another mode of infection is by the blood stream, the best example of which is T. B. secondary to Pulmonary T. B.

Among the so-called "Focal infections" Pyosalpinx is not to be forgotten. The teeth and tonsils have taken up so much of our attention that we are liable to forget the gall bladder, the veriform appendix and the purulent pus-tube. The signs of tubal infection vary from mild complaint to severe constitutional disorder. Febrile manifestations may occur without local pain or tenderness. Large pus-tubes may be present without pelvic pain and only discovered on routine examination. The various arthritic affections in women, the headaches, backaches, etc., and various unexplained fevers of more or less short duration may come from an unsuspected pyosalpinx.

Symptoms:—In the acute stage the patient complains of pain in the lower abdomen increased by movements. She is usually confined to bed with moderate fever, 101 to 103 degrees, or in puerperal infections chills and temperature up to 105 degrees. The lower abdomen is tender on pressure, the areas of tenderness being confined to one or both tubal regions or general extension over the lower abdomen. Usually, there is a vaginal discharge due to the endometrial inflammation with a history of recent labor, abortion, instrumentation or gonnorrhea, or there may be history of a chronic infection due to these casual factors. On bimanual examination there is tenderness in the body of the uterus and about the tube on one or both sides. If there is a mass of exudate, it may be felt to one side or behind the uterus. Very often the exudate extends all around the uterus giving it the so-called "plaster of paris" feeling. It gives the sensation of a firm roof across the pelvis just above the vagina. If suppuration has occurred, fluctuation may be detected and a rectal examination should not be forgotten as often it gives better access to the posterior surface of the mass.

The chief symptoms of Chronic Salpingitis are backache, pain in the pelvis, patient is not able to walk or work as she used to; there are menstrual disturbances, dysmennorrhoea and mennorrhagia with

vaginal discharge; exacerbation of symptoms, when patient has pain and some fever and may have to go to bed for a few days or weeks. There is tenderness in the tubal regions with thickening of tubes and possibly a mass may be felt. The uterus is more or less fixed and painful on movement depending on the amount of exudate.

There are several acute pelvic conditions from which tubal infections must be differentiated and happy is he who can always solve these problems to his own satisfaction. The diagnosis must be reached by a careful consideration of all the symptoms present and the definite exclusion, one by one, of other conditions which may produce similar symptoms.

The following are the more common conditions complicating a diagnosis: (1) Acute Endometritis. (2) Tubal Pregnancy. (3) Appendicitis. (4) Suppurating tumour. (5) Ovarian tumour with twisted pedicle.

In Acute Endometritis on bimanual examination tenderness is confined to the uterus and no marked tenderness in peri-uterine structures and no mass found there.

Tubal Pregnancy, after the primary rupture presents the symptoms and signs of ordinary acute or sub-acute salpingitis but with certain peculiarities. As salpingitis is the more common affection, it is to be assumed that the trouble is tubal infection and not tubal pregnancy, unless there are special symptoms pointing to the latter and these are not always pathognomenic, e. g.

(a) missed menstruation;
(b) sudden onset of pain with or without shock;
(c) bloody vaginal discharge usually within a few days of onset of pain with sometimes shreds of membrane and clots leading to supposition of miscarriage;
(d) exacerbations of pain without apparent cause and without corresponding elevation of temperature.

Gonnorrheal pyo-salpinx after the acute symptoms subside may lie dormant and unsuspected for a long period. During this quietest period the pus-tube, containing usually sterile fluid, is tolerated the same as a small tumour or other non-irritating body. The patient being practically well and without decided pelvic disturbance. Such a pus-tube may at any time develop acute symptoms, and the onset of pain may suggest Tubal Pregnancy.

In *Appendicitis* pain is usually all over the abdomen—the point of greatest tenderness and the mass, if one is felt, is in appendix region; also there is usually history of gastric or bowel disturbance preceding or associated with attack of pain; while in salpingitis, there is usually history of uterine disturbance, dysmennorrhoea, prolonged menstruation, vaginal discharge, and history of previous uterine disease. In all right sided inflammations, appendicitis should never be forgotten, as it may be overlooked if one's mind is too intent on pelvic disease. The points of interest are that Pyosalpinx is usually a bilateral disease

and that with it the uterus is generally fixed and tender and the signs are lower down than those of appendiceal inflammation. Although, of course, one finds sometimes the appendix adherent deeply in the pelvis. The history should help to differentiate these conditions but unhappily a truthful and intelligent statement is not always available.

Suppurating tumour, usually a dermoid cyst connected with the ovary, may give rise to a mass in the same region as one finds in salpingitis. Differential diagnosis is difficult. If patient is a girl or a woman who has never been pregnant or had any uterine infection, probability is in favour of Dermoid tumour. Also history of tumour existing before acute symptoms developed, and absence of vaginal discharge or uterine infection are in favour of a dermoid.

Ovarian Tumour with twisted pedicle may simulate salpingitis. Here bimanual examination reveals a very definite condition, namely, a well-defined rounded tumour, extremely sensitive to the touch, apart from the uterus and unilateral. A careful investigation of the history will establish a correct diagnosis.

There is much diversity of opinion regarding the operative treatment of salpingitis and the question is always open to debate. The pendulum has been swinging back and forth from operating in the acute stage to waiting for months for period of quiescence. One of the tragedies of gynecology is that we sit by and calmly allow a process in the tube to result in extensive pelvic pathology. As in other branches of medicine our aim in gynecology should be the prevention of pathology. We are not preventing a pathological process when we permit a suppurating tube to involve adjacent structures in inflammation, and form adhesions which eventually require extensive surgery. Because a salpingitis subsides after several weeks it does not necessarily follow that there will not be subsequent attacks leading to the development of a pus-tube, for which we will be compelled to enter the pelvis. At such a time diseased ovaries are removed or an ovary in doubtful condition is left behind to be removed later when causing symptoms. This is not conservative gynecology. No very long time is necessary to elapse after an acute attack before operation may safely be done. The benefit to be derived from delay of a month or more, as advocated 10 to 15 years ago, has been much exaggerated. The fear of mortality in these patients is unfounded when the proper technique is followed, and the sub-acute condition is easier to deal with than the chronic.

Treatment varies as to whether we are dealing with salpingitis following parturition or salpingitis following acute gonnorrhoeal infection.

Puerperal salpingitis is a grave condition by reason of the extensive general pelvic inflammation present. The degree of peritonitis and the seriousness of the symptoms decide one whether to operate or treat palliatively. Cases of B. Coli infection die and cases of Streptococcici nfection more often recover. Radical surgery may be the only

treatment which will give these desperate cases a chance of life, and even removal of uterus, tubes and ovaries may be necessary.

The following general measures may be tried:—Rest; Fowler's position; Ice-cap applied to abdomen; Forced fluids; Proctolysis; Foreign proteins and serums; Quinine and Ergot; Fresh air and Sunlight. The essential features in these cases is to aid Nature in the limitation of the infective process, and in the elimination of the infective material.

In rapidly spreading Peritonitis such cases as are seen following labor and miscarriage, and which constitute a severe type of infection, vaginal or abdominal section, or both, should be done. If Peritonitis is confined to the pelvis, vaginal section with rubber tube drainage should be done avoiding irrigation and not putting dependence on gauze drainage. If peritonitis is getting beyond the pelvis, open the abdomen by median incision and establish free drainage to the depth of the pelvis with or without removing the affected tube, or tubes, as seems best in particular cases.

Oschner's treatment, viz; stomach lavage and withholding nourishment by mouth to prevent injurious intestinal peristalsis, with Fowler's posture for drainage, and introduction of large quantities of fluid into the system, to strengthen the organism and aid elimination, is essential to success. If the patient recovers pathology of a more or less severe type may require further operative interference.

Neisser's Baccillus seems to take a special delight in attacking the oviducts. It may form a partnership with another organism but as a rule it is monarch of all its surveys in its own field of selection. Rarely, if ever, does the gonnococcus invade the cellular tissues of the pelvis.

Victor Bonney says "A pyosalpinx or an ovarian abscess, in my opinion, is a disgrace to the surgeon, if the delay, which allowed of such forming, can be laid to his door. The parallel with appendicitis is a fair one. There the surgeon seeks to operate before abscess formation, because the operation is safer than after an abscess has formed. In salpingitis also the operation is safer before abscess formation, but in salpingitis there is additional reason for early operation. No one wants to conserve an appendix healthy or otherwise, but the ovary is a different matter and now evidence is suggesting that the tubes may be saved if operated on early enough." A large number of cases diagnosed as acute appendicitis in women become cases of acute salpingitis when the adbomen is opened. If the infected tube is removed, there is as a rule, no disturbance of the typical convalescence but if the tube is allowed to remain—what happens? It may regenerate, yes, it also may go on to pus-tube formation with the subsequent sequelae, and more often it becomes more or less of a hard sclerosed cord absolutely functionless but nevertheless pregnant with the possibility of acute exacerbation of symptoms at any time. Safety first! The old slogan should be applied to these cases. Why

leave a minature floating mine in a woman's pelvis, already to detonate on the slightest provocation, and perhaps cause irreparable damage when the menace can be removed with perfect safety in the early stages.

Gonnorrheal pus-tubes can regenerate sufficiently to permit ovulation and, pregnancy and, still retain the infecting organisms, which later may become active and the following case is very instructive. "Patient married—healthy child born one year after marriage —normal puerperium—few months later infected by Neisser's B. and subsequently sterile for eight years when she became pregnant, and was delivered of a healthy boy at term—spontaneous delivery. Twenty-four hours later all signs of a general septicaemia developed which would have caused extreme anxiety, if previous history of the patient had not been known. Right prosalpinx developed and was opened and drained through an abdominal incision ten days later." The above case illustrates the fact that although the tubes had regenerated sufficiently to permit pregnancy, yet the right tube contained latent organisms which only required the encouragement of child-birth to set the fire going anew.

The all important question we have to ask ourselves is what is the after history of these patients? What happens to those not operated on? Perhaps complete recovery. The germs are destroyed, the plastic and serous exudate is absorbed, the pain disappears, the patient feels well and function is restored. This most satisfactory termination is more theoretical than real and is more liable to take place following puerperal infection than in gonnorrheal. In the latter condition, there is not the same danger to life but the ultimate danger to health is more marked. Sterility and permanent invalidism is the common sequel. If there is only partial recovery, functional recovery is not complete. The patient feels well but she is sterile due to remaining infiltration and adhesions that occlude the tubes and otherwise damage them. Again the patient after surviving the acute attack may succumb to the persistent septic absorption.

Of the operative cases, a large proportion are permanently cured. The patient's health is restored and she is capable of child-bearing. There may be partial recovery with resultant sterility, although the patient is in apparent good health. The cases with post-operative lesions of adhesions and plastic exudate present a serious complex of symptoms and may require further surgery. The virulent cases may die in spite of interference but on the other hand many hopeless cases are saved by timely operation.

After all decision as to *whether*, or *when*, or *how*, to operate in salpingitis comes of experience and careful observation. There is something about these patients, the facial expression, the feel of the pelvis, the story of the disease, the lay of the land, that carries its own conviction of what will be safe and successful in each individual case.

Case Reports*

Dr. J. A. Sponagle, Middleton, N. S.

MR. President, and members of the Valley Medical Society, in response to the request of our worthy and indefatigable Secretary, and having a large amount of appreciation of the work that falls to the lot of that official, I am reporting a couple of cases that may, or may not, be of some interest.

1. A case of Pregnancy complicated by a large Ovarian Cyst. Mrs. C. aet. 40. Four previous normal confinements; no miscarriages. Last time of menstruation reported as Sept. 10, 1925. No morning sickness. Had noticed an abdominal fullness for some time back,—so much so that some of the neighbors suspected pregnancy the previous summer. In December noticed that the abdomen suddenly became much larger. I met her at a neighbor's house about the first of January; she looked like a woman well advanced in pregnancy.

I was first called to see her Feb. 2nd of this year, on account of a severe pain in left side, lower abdomen, which took her suddenly, that morning, on attempting to get out of bed. She was a thin spare woman, pulse varying from 120 to 130, normal temperature, much bothered with a cough. Abdominal enlargement very pronounced, abdomen very tender not permitting much palpation. Vaginal examination revealed an enlarged uterus and ballottment the presence of some intra uterine body. Breasts very small and flabby and not suggestive of pregnancy. She was in poor shape and that afternoon was removed to Soldiers Memorial Hospital, Middleton.

On the following afternoon, the abdominal tenderness having subsided, in company with Dr. L. R. Morse, a further examination was made. Among the possibilities we had to consider, were abdominal ascites, an abdominal tumor,—either ovarian or of some other variety—a cystic kidney, a pregnancy of an abnormal character, as for instance hydramnios, or a normal pregnancy plus an abdominal tumor. By careful manipulation we thought we could make out a slight sulcus about half way between the Symphysis Pubes and Umbilicus, and that an enlarged uterus, separate and apart from the other mass, could be delineated. It was decided to observe her for a time and endeavor to get her into better shape for any future surgical measures.

After a few days to relieve distress from distension a trocar was introduced and about three quarts of dark green viscid fluid was aspirated,—apparently from an ovarian cyst. This opinion was confirmed by Dr. Nicholls to whom a specimen was sent, although

*Presented at the Fall Meeting of the Valley Medical Society at Berwick, October 12th, 1926.

he suggested the possibility of it being due to exudation from a gelatinous intra-peritoneal malignant tumor. On Feb. 16th, a laparotomy was done, Dr. L. R. Morse assisting and Dr. Messenger being the Anaesthetist. A median line incision was made, mostly above umbilicus revealing a large ovarian cyst, the pedicle being attached to the right fimbriated body of the uterus. In order to deliver it, it was necessary to use the trocar and an unmeasured amount of fluid obtained. There were some adhesions, upper left quadrant. Pedicle tied off with stout silk and incision closed in the usual way, peritoneum, fascia and skin, with a small cigarette drain which was removed in 24 hours. The solid part of the tumor, which was a multi-locular Cyst, weighed 8 pounds. Patient made a good and uneventful recovery and left hospital after operation in 14 days.

On May 25th was again admitted to hospital and was delivered of a fine boy, apparently full term, with no complications. Since then has been in good health doing the work that usually falls to the lot of a woman on a large farm.

2. A Case of Appendicitis.—On January 26th, 1925 was called to New Albany to see a youth about 15 who had been sick for a week. I found him running a temperature, and with a large mass in the right lower quadrant, and a history of an acute abdominal condition. There was no difficulty in diagnosing Appendicitis. The next day he was brought into the Soldiers Memorial Hospital by train and operated on that afternoon. We ran into a large appendicular abscess. A careful search was made for the offending organ, but the patient's condition was not good, and it was decided that drainage offered the best chance of recovery. The patient had somewhat of a stormy time for a few days, but after a somewhat prolonged stay in the hospital, was eventually discharged with a persisting sinus in the track of the incision. After a few months it had apparently healed, but broke out again. The boy was attending High School in Middleton from January to June of this year and every stunt was tried to heal it up. No opening of any depth could be discovered by probe. At length the boy was advised to re-enter hospital for a laparotomy to discover the cause if possible. Accordingly on July 12th, he was again opened up. Incision inner edge of Right Rectus. A regular forest of adhesions, in which Omentum was freely mixed, was found in the right lower quadrant. After a laborious session loosing them up, the base of the appendix, at its attachment to the Caecum, was eventually identified, and on tracing it along found that the tip was attached to abdominal wall opposite the sinus tract. A probe from outside passed into it. The most of the appendix did not look too bad, but the end was bulbous and contained purulent material. It was separated from the bowel at its base and carefully dissected out, and, as far as possible, raw surfaces covered over. Incision closed in the usual way. Sinus tract curretted out and packed. The boy went home in a couple of weeks and has made a good recovery.

Possibly you will say there was nothing unusual about this case, and if we had gone on and removed the appendix at the first operation, we would have saved the patient, the patient's friends, and ourselves much trouble. This is all granted. On the other hand, at the time of the first operation, the boy was decidedly septic, and a prolonged operation and the breaking down of Nature's protecting wall, exposed him to a number of risks, viz. general septic peritonitis and general septicaemia, to which in his exhausted condition, he would be very susceptible. My first experience in such cases was in 1897, when under rather crude conditions, I opened and drained a deep appendicular abscess in a very sick child. This child had a particularly rough time, due to a certain extent, no doubt, to poor technique, but has never had any trouble since, and is now a hale hearty woman. We have had a fairly large number of cases in our hospital where drain age alone was done, and so far as we can see, have done as well as those in which the offending organ had been removed. This was the first one, so far, that required a second operation. Of course, we always get the appendix, if we can, but would rather have a live patient than an appendix, if a choice has to be made between the two.

I thank you for your patience, Gentlemen.

A LARGE BABY.

MANY unusual cases occur in the general practitioner's daily work, and I believe the following case is unique. I think it has been my experience to be present and assist in the delivery of one of the largest babies ever born.

I was called to the case on Sunday, Aug. 29, 1926 at 2.30 P. M., and found my patient a woman of 42 years, very very stout, sitting on the edge of her bed. She was not having pains but large quantities of amniotic fluid were coming away per vagina.

History:—Eighteen days past her expected date. Had been in bed five weeks on account of edema of ankles and lower abdominal pain or discomfort. Twelve previous confinements, all children living except the first one. The five last births were all instrumental and difficult and large babies—10 to 12 pounds—Hydramnios present in all cases. No miscarriages or abortions.

Examination:—An extensively enlarged abdomen. I could not palpate the head or any of the small parts, as the foetus moved freely in the large amount of fluid still present in the uterus. The "waters" had commenced to come away with a rush just previously, without pain. She had had pains the previous day which had stopped at

midnight, 14 hours previously. Vaginal examination showed cervix soft; slightly dilated, and presenting part, I thought, the head. No pains beginning I returned home after one hour and was called again at 9.30 P. M. Pains had become quite strong and of a bearing down nature. Patient said that a 2½ gallon bucket of liquor amnii had come away from 2 P. M. till 9.30 P. M., 6½ hours. The abdomen was appreciably smaller, cervix fully dilated, breech presenting with right sacrum anterior. 10 P. M. no apparent advance. Tried to get a leg down and failed. 10.30, forceps applied over iliac crests; failed to hold and after three attempts tried again to bring down a leg. 11 P. M. Patient, nurse and myself getting exhausted sent for help, in the meantime making another attempt to bring down a leg. 11.30, Dr. Grant arrived, examined patient and tried to bring down a leg and failed. 11.45, Dr. Grant succeeded in bringing down the right leg, traction made no advance. 12 P. M., patient at last consented to take chloroform. Traction continued, no advance. Foetal sounds heard at this time—rate fast. 12.10, forceps applied again to crests, slipped off each time. We both applied forcible traction on the leg—felt something give way and fearing we were tearing the limb from the body, stopped and made arrangements to remove patient to hospital. 1.30 A. M.—Patient coming out of chloroform, pains still present. I thought of trying one blade of the forceps to act as a guide—This was inserted posteriorly and heavy traction made—the left sacrum, to our relief, glided over the single blade of the forceps—the buttocks came down on the remains of a perineum and was born. The after coming head came through with little or no trouble. There was another large gush of amniotic fluid—the placenta and membranes came away intact at 2 A. M.—Membranes very thin and of a tremendous capacity. The foetal heart was silent and despite our efforts no signs of resuscitation occurred with the child. The baby was dressed in a nightshirt, with a towel around it weight 20 lbs, 14½ oz. Towel and nightshirt weighed next day, 12½ oz. Baby's net weight, 20 lbs., 2 oz. Measurements taken, chest 17½ in.—head to toes 27 in. Occipito-frontal measurement 16 in.

The mother had a fairly normal recovery. Temperature never reached 100 F, her pulse never exceeded 110. On the 12th day sat on the side of her bed. On the 14th day up and dressed and about the house. She has a rectocele and a cystocele of some consequence which were present before this birth and are probably no worse than previously. Involution seems to be taking place slowly—still flowing a little on the 23rd day, but the flow is getting more scanty each day. She gives a history of flowing for a month after her other confinements.

(Signed) ALLAN R. MORTON.
WM. GRANT.

Catholic Hospital Association

Dr. W. F. McKinnon, Antigonish.

(Being an address delivered at the Annnal Meeting of the Maritime Section held in Antigonish, October 10th, 1926).

DR. McKinnon, after referring to the great history of the religious orders in the nursing profession, and after paying a well merited tribute to the fine work accomplished by the Sisters of St. Martha, proceeded as follows:—

I shall first refer to our Ethylene equipment. Ethylene as you know is one of the latest general anesthetics.

It is hard to restrain one's enthusiasm in speaking of the virtues of this excellent anesthetic. While we have by no means forgotten or neglected our good friend Ether, there are so many occasions that the use of Ethylene makes the Surgeon's burden easier, and the patient's outlook brighter, that we have come to look upon Ethylene as one of the greatest factors for good in our Institution. An anesthetic is always dreaded. The fear of it has kept many sufferers from seeking relief from their miseries. The reputation of Ethylene has so spread in this hospital constituency that patients come for operation demanding Ethylene as their anesthetic. It is pleasant to take. I myself was curious to know its action, and I tested it out when I had a tooth extracted. I was off the table within two minutes, with absolutely no discomfort and able to visit my patients. A member of my family had occasion to have the tonsils removed. The patient was awake within three minutes of the administration, the tonsils removed and expressing delight at feeling so well. For prolonged operations, our experience has been equally satisfactory. In our experience complete relaxation is always obtained; the patient remains warm and dry; the salivary glands remain inactive; there is no bronchial irritation and it has been used with great satisfaction in Acute Coryza, Empyema, Acute and Chronic Bronchitis, Asthma and advanced tuberculosis of the lungs. In Chronic Bright's Disease complicated with Articular Rheumatism, I have had it recently used for teeth extraction and the patient was able to leave the hospital within a few hours. I may say that in not a single case has the patient to be strapped or restrained in any way. The patient does much better if a hypodermic of Morphine and Atropine is given an hour before the operation. Sometimes the patient becomes too comfortable and respiration requires a little stimulating. This can be done effectively by the use of a little CO_2. Formerly when we had three or four cases

under ether anesthesia, special nurses would be required for the post anesthetic period; under Etheylene none are required. Again in addition to vomiting the patients were subjected often to severe gas pains, and again these features are practically eliminated. Ethylene is a more powerful anesthetic than N_2O and a given quantity in the nerve cells produces a deeper anesthetic. This is equivalent to widening the anesthesia range. For this reason it is possible to produce a quiet anesthesia in children where the metabolic rate and the oxygen requirements are high. Such an anesthesia could not be produced by nitrous oxide. Our anesthetist has furnished me with some cases, a few of which I shall cite.

Case 1.

A woman, aged 45 had Ether once before and suffered greatly from after effects, on being visited two hours after taking Ethylene she was enjoying a glass of water and said she felt fine with no unpleasant after effects.

Case 2.

A man, aged 30, never had an anesthetic before. The operation lasted 30 minutes, after removing the cone the patient appeared quite bright and asked to see his appendix—seen six hours later, he said he was very hungry.

Case 3.

Man, aged 40. Remained asleep five minutes. Seen two hours later said he suffered from pain in the incision. After a hypo he slept two hours; did not complain after.

Case 4.

Girl, aged 14, Peritonitis, Pulse 140, breathing rapid, operation lasted 40 minutes. On awakening on table, patient vomited. Took water following day and doing well.

The second matter I wish to deal with, is our Physiotherapy Department. This addition to our armamentarium has attracted attention and visiting Physicians have been loud in their praises of this department.

It consists of the Electro-therapeutic, embracing Diatheramy, Ultra-Violet Ray, Thermotherapy and Electro-bath, and the Hydro-therapeutic department which embraces the Turkish bath, sedative bath, scotch douche and arm and leg baths. This department has been in operation since March 24th, 1926 and 52 cases have been treated.

Personally I have great faith in this department. There are certain classes of patients that are especially benefited, such as. Neurasthenic, Rheumatic, Kidney and Alcoholic cases. So far we have treated Neuritis, Neurasthenia, Anemia, Insomnia, Arthritis, Eczema,

Psoriasis, Alcoholism, Nephritis, and Rheumatism, all were relieved and some were cured. This treatment is, of course, given in conjunction with medical treatment. In a marked case of Anemia, under my observation, the addition of air-cooled Ultra-Violet irridiation gave most gratifying results. On admission the patient's red blood count was 2,300,000 and Haemoglobin 35% after 10 days treatment the red blood count was 3,800,000 and Haemoglobin 53%. This patient made a rapid recovery.

In a neurasthenic case, that I had treated with indifferent success for some time, on being given Hydrotherapeutic treatment, she improved rapidly.

In several alcoholics, the sedative bath was of great assistance in quieting the patient and promoting sleep.

I have at present in the hospital a patient who has been suffering for many months from Articular Rheumatism. She had to be carried into the hospital. After two weeks treatment of Physio-therapy, she is greatly relieved and able to walk a short distance.

Septic wounds are benefited by a mild exposure of Ultra-Violet rays. An intractable septic arm case at present in the hospital, showed marked improvement after the application of Ultra-Violet rays.

I could exhaust your patience on this subject, and as I am trying to be as brief as possible, I shall rest here with the assertion that Physiotherapy has a great future, and that the institution that neglects its employment, is not taking advantage of a very important aid for the relief of many poor sufferers.

Reverend Sisters: I assure you that I esteem it a privilege to address you to-day, and I trust that your visit and conference at St. Martha's will bear excellent fruit and that you will not be loath to pay us another visit in the near future.

Some Incision!

In an article on Blair's operation for Cancer of the tongue in "Annals of Surgery", Jan. 1926, Page 146, occurs the following paragraph:—

"Beginning at the symphysis pubis, the anterior bellies of the diagastrics, the geniohyoids, the genihyoglossi and the mylohyoids were divided with a knife closely hugging the bone."

Some proof reading!

Intravenous Injections

W. J. Egan, M.D., C.M., Sydney.

I QUOTE the following from the *C. M. A. Journal*, October issue, dealing with mediaeval medicine:

> "Few outside the medical profession, or we might say, within it, know that the architect of St. Paul's was the same Dr. Christopher Wren who was the originator of intravenous injections."

It has been said that early Greek and Egyptian carvings indicate transfusion operations, but of that I have no knowledge.

It is true that about 1667, a London scientist, Mr. Oldenburg, does declare that the,—

> "discovery of a method of conveying liquors immediately into the mass of blood is due to Sir Christopher Wren, at that time Savillian Professor in the University of Oxford."

And goes on to describe the method thus:—

> "Wren's method was to make a ligature on the veins, and having made an opening in them on the side of the ligature towards the heart, to introduce into them slender quills fastened to bladders (in the manner of clyster-pipe) containing the matter to be injected; performing the operation upon pretty big and lean dogs, that the vessels might be large enough and easily accessible.
>
> These experiments were made at different times upon several dogs. Opium and the infusion of crocus metallorum were injected into the hind legs of these animals. The opium soon stupified but did not kill the dogs; but a large dose of the crocus metallorum induced vomiting in all and death in some of them."

(Was Crocus Metallorum an oxide of Iron? W. J. E.)

> These experiments mentioned by Oldenburg were more fully related by the Hon. Robert Boyle, probably the most profound English Scientist of that age, in his excellent book on the "Usefulness of Experimental Philosophy."

About this time too, there was an international contention regarding the history of transfusions, several countries claiming to be the pioneers, the discussion revealing in the end that Italian Scientists and probably Frenchmen too had been acquainted with such operations before Sir Christopher Wren had been born. It transpired that long before Wren's work, transfusion from dog to dog and from lamb to lamb,

as well as transfusions of various liquids, had been quite commonplace operations.

Soon the Scientific world, through the success of these transfusions began to dream of the possible rejuvenation of older animals whether human or otherwise through the injection of the blood of younger ones, an attitude possibly less erratic than that exhibited by the more modern advocates of monkey glands.

The following experiment by Signior Griffoni, at Undina, Italy, on the 20th of May, 1667, is well authenticated. Here an old and deaf mastiff certainly appears to have benefited by the treatment. I quote:—

> "This dog, thirteen years old and deaf for some three years, was so feeble that he walked very little, and was so unable to lift his hind feet that he could only trail his body forward. After Signior Griffoni had transfused the blood of a lamb into his veins, he remained for an hour upon the table where he was yet untied; but leaping down afterwards, he went to find his masters who were in other chambers. Two days afterwards he went abroad and ran up and down the streets with the other dogs, without trailing his feet as he did before. His appetite also returned to him and he began to eat more greedily than before. But what is the more surprising is that from that time forward his hearing began to return, so that on the 13th of June he appeared to hear quite well, answering the call of his masters."

About that time too, a certain Mr. Denys, Professor of Mathematics and Natural Philosophy at Paris, states in a letter to Mr. Oldenburg, who was then in London, that they recently in Paris "transfused the blood of four Wethers into a horse 26 years old, and that this horse had thence received much increase of strength and more than ordinary appetite."

To show you that our professional fore-bears of that time were very human like ourselves, quite a heated international discussion arose as to which country, England, France or Italy was the first to report transfusions into the veins. In the end Dr. Boyle satisfies himself as to the Italian claim in the following statement:—

"An Italian philosopher in a tract entitled,—

"RELATIONE DELL ESPERIENZE FATTE IN INGHILTERRE, FRANCIA AND ITALIA, INTORNO LA TRANSFUSIONE DEL SANGUE,"

lately printed in Rome, undertakes to prove that the transfusion is of yet greater antiquity, as having been known to Libavius above fifty years since (or about 1615). The Roman author quotes a place out of the said Libavius, (In defensione syntagmatis arcanorum chymicorum contra heningum schneumannum, Actione 2 Frankof A. D. 1615), where the transfusion is so plainly described, that one can hardly discourse of it with more clearness than is there done in these words:"

" 'Adsit (says Libavius) Juvenis Robustus Sanus, sanguine spirituoso plenus: Adstet exhaustus veribus, tenuis, macilentus, vix animam trahens. Magister artis habeat tubulos argenteos inter se congruentes, aperiat arteriam Robusti, and tubulum inserat mumiatque; mox et aegroti arteriam findat, et tubulum foemineum infigat. Jam duos tubulos sibe mutuo applicet, et ex sano sanguis arterialis, calens et spirituosus saliet in aegrotum, unaque vitae fontem afferet omnemque languorum pellet.' "

"This indeed is clear enough and obliges us to allow a greater antiquity to this operation than we were before aware of; though it is true that Libavius did not propose it but only to ridicule it; besides he contrives it with great danger to both the recipient and the emittent, by proposing to open arteries in both; which indeed might be practised upon brutes, but ought by no means upon man"

In other some articles I may be tempted to transcribe an account of a few of these early transfusions with comments.

The Bulletin Widely Read.

The readers of the BULLETIN will be surprised to know how widely this magazine is read. An editorial on Prohibition appeared in the June 1926 issue, and an editorial comment in the Nov. 27th issue of the *British Medical Journal* on the article is as follows:—

Resentment Against Liquor System.

"A forcible protest has appeared in a recent issue of the *Nove Scotia Medical Bulletin* with regard to the control of liquor in that province. The ground taken is that the profession has been imposed upon (he speaks colloquially of "being made the goat"!) by the local Government, in being made the sole medium through which the public can obtain their supplies of spirits. He describes the all too familiar scene of streams of visitors at his office, each one pulling out his dollar fee and making the laconic demand "Scrip, Doc." It is, he says, to be deprecated that money could be made out of it—even, if so desired, large quantities of it. However, those apparently acute troubles are over, since supplies of alcoholic liquors are much more freely obtainable from "bootleggers," leaving the doctors fewer prescriptions to write. But further aggravation has been caused by the recent instructions from the Liquor Commission to the medical profession making it necessary for those issuing prescriptions to make affidavit every quarter of the number issued. The point is well taken. It illustrates one of the less obvious results of prohibition. Each province in Canada has its own method of controlling the sale of liquor, and it is to be presumed that each separate plan is the expression of the majority's desire, but there seems to be little doubt that the method of controlling the sale in the province of Quebec is producing the most orderly distribution. There is in Quebec a Government liquor commission at whose shops alone liquor may be obtained (with the exception of licensed establishments for beer and light wines), and this relieves medical men of having to make special prescriptions for alcohol, with all the undesirable features that this involves. The profit made by the province is naturally high—enviably so in the eyes of some other provinces; but certainly no more excess is seen in this province than in those with complete prohibition of alcohol."

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VOL. VI. FEBRUARY 1927 No. 2

La Politesse

THERE is the man who has no manners. There is the man who would sooner be accused of murder than of using the wrong fork with the fish. There is the man to whom *politesse* is and can only be the outward manifestation of an inner and abiding sense of the fitness of things. It is a story of one of the last I wish to tell, to point the moral of a courtliness, a thoughtfulness, a kind-heartedness, that is all too rare in this our world.

There was a certain young physician who, having been brought up in humble circumstances, had worked his way by the sweat of his brow through a medical school. He was a young man of promise, and has since fulfilled that promise. As a resident medical officer of a great metropolitan hospital he was invited to a dinner given by his Chief. Now his Chief was already a very famous healer, and to his dinners came the great and the near-great. Among these the young physician moved with a certain trepidation, the result of his strangeness to those surroundings. The guests sat themselves down to eat. Course upon course came and went. *Enfin*, arrived the last course—ice-cream—and with it the finger bowls. Now the young physician had never seen finger bowls, but with the assurance born of the excellent manner in which he had until then handled his table utensils, and born likewise, no doubt, of the wine which he had drunk, he decided to put these things to what he took to be their proper use. He poured the water from the finger bowl into the whisky the butler had just placed near at his side, and he dumped the ice-cream into the finger-bowl and proceeded to eat it. It might have been a ghastly moment but for the wink the young man's Chief passed his wife, who, with that gentle yet swift wit which characterized her, immediately emptied her finger-bowl into her empty glass, poured her ice-cream into it and proceeded to eat it as though this were her custom. Her good husband in the meantime had done the same thing. The guests,

though doubtless with amazement, followed suit, and the young physician's pride was saved.

Who was his Chief?

William Osler. H. B. A.

Why Not Have a Medical Historical Museum?

A NUMBER of old surgical instruments which were used by the late Dr. Augustus Robinson, of Annapolis Royal, have been presented to the Medical Faculty of Dalhousie University. This addition to the Faculty's collection of articles of historical interest is very welcome. The Faculty is anxious to obtain materials for a museum, and will be particularly pleased to receive mementoes of physicians who have practiced in the Maritime Provinces and Newfoundland. Articles contributed for this purpose will be carefully labelled, with the names of their former owners and of the donors included on the labels. There is no better way of keeping the prowess and accomplishments of stalwarts of former days in the minds of newer generations of Æsculapians. There can be little doubt that many interesting relics are now placed where few can benefit by them. In a museum, they would be carefully preserved and would be available for study by any interested physician. If any of our readers know of such relics, they would render a service to the profession by communicating the particulars to the Secretary of the Faculty of Medicine of Dalhousie University. Old instruments, appliances, office paraphernalia, portraits, etc., have much interest for the medical antiquarian, and are of great value in illustrating the progress of medicine. W. H. H.

Dalhousie's Electrocardiograph made Available to the Profession.

AT the suggestion of some members of the profession, the authorities of Dalhousie University have agreed to place the electrocardiograph of the Department of Physiology at the disposal of physicians who may wish to make use of it. The instrument is being operated by Professor Dreyer, who will undertake to make cardiograms of patients who may be sent to him by physicians. A fee of $10.00 has been set for patients who are able to pay, and appointments for such should be made by arrangement with Dr. Dreyer. For those who cannot afford to pay, applications for appointments should be made to the Dalhousie Public Health Clinic. The instrument is located in the Medical Sciences Building, College Street. The fee of $10.00 has been set tentatively, with the hope that experience may justify its reduction within a short time. The University wishes merely to be reimbursed the cost of operation of the apparatus.

Popular Health Talks.

There is so much that is misleading, to say the least, in the many health talks appearing in the newspapers at the present day, that when the "talk" is right it might do no harm to mention it. Regarding a recent "talk" by Dr. J. W. Barton on diagnosing lung conditions, Dr. T. M. Sieniewicz of Halifax comments as follows:—

"This new method referred to deals with the use of iodized oil in the diagnosis and treatment of bronchial affections. It is written so that the average layman can understand its method of application and its value both as an aid to diagnosis and as a therapeutic agent. The article is based on well established facts.

This summer at the Dalhousie Post-Graduate Course we were given the opportunity of hearing Dr. Stuart Pritchard of Battle Creek, Michigan, make quite extensive reference to the use of Lipiodol. He was also good enough while here to demonstrate on several patients its method of application and its value from the standpoint of X-Ray study of non-tuberculous pulmonary diseases, especially that of bronchiectasis. It should also be mentioned at this point that Lipiodol was first employed in 1921 as an aid in locating and demonstrating obstructions of the spinal canal. I would briefly point out that its method of application is very simple and really requires no special training. I would refer those desiring detailed information on this new field work to Dr. Pritchard's reprints, which he would gladly furnish on request. Lipiodol can be obtained from E. Fougera and Company, 90-92 Beekman Street, New York City."

The Acadia Athenaeum, the official publication of the students of Acadia University, answers the question of how much do we know about cancer so tersely and wisely, that it is worth quoting:—

"Cancer is not communicable or inheritable; it always starts as a localized disease, and with prompt treatment is often curable, but delay means death. The application of our existing knowledge of cancer would save the lives of 40,000 men and women each year in the United States alone. These facts stand out above all the fantastic theories by which quacks are doing incalculable harm."

The alert prescriber. A man in the car was telling how good his doctor was; "clever," said he, "well I should say he was. The other day I called him in when I had swallowed five cents. He said if the coin was not counterfeit it would pass, and made me cough up two dollars."

OBITUARY

HON. Jason M. Mack died at his home in Liverpool on January 18th, of Angina Pectoris in his 84th year. He was a lawyer by profession being admitted to the bar in 1869. He was the first Warden of Queens County. He was elected to the House of Assembly in 1882; was appointed to the Legislative Council in 1899; was appointed leader of the Government in the Council and a member of the Murray Administration in 1907. Upon the death of Hon. M. H. Goudge in 1921 he was appointed President of the Council. He is survived by one brother, Dr. Joshua N. Mack of Brenton St., Halifax, a graduate of Bellevue in 1875 and retired from practice a few years ago. Dr. F. G. Mack of Halifax is a nephew of the deceased and was present at the Funeral.

The death occurred at Bear River, January 8th, 1927 of Mr. W. Emerson Read aged 66 years. He was a son of the late Rev. E. O. Read for many years a prominent Baptist Minister in Western Nova Scotia. He was a prominent mason and greatly respected in the community. Dr. W. F. Read of Digby is a brother of the deceased.

Dr. J. W. Smith of Liverpool spent several days in January at his old home in Selma, Hants County, on the sad mission of attending the funeral of his sister-in-law, Mrs. Leonard Smith.

The death occurred in Halifax on January 12th, of Mrs. J. S. Wallace after a year's illness. Dr. E. T. Granville of Bedford is a brother of the deceased.

Mrs. Sarah McCurdy died recently at the home of one of her sons, Mr. John B. Archibald, Middle Musquodoboit, after a long illness. Another surviving son is Dr. M. G. Archibald of Kamloops, B. C., who made a short visit to his mother last August.

Sympathy will be extended to Dr. W. T. and Mrs. McKeough of North Sydney on the death recently of their infant son.

The death occurred early in January at Providence, R. I., of Capt. T. W. Wilson, a native of Barrington Passage, at the advanced age of 93 years. One daughter surviving is the wife of Dr. F. P. Smith of Mill Village, and Mrs. Banks, wife of Dr. H. H. Banks of Barrington is a niece of the deceased.

PERSONALS

DR. Duncan Murray of Pictou was a patient in Camp Hill Hospital in January returning home on the 18th ult.

Dr. J. G. B. Lynch of Sydney is now Vice-Commodore of the Cape Breton Yacht Club.

Mrs. Campbell, wife of Dr. D. A. Campbell of Bridgewater, was a patient for a time in January in the Dawson Memorial Hospital.

Dr. and Mrs. H. Rindress of North Sydney are spending several weeks in Boston.

Dr. W. W. Patton of Dominion was in Halifax January 18th, and was a guest at the Rotary Luncheon.

Dr. D. W. Hoare, Dalhousie 1921, now with the Penn. Mutual Insurance Co., Pennsylvania, recently spent a short vacation with his parents at their home in Truro, returning to his work the middle of January.

Miss Evelyn, daughter of Dr. and Mrs. Gilroy of Oxford, has entered upon the Dietitian course in the Rhode Island Hospital.

Dr. A. F. Miller was host to the Hon. A. B. Morine, Mrs. Morine, and their little grand-daughter of St. John's, Nfld., on the occasion of their recent visit to Kentville.

Dr. J. G. B. Lynch of Sydney recently gave an address on the Progress of Medical Science before the local C. W. L.

Mrs. MacAulay, wife of Dr. J. F. MacAulay of Sydney, was operated upon for Appendicitis in the City Hospital January. 21st She is having a satisfactory convalescence.

Dr. S. G. and Mrs. McKenzie of Westville spent a few days visiting friends in Halifax in January.

Dr. John Cameron, of the Dalhousie Medical College Staff is giving a series of lectures to the students of the School of Art, dealing with the Art of Greece, Egypt, Babylon and Assyria.

Miss Marjorie May Egan, daughter of Mr. and Mrs. T. J. Egan of Halifax was recently married in New York to Dr. Hubert Lyons, a son of ex-postmaster Lyons of Kentville.

Dr. M. E. McGarry of Margaree spent a week in January at Isaac's Harbor, where he formerly practised. By the way, there was an election in Guysboro at the same time.

Dr. W. J. McDonald, Dalhousie 1925, of Truro, is now on the Staff of the Alabama Health Board. At present he is directing a campaign against an epidemic of Small Pox in Phoenix, Georgia. Mrs. McDonald left the latter part of January to join her husband.

Christmas forenoon, Dr. A. S. Burns personated Santa Claus for the patients of the N. S. Sanatorium.

Evolution was the subject ot an address before the Y's men's Club ot Sydney by Dr. D. A. McLeod, at a regular Club meeting recently.

Dr. K. A. Baird of Fredericton, N. B., a graduate ot Dalhousie in 1919, and for a number of years a medical missionary, has taken over the office and good-will of practice from Dr. N. H. Gosse of Canning, N. S., and is now located there.

Doctors Bishop, Forbes, McGrath and G. Burns of Kentville made a wonderful showing in a hockey match January 14th. With the help of one or two lawyers they played a 5 to 5 draw with a team of merchants before "400 laughing fans."

Dr. M. G. Tompkins of Dominion is President for 1927 of the Highland Golf Club.

Dr. I. R. Sutherland Dal. 1925, is ardently supporting Hockey in Annapolis Royal where he has located.

Dr. G. W. Smith, Dal. 1925, is now on the staff of the Tuberculosis Commission holding clinics and consultations in Western Nova Scotia.

Dr. H. B. Havey of Stewiacke was recently laid up for a short time by an injury to his knee, the result of a fall.

Dr. J. Heartz-Bell of Halifax spent the Christmas and New Year holiday in Amherst at the home of her father, the Rev. Dr. Heartz, the veteran and eminent Methodist Divine.

"I am no whisperer," he said, and they all agreed with him.

Dr. H. G. McLeod, Dal, 1922, of Middleton, and who practised both there and at Middle Musquodoboit, passed the Maine State Board in November 1926 and is now applying for registration in the State of Iowa, as he is located at Greene, Butler Co., Iowa.

Dr. J. Fabian Bates, Dalhousie 1926, is a valuable defence player on the Glace Bay Hockey team.

The Town of Pictou will have a new hospital this year. The necessary Building and Finance committees have been appointed. The present Cottage Hospital has been of great benefit to the community.

Dr. James Reid of Windsor spent the New Year holiday visiting his sisters in New York.

The annual dance of the Dalhousie Medical Students was held at Studleigh on the evening of January 10th and was an exceedingly brilliant affair.

Dr. F. F. Chute represents Canning in the Kings County Municipal Council.

Dr. G. A. Dunn and Mrs. Dunn of Pictou spent two weeks in January visiting friends in Boston and New York. The Doctor visited hospitals.

Dr. W. McK. McLeod of Sydney, frequently supplies the pulpits of Presbyterian Churches in Sydney and vicinity.

Dr. D. StC. Campbell of Halifax has been for some time doing health work on the Alabama State Board of Health with headquarters at Montgomery, Ala.

"Dinty" Moore, Dal. 1924, known to the public as Dr. F. L. Moore of Economy, is having a very slow recovery from his recent two distinct attacks of Pneumonia. A very considerable Empyema developed and convalescence is tedious.

Dr. J. C. Webster of Moncton, who has addressed many medical societies in Nova Scotia, mostly on some historical subject, will represent many Canadian societies at the coming 200th anniversary celebration in London of the birth of General Wolfe.

Jordan W. Smith, Jr., son of Dr. J. W. Smith of Liverpool, won the grand prize for Districts two and three in the recent *Chronicle* and *Echo* contest. With 29,592,500 Credits he scored second highest for the whole province, and, incidentally, secures a $2,245.00 Studebaker Sedan. Mr. Smith is an ex-patient of the Nova Scotia Sanatorium and his recent strenuous canvass shows he has made a full recovery. The genial Doctor has the hearty congratulations of the profession upon his son's accomplishment.

Dr. N. H. Gosse of Canning has placed his two boys in school in Halifax and as soon as the health of Mrs. Gosse has sufficiently improved, he will go for post-graduate work in the U. S. and later to Europe. Mrs. Gosse is making a slow but steady recovery from her recent illness.

Dr. L. N. Bourque of Moncton was severely injured on January 23rd, when his car skidded and bumped into the incoming Ocean Limited. That the train was moving slowly was probably all that saved his life as the car was dragged for a distance and the Doctor thrown through the window.

The Cape Breton County Council has made some changes in Health Officers. The County has been divided into three districts. Dr. G. O. Hutchinson is in charge of the Southern district at a salary of $500.00 and $300.00 expenses; Dr. A. G. Gouthro of Little Bras d'Or at a similar salary in the North; while the veteran Dr. A. S. Kendall holds the Centre at a salary of $1,500.00. Evidently in Cape Breton a Health Officer is supposed to do something; in most places the position calls for a *retainer fee* only.

Ex-Governor J. R. Douglas, Dr. C. A. McQueen and Mayor H. D. Biden, all of Amherst, are spending two months in the South of France and in Italy.

We regret to learn that owing to ill health Dr. Gerald Grant of Halifax is taking an extended trip. Mrs. Grant is accompanying him.

Dr. Charles Spiro, McGill 1923, after post-graduate work in New York and Vienna has returned to Nova Scotia, and has located in New Glasgow where he received his early education.

The Workmens' Compensation Board Inquiry carried on by Dr. W. J. Egan has been completed. It remains to be seen whether "Doctor" Paton will aggree to accept the diagnosis and change the treatment.

Why is the pig the most peculiar of all animals? Because it is killed first and "cured" afterwards.

The mistakes of doctors and lawyers have been compared, and also the carpenter and doctor as follows:—The doctor passing the Irish carpenter says, "Paint and putty cover a lot of your bad work." "That may be, your honor," replied Pat, "but spade and shovel cover a lot of yours."

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

CAPE BRETON

President.....Dr. D. W. Archibald, Sydney Mines.
Vice-President.....Dr. M. G. Tompkins, Dominion.
Dr. J. C. Morrison, New Waterford.
Secretary-Treasurer.....Dr. Ray Ross, Sydney.

Nominated to the Executive of the Medical Society of Nova Scotia

Dr. D. McNeil, Glace Bay; Dr. Dan McDonald, North Sydney; Dr. E. J. Johnston, Sydney.

Annual Meeting 2nd Thursday in May.

COLCHESTER-HANTS

Officers 1926-27

President.....Dr. Daniel Murray, Tatamagouche.
Vice-President.....Dr. Gordon Kent Smith, Hantsport.
Secretary-Treasurer.....Dr. H. V. Kent, Truro.

Executive Committee

Dr. A. R. Reid, Windsor. Dr. Arthur Hines, Cheverie.
Dr. F. L. Moore, Economy.

Members of The N. S. Executive.

Dr. F. D. Charman, Truro. Dr. F. R. Shankell, Windsor.

CUMBERLAND COUNTY.

Officers 1926-27

President.....Dr. Ross Millar, Amherst.
Vice-President.....Dr. M. J. Wardrope, Springfield.
Secretary-Treasurer.....Dr. W. T. Purdy, Amherst.

Nominated to the Executive of the Medical Society of Nova Scotia.

Dr. J. A. Munro, Amherst, and Dr. W. T. Purdy, Amherst.

EASTERN COUNTIES

Hon. Pfesident.....Dr. G. E. Buckley, Guysboro.
President.....Dr. J. J. McRitchie, Goldboro.
1st Vice-President.....Dr. R. F. McDonald, Antigonish.
2nd Vice-President.....Dr. M. E. McGarry, Margaree.
Secretary-Treasurer.....Dr. P. S. Campbell, Port Hood.

Executive Committee.

Dr. O. R. Stone. Dr. P. S. Cochrane.
Dr. W. F. McKinnon. Dr. J. A. McDonald.
Dr. D. M. Chisholm. Dr. J. S. Brean.

Representative to Provincial Executive

Dr. J. L. McIsaac.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

LUNENBURG-QUEENS

Officers 1926-27

President.....Dr. F. R. Davis, Bridgewater.
Vice-President.....Dr. G. A. Barss, Rose Bay.
Secretary-Treasurer.....Dr. C. A. Donkin, Bridgewater.

Executive

The above Officers with:

The officers and Dr. W. N. Cochran, Mahone Bay and Dr. A. E. G. Forbes, Lunenburg.

Nominated to the Executive of the Medical Society of Nova Scotia

Dr. W. N. Rehfuss, Bridgewater and Dr. W. N. Cochran, Mahone Bay.

Annual Meeting is held on the second Tuesday in June of each year, and other Meetings on the second Tuesday of August and January, the time and place of the two latter Meetings to be decided by the Executive.

PICTOU COUNTY

President.....Dr. Clarence Miller, New Glasgow.
Vice-President.....M. R. Young, Pictou.
Secretary-Treasurer.....Dr. John Bell, New Glasgow.

Executive

Medical Society of Nova Scotia..Dr. S. G. McKenzie, Westville.
Dr. G. A. Dunn, Pictou.

Date of Annual Meeting—July 1927.

VALLEY MEDICAL SOCIETY

President.....Dr. William Grant, Wolfville.
Vice-President.....Dr. W. R. Dickie, Barton.
" " .....Dr. A. A. Deckman, Bridgetown.
" " .....Dr. J. P. McGrath, Kentville.
Secretary-Treasurer.....Dr. C. E. A. DeWitt, Wolfville.

Executive

Medical Society of Nova Scotia..Dr. R. O. Bethune, Berwick
Dr. L. L. Crowe, Bridgetown
Dr. A. B. Campbell, Bear River

Date of Annual Meeting in May.
Semi Annual in October.

WESTERN NOVA SCOTIA MEDICAL ASSOCIATION

Officers 1926-27

President.....Dr. W. C. O'Brien for Wedgeport, Yar. Co.
Vice-President.....Dr. S. H. Thibault for Digby County.
" " .....Dr. L. O. Fuller for Shelburne County.
" " .....Dr. A. R. Melanson for Yarmouth County.
Secretary-Treasurer.....Dr. Thomas A. Lebbetter, Yarmouth.

Representatives to the Nova Scotia Medical Society Executive:—
Doctors A. R. Campbell and C. A. Webster, of Yarmouth.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

HALIFAX BRANCH

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Vice-President ..... Dr. G. H. Murphy, 28 Carleton St.
" " ..... Dr. S. R. Johnson, 54 Inglis St.
" " ..... Dr. A. E. Doull, 34½ Morris St.
Sec.-Treas. ..... Dr. V. O. Mader, 7 Spring Garden Road.
Executive ..... The Officers and Drs. Graham and Muir.

PROPOSED PROGRAMME FOR THE SEASON.

Oct. 13th, 1926. Opening Meeting....Ashburn Presidential Address.

Oct. 27th, 1926. N. S. Hospital, Dr. Lawlor and Staff.

Nov. 10th, 1926. Room 11 Medical Science Building "Arthritis and Arthopathies." Discussion opened by Dr. Philip McLarren, followed by Dr. Lyons and Dr. D. J. MacDonald.

Nov. 24th, 1926. Victoria General Hospital, Surgical Clinic.

Dec. 8th, 1926. Room 11 Medical Science Building, Dr. Lawlor.

Jan. 5th, 1927. Victoria General Hospital, Medical Clinic.

Jan. 19th, 1927. Room 11 Medical Science Building.
Dr. Babkin—"The exogenous and endogenous chemical stimuli of motility of the alimentary canal.

Feb. 2nd, 1927. Childrens' Hospital. Clinical Evening.

Feb. 16th, 1927. Room 11 Medical Science Building.
Dr. Evatt Mathers–"Corneal Ulcer."

Mar. 2nd, 1927. Room 11 Medical Science Building.
Dr. Hector McKay, New Glasgow.

Mar. 30th, 1927. Room 11 Medical Science Building.
President McKenzie—"Medical Education."

Apr. 13th, 1927. Room 11 Medical Science Building. "Goitre."
Doctors Eberts and Gordon, Montreal.

Apr. 27th, 1927. Annual Meeting. Election of Officers, etc.

The *Denver Chemical Company*, the manufacturers of Antiphlogistine, a preparation in very general use for over thirty years, publish a little booklet from time to time that is interesting to read. It is called,—"The Bloodless Phlebotomist," and the Vol. 6 No. 2 issue, just to hand, contains several notes of interest. Among these are,—'An incident in the childhood of Lloyd George'; well authenticated instances of abortive human tails; the introduction of Syphilis into Europe, etc. We note the *fac simile* of a duly recorded patent in the U. S. Patent Office under date of Nov. 14, 1854 for removing tape worms.

"The invention consists in a trap which is baited attached to a string, and swallowed by the patient, after a fast of suitable duration to make the worm hungry. The worm seizes the bait, and its head is caught in the trap, which is then withdrawn from the patient's stomach by the string which has been left hanging from the mouth, dragging after it the whole length of the worm."

Give the next number of this booklet a perusal, it will pay.
