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Abruptio Placentae

MALCOLM R. ELLIOTT, M.D., Wolfville, N. S.

THE term "abruptio placentae" (ab and rumpere, to break away from) or ablatio placentae, refers to those cases where uterine bleeding occurs from the separation of the placenta from its normal site; i.e. separation above the upper zone of dilatation. Until recently this condition was called "accidental haemorrhage", and is still so termed by British authorities. It is, in reality, an abortion at or near term.

DeLee states that complete separation of the highly situated placenta is rare and probably occurs much less often than once in 500 cases. In over 20,000 confinements at the Chicago Lying-in Hospital there were only fourteen cases of complete placental detachment with haemorrhage, but there were in addition thirty-five partial detachments, the placenta showing a firm antepartum clot and the clinical course of labor having been distinctly pathologic.

The causes are many and varied. A history of trauma may be obtained, such as intended or accidental violence, of over-exertion, coughing, etc. Sometimes there are co-existent pathological changes at the utero-placental site. Where a true or relatively short cord is present, late in the second stage of labor, the placenta may be pulled from its insertion. The sudden emptying of a large hydramnion causing a negative pressure in the uterus, the loosening of the placenta sometimes seen after the delivery of the first twin and intrauterine manipulation during labor may be possible causes.

Under localized pathological changes at the utero-placental site may be mentioned infarctions of the uterus due to emboli; any mechanical condition cutting off the circulation to a part of the uterine wall, and such placental diseases as syphilis and tuberculosis, which may lead to fatty and amyloid degeneration.

In conditions where there are systemic evidences of toxæmia and pathological changes in the kidney, uterus and placenta, minute haemorrhages are usually noted between the muscle fibres and fascia, and in addition inflammatory and degenerative changes in the uterus and placenta, albumen and cases in the urine with oedema and increased blood pressure. Eclampsia is three or four times more frequent in primiparous women while premature detachment of the placenta is particularly a disease of the multiparous women. Holmes states that coincident eclampsia was noted in 1.8 per cent. of abruptio cases. Whether a diseased ovum furnishes the disturbing element or the latter reaches the uterus from elsewhere is not known, but the evidence points to a placental toxin.

Maternal systemic diseases such as chronic nephritis, Basedow's disease, and arterio-sclerosis may be associated with this condition. Burgess reported a number of cases in the influenza epidemic of 1918. Severe mental shock causing disturbance of the local circulation may start a haemorrhage.

The weight of opinion seems to be that toxæmia plays a major role in most severe cases of abruptio.

The detachment may be either partial or complete. Partial separation may take place either centrally or at the margin. In central separation the

bleeding may be totally concealed. Where the separation is extensive the counter pressure exerted by the foetus and amniotic sac is not sufficient to act as a tampon and prevent the escape of blood. In complete detachment the entire placenta is separated from the uterine wall leaving the sinuses open. In these cases the child dies promptly and the mother's life is in great danger, as the cavity of the uterus is exposed to the full force of the arterial circulation. The placenta in cases of abruptio may show the evidences of several haemorrhages or red infarcto of varying dates; it may be torb or compressed by the clots or it may show no signs save a large retro-placental haematoma. In a type described by Couvclaire the uterine muscle becomes infiltrated with blood.

There are mild and grave cases. Sometimes the first slight haemorrhage under the placenta sets the uterus into vigorous action, which prevents any considerable bleeding and quickly delivers the child, often alive. The severity of the symptoms depends upon the blood loss and shock. In severe cases there may be sudden severe pain in the abdomen, often at the site of the placenta, of a tearing character at first, later a dull tense ache. Nausea or vomiting may occur. Then the symptoms of acute anaemia supervene together with those of shock, of sudden distention of the uterus and absorption of toxins from the wounded tissue. Owing to combined influence of shock and haemorrhage the pulse is not always a sure index of what is going on in the circulatory system. Hourly tests of haemoglobin might indicate the course of the anaemia. The blood pressure varies with the degree of shock and a complicating toxæmia. Examination of the abdomen shows that the uterus is larger than corresponds to the given period of pregnancy and grows larger as time passes. A board-like consistency is considered by DeLee as diagnostic, but according to Magwood in many cases it may be flabby and dilated. The child is not felt. If the fetal heart is heard it may be assumed that there is a partial separation of the placenta. In such cases labor usually comes on at once and the case terminates spontaneously—safely for the mother but not often for the infant. Frequently the pains are weak seriously compromising the picture. Post-partum atony is an occasional complication due to overdistention and myometrial disease.

A careful history and examination will rule out the acute abdominal emergencies. Placenta prævia can usually be diagnosed from the history, from the fact that the bleeding is external, painless and irrospective of trauma and a low implanted placenta can be detected. Rupture of the uterus occurs during labor; the uterus no longer contracts and no presenting part may be felt.

The prognosis is always serious. According to DeLee it is safe to say that one-half of the women and 95% of the babies in complete detachment with concealed haemorrhage will die, while a larger proportion will be saved in the case of partial detachment under skilful treatment.

In mild cases most authorities advise an expectant form of treatment. However, in more severe cases the attitude must be different for prompt diagnosis and treatment is demanded. The indications are to empty the uterus, to stop the haemorrhage and relieve the anaemia by the means which will be quickest, and with the least danger to the mother.

One cannot count on satisfactory pains from a distended and blood-infiltrated uterus. DeLee has recommended fluid extract of ergot in twenty minim doses every two hours, being the only instance where he uses the drug

while the ovum is still in the uterus. Pituitary extract in four minim doses may also be used to stimulate uterine contractions. If the cervix is soft and partly open the dilatation may be completed mammally and forceps or version done. If labor is not well advanced we have a choice of metreurysis, version, vaginal tamponade or Caesarean section. The placenta must be delivered promptly together with all the clotted blood. Subsequent tamponade may be necessary. Saline transfusions and hypodermoclysis should be carried out as early as possible and continued through the period of shock. Blood transfusions are indicated if conditions will permit.

The following case illustrates some of the points noted.

Mrs. F., a multipara, age 33, fifth pregnancy, had a past history of two abortions in the third month and some symptoms of eclamption in the last weeks of the first full term pregnancy. During the present pregnancy was in excellent health until the end of the term. A few days previous to November 15th, 1933, moderate oedema of the ankles was noticed. On this morning she was seized with severe lower abdominal pain and felt decidedly weak and faint. The pain continued and was relieved by morphia. The general symptoms of collapse continued during the morning. Pulse above 110. Urinalysis which had been negative to date now showed a slight trace of albumen with hyaline casts. About 3.30 p.m. she was admitted to the hospital feeling somewhat better, but faint on sitting up, rather dull and apathetic. A little later uterine contractions began. No show, no evidence of fetal heart sounds or movements. O. D. P. position, head not engaged. Os fatulous, with some dilatation. No particular change until 2.30 a.m. when there was a sharp flow of bright blood. There were moderate pains with considerable steady flow of blood during the next two hours. Poor progress was now made. The pulse rate began to rise and there was evidence of a marked degree of shock. Uterus rather soft and flaccid at this stage. Under ether anaesthesia forceps were applied to the unrotated head and a still-born baby was delivered with difficulty; weight 8 lbs.12 oz. Large, firm, dark clots followed. The placenta was also delivered immediately showing evidence of previous complete separation. Sub-mammary hypodermoclysis during the last stage of labor and subsequently. Ernutin and pituitrin.

The patient made a slow recovery from the shock and anaemia.

Health and Youth

By C. E. A. DEWITT, M.D., Wolfville, N. S.

WHEN I was asked to write a paper on some phase of our health programme in connection with the youth of our day, I presume it was because I have been in close contact as a physician to preparatory and university students for a good many years. After practising twenty-four years in a university town, fifteen of which have been in direct relationship with student life, one is bound to be impressed with certain definite facts regarding health problems. Most colleges realize that investment funds which they make in their students is a poor one if the student is unable to complete his college course or later is unable to live a productive life.

We are beginning to realize also the importance of mental hygiene among our young girls and boys and the fact, that the student must possess not only bodily health and intellectual attainment, but emotional balance as well, and must be able to adjust himself harmoniously and effectually in his social environment.

His health is a composite of physical, mental and emotional health and if he does not possess this threefold attribute the educating process has been a failure. Medical service in various colleges varies from first aid treatment and health talks to elaborate set-up of numerous doctors, dentists, nurses, specialists, laboratory and X-ray equipment, dispensary, hospital, etc. and unfortunately initial examinations are made in many instances and then the student goes on his way, and as far as his health is concerned nobody seems to care.

To bring my subject down to something concrete I shall explain our work as carried out at Acadia University and shall attempt to show you our aims, our organization, our follow-up methods, and our results, which, I feel you will agree with me, have fully justified the programme we have adopted in trying to prevent disease and ill-health, not only to the individual student alone, but to the community at large.

Our chief aim is to prevent disease as far as we possibly can by keeping the students in good physical condition and checking, as soon as possible, any surgical or medical case. I think you will all agree with me when I say that active aggressive health is the most important human resource. This is true because of the determining influence of health upon the success of every human enterprise. It is of supreme importance in its relation to the quality of all physical efficiency and to the value of all mental work. On account of this fact any phase of educational method, which develops health intelligence and health habits in human beings, is of very great educational and practical importance. This is now recognized in our schools and colleges.

In the department under my supervision we have attempted to secure a method of instruction in Hygiene, which will develop permanent health habits and perhaps the most important is the physical examination (and the results obtained from such examinations) that each individual student re-

ceives. These examinations are made as soon as possible after the student arrives at the beginning of the school year so that any contagious disease or physical defect may be attended to as soon as possible.

Charts are used for each individual student which include complete history taking and physical examination record, with an additional section for female students. These examinations necessarily take a good deal of time, from twenty minutes to half an hour per student, this exclusive of certain laboratory tests which are essential. Owing to the fact that we are in close proximity to the Nova Scotia Sanatorium, any suspicious tubercular cases are X-rayed and fluoroscoped. (I might mention here that we have organized the Acadia Tuberculosis League, our funds here being raised by the sale of the Tuberculosis League Christmas stamp, and by retaining our share of these funds we have laid aside a sum which is used exclusively for any needy tubercular case connected with the student body).

I have assisting me in this work of physical examinations the Head University Nurse in the case of all female students and the Professor of Physical Education when examining the boys. This work takes about three weeks to complete (that is, new students), but the greater part of it is done during the new student week, which precedes the opening of the University proper.

When students are found to have physical defects they are notified of these, or when any special abnormal condition is detected these students are told to report for reexamination every two weeks until further notice. A careful record is kept of such cases and if they do not report they are notified. Students are also instructed if they are to take the full course in Physical Education (which is compulsory for all first and second year students) or if they are to take modified, corrective work, or if they are exempt from all gymnasium work and athletic games.

The important feature in our plan lies in the instruction to the individual. If the student is found affected by communicable disease, which is a menace to the health and hygiene of his associates, he is required to remove the complaint or leave school. Or, if the individual is found suffering from the influence of incapacitating physical defects, which can be remedied, the fact is brought to the attention of the parents, and here we find that a very important work can be done in connection with the discovery of cases such as tuberculosis, which means not only the possible arrest of such a disease in case of the individual student, but also prevent the spreading of it among his or her associates. Examinations by the thousands have been done by doctors in connection with the army, industry, schools, colleges and insurance companies. The evidence all shows that malfunction, physical defects and diseased organs are extremely common. There would be no object in referring to the prevalence of imperfections and malfunctions were it not for the fact that many of these are preventable.

Now you might ask—Do we get the co-operation of the students in this work? Do they appreciate the value of it to themselves? Have we a higher standard of health among the upper class students today than we had a few years ago? I can answer frankly that we positively have. The majority of students are helping by co-operating with us and this has only been brought about by educational means and the knowledge to the student that he or she can consult at any time, no matter how trivial the complaint, the physician and nurses in charge of our health organization.

The following statistics are of interest:

Tabulation of Histories of Entering Acadia University Students over a period of five years, 1928-1933.

Diseases, Operations, Accidents and other Conditions.

	Men No. examined, 411		Women No. examined, 248	
	No. of students	Approximate percent.	No. of students	Approximate percent.
Scarlet Fever	71	17	48	15
Diphtheria	18	4	12	5
Measles	338	82	233	93
Chicken Pox	178	43	156	63
Smallpox	1	1-	7	3
Infantile paralysis	7	2	3	1
Whooping Cough	225	55	195	79
St. Vitus dance	3	1-	3	1-
Typhoid	7	2	5	2
Malaria	3	1-	1	1-
Influenza	95	23	119	47
Pneumonia	51	12	30	12
Pleurisy	19	5	14	6
Bronchitis	25	6	32	12
Colds	215	52	200	81
Spitting Blood	7	2	4	2
Hay Fever	12	3	8	3
Asthma	2	1-	4	2
Rheumatism	12	3	21	8
Tonsilitis	62	15	70	27
Headache	99	24	92	37
Earache	58	14	59	24
Neuritis	3	1-	10	4
Epilepsy	0	0	0	0
Insomnia	4	1	9	3
Palpitation	6	1	8	3
Shortness of Breath	11	3	13	5
Indigestion	42	12	26	10
Acute abdominal Pain	3	1-	6	2
Appendicitis	11	3	18	7
Haemorrhoids	2	1-	0	0
Jaundice	23	6	24	10
Boils	50	12	22	9
Other Skin Diseases	40	10	8	3
Tonsillectomies	109	24	110	44
Appendectomies	20	5	12	5
Mastoidectomies	2	1-	4	2
Vaccinated	320	78	218	88
Injuries about joints (sprains, etc.)	20	5	27	11
Fractures	59	14	5	2

In the tabulation of histories it is interesting to note the small percentage of students who have had Diphtheria, 4% men, 5% women. Typhoid fever, 2% men, 2% women, showing how well these diseases are under control.

The large number who have had measles—82% men, 93% women. Other common diseases showing a high percentage, and in most cases much higher in the female student than the male, are whooping cough, influenza, colds. History of appendicitis is higher in the female than the male, but appendectomies performed are the same in each case, 5%.

It is interesting also to note the percentage of vaccinations, 78% in male students, 88% in female.

**Physical defects of entering Acadia University
Students over a Period of Five Years—1928-1933.**

	Men No. examined, 411		Women No. examined, 248	
	No. of students	Approximate percent.	No. of students	Approximate percent.
Eyes (diseases & anatomical defects).....	2	1-	0	0
Defects of Vision.....	63	15	46	18
Ears (diseases & anatomical defects).....	2	1-	0	0
Defective hearing.....	6	1½	3	1
Nose and Throat (Diseases and Anatomical Defects).....	126	30	140	56
Dental Caries.....	39	9	4	1½
Pyorrhoea.....	1	1-	0	0
Skin Abnormalities.....	0	0	8	3
Bones, joints & muscles (abnormalities)....	17	4	6	2½
Heart (organic and functional).....	15	3½	18	7
Respiratory system (suspected pathology)...	10	2	4	2
Tuberculosis.....	2	1-	1	1-
Abdominal system (suspected pathology)...	3	1-	0	0
Genito-urinary (suspected pathology).....	17	4	0	0
Defects of feet.....	24	6	15	6
Albumin present.....	12	3	1	1-
Sugar present.....	3	1-	2	1-
Hypertrophied thyroid.....	1	1-	13	5
Blood Pressure (abnormal).....	13	3	1	1-
Hernia.....	10	2	0	0
Physical Activities (exempt).....	11	2	17	7
Physical Activities (modified).....	31	8	13	5

From the above statistics it will be seen that 411 men and 248 women, practically all of whom were freshmen, just entering the University, were examined.

It may be of interest to know the average age, height and weight of these students:

Females—average age, 18 yrs.; height, 63 inches; weight, 120 lbs.

Males—average age, 18.6 yrs.; height, 68 inches; weight, 140 lbs.

Under the conditions of the examination, no attempt is made to evaluate any condition that is time consuming, as the student chart is marked for a recall, such students are later recalled when a very careful examination of any suspected pathology is made.

Comparison of the defects existing in both men and women students are interesting, as will be noticed in the following statistics:

Nose and throat defects higher percentage in women than men.

Dental caries “ “ “ “ men “ women.

Hypertrophied Thyroid “ “ “ women “ men.

Bones, joints, muscles “ “ “ men “ women.

Blood Pressure (abnormal) “ “ “ men “ women.

Another important factor in getting the co-operation of the students is the required course in hygiene that all new students must attend. These are

given once a week, during the first term, and are made as interesting and instructive as possible. Until recently we used one or another of the text books that we considered most nearly of College grade, but the amount of interest we were able to get from the students was not sufficient.

Therefore we outlined a series of lectures (with text books available for students in the library for special reading) that would be interesting, instructive and a certain practical knowledge that could be put into use in their daily lives. We began a systematic effort to learn what could be added to the usual content of college hygiene in order to stimulate the interest and stir the imagination of the students. For instance, we found that the average student knew practically nothing about the anatomy, physiology, pathology, etc. of the human body, nothing of the genesis of life, the phenomena of reproduction, or the process of growth and development. (Fortunately, in recent years, more students are gaining this knowledge, due to the fact that a larger number are taking biology subjects). Hardly a day passes that I am not asked questions, which shows the ignorance which our young people, grown to college age, still possess in regard to these important matters. It goes to show that the little smattering of such subjects, as taught in our public schools, amounts to practically nothing.

And so we found out that in order to make the application of hygiene practical, the student must have this essential knowledge to make it intelligent. Perhaps we are stressing less than formerly the inculcation of opinions about how to achieve health and are striving rather to put the student in the way of acquiring more knowledge of the nature of human life and human adjustments, in order that he may be able to reach valid conclusions of his own concerning the importance of health as a factor in the attainment of his major objectives. A certain amount of home and community hygiene is also given and the great object of it all is that the health knowledge acquired by the student be carried over into his daily life, as—dependable health habits and attitudes of mind.

I am glad to say we see that many of the students are now trying to cooperate with us in preventing illness and keeping fit.

A very important aid in this respect is the close relationship we try to maintain between our health service and the Department of Physical Education. These two departments cannot be separated. For instance, we have found that these subjects (preventive medicine and physical education) have the following nine activities in common:—

1. The activity of a group interested in finding out the status of the student as revealed by physical examination.
2. The follow-up work based on these examinations for the correction of such physical defects as may be remediable.
3. The treatment of minor illnesses and the giving of medical advice to the members of the student body.
4. The institution of preventive measures, as—vaccinations, quarantine, sanitary inspections, etc.
5. The prescribing and carrying out of special activities in an attempt to correct that part of the physical defects that may be thought to be remedial through special exercises.
6. The teaching of Hygiene.

7. The supervision of physical exercises and the teaching of games to that part of the student body that may be considered as in normal physical condition.
8. The turning out of varsity teams to represent the Institution.
9. The institution of proper treatment for athletic injuries.

We try to co-operate closely for the care of the injured athlete, for the athlete is primarily a member of the student body, and the question of the relationship between preventive medicine and physical education resolves itself into the necessity of physical exercise for health, or conversely, the lack of exercise causing disease, and we always try to bear in mind the old saying—"What's one man's meat is another man's poison". I am glad to say that during the last few years our students are co-operating with us and are seeing the value to themselves in keeping fit in regard to all athletic activities. We have tried to make them see how important it is to take the best care of their bodies after such games as football, hockey, basketball, tennis or any other line of sport, the great importance of the hygiene of temperature regulation. Showers and rub down must be taken in every instance if the body is to be kept from chilling and the consequent lowering of resistance to our all too prevalent epidemics of colds, influenza and other respiratory conditions. The students can and should help in this respect and thus avoid many days of sickness and loss of time from work.

Again we have proved in the way of preventive medicine in our Institutions that very often, among the employees as well as the students, infectious disease may often exist. On several different occasions we have examined at the beginning of the term and found cases of tuberculosis (in two of the cases active and moderately advanced) among the female help. The results that might and do follow such cases as these, who are allowed to go among young students in dining room, chamber maid work, or wherever their work may take them, can only be disastrous.

And so we who are interested in health work among the young people of our day might well ask ourselves—does health education offer possibilities? And the students themselves might ask these questions:—

Can I improve my physical efficiency and thus promote my chance of success in life?

What specific knowledge and practices can I acquire which will aid me in warding off infections and disease?

There are many very specific personal habits and attitudes of mind which may be cultivated and which promote one's realization of the highest and mental possibilities.

To sum up:

Just what has this health work among young adults shown us?—That students of college age are ignorant of certain fundamental facts in regard to health problems that should have been acquired earlier in life. We are all aware that one of the important advances in modern education has been the improvement in the teaching of Hygiene and the advance of the practise of preventive medicine in the schools, and yet, should we not extend this teaching still further by giving our present teachers and undergraduate students of education more knowledge of health education and thus contribute more fully to the well-being of mankind. Teachers in our public schools must be made to realize that health education is a tremendously interesting subject

and then when we come to High School boys and girls a series of lectures in Hygiene, given by a medical man, would be worth while. The subject of Hygiene of the Reproductive System and so-called Sex-Hygiene can be approached in such a way as to give valuable information, because girls and boys of High School age have accumulated a vast body of misconceptions regarding these subjects.

Health examinations are probably of little value unless supplemented by follow-up health conferences. This is true in Public School life as well as Secondary Schools and Colleges and statistics show that many physical defects should have been remedied earlier in life.

The important place that physical education has in the health programme is due to the fact that it includes instruction in the laws of hygiene and promotes the formation of healthful habits of living. The health and physical education programme is surely justified on the basis of its educational contribution. It is not a luxury or an extra and it includes not only subject matter thought and learned, but actually is a way of life, participated in and practised and made a part of the student himself for all life situations.

SUMMER DIARRHEA IN BABIES

Casec (calcium caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with 8 level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextrin-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six tablespoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. Please send for samples to Mead Johnson & Company, Evansville, Indiana.

Report on Tissues sent for examination to the Pathological Laboratory, from May 1st, to May 31st, 1934.

The number of tissues sectioned is 188. In addition to this, 29 tissues from 5 autopsies were sectioned, making 217 tissues in all.

Tumours, malignant.....	36
Tumours, simple.....	6
Tumours, suspicious.....	4
Other conditions.....	140
Tissues from autopsies.....	29
Unreported.....	2—217

There will be a most interesting ladies' programme this year. Each minute will be occupied.

Coronary Thrombosis

By PERRY S. COCHRANE, M.D., Wolfville, and
RONALD G. FORBES, M.D., Kentville.

CORONARY Thrombosis, also called Coronary Occlusion or Cardiac Infarction. It is an obstruction, usually acute, of a branch of one of the coronary arteries resulting in infarction and death of the heart muscle in the area supplied by the occluded vessel.

History: To the American clinicians belongs most of the credit for the working out of the details which comprise the complete clinical picture of this condition. They also emphasized its frequency and significance.

Dock as far back as 1896 recognized the condition during life in one patient and reported the case along with the autopsy confirmation. The earliest adequate description of the clinical symptoms and physical signs was in the German literature in 1910 by two Russians. In 1911 four more cases were described in Germany and in 1912 Herrick in America first emphasized the fact that Coronary Thrombosis was a definite clinical entity quite recognizable during life.

In spite of the reports and descriptions occurring in the literature from time to time there wasn't much general interest in this condition until about 1918 when several workers took the condition seriously.

The Pathologists had observed the condition and described the autopsy findings forty to fifty years ago. In medical books until recent years one finds Coronary Thrombosis described under circulatory disturbances of the heart or as a probable cause of Angina Pectoris; but only within the last five or six years has it been described as a definite clinical entity.

Incidence and Etiology. More frequent between fifty and seventy years of age, not uncommon between forty and fifty, rare over seventy, and not very common under forty, as Levine reports only three cases out of one hundred and forty-five between the ages of thirty to thirty-nine. Men are affected three times as often as women.

There is no single factor at work in the causation, but among the causes are those of hypertension and sclerosis. Quite frequently there are symptoms suggestive of Angina and examination reveals evidence of sclerosis.

Heredity is a factor as indicating a familial tendency to chronic vascular disease; often seen in father and son or in two brothers. Syphilis while causing changes in the aorta and even in the coronaries is a very infrequent cause of cardiac infarction, but it is not rare in diabetes. Rare in rheumatic hearts and auricular fibrillation. Small percentage shows no definite underlying cause.

Pathology: Occurs more frequently even to-day than is generally recognized. The obstruction is usually due to the development of a thrombus which blocks the lumen of a branch of one or the other of the main coronary arteries. In rare instances the occlusion may be due to a progressive narrowing by arterio-sclerosis. The thrombus is generally associated with atheromatous endocarditis which may be a local or a general condition. Left coronary or

its branches is the commonest site. The obstruction produces an anaemic infarct of the heart generally in the anterior apical portion of the left ventricle or near its base and in the intra-ventricular septum. Coronaries are not strictly speaking endarteries, but their anastomoses are not sufficient to carry on the functions of a large branch. The infarcted area undergoes neurosis and liquefaction with absorption. Healing takes place by scar tissue. The heart may rupture at the site of the infarct or the scar may stretch and form a cardiac aneurysm, or healing may be complete with a firm cicatrix.

Symptoms: The outstanding symptom in a typical case is severe pain which usually comes on without exertion or other assignable cause, thus differentiating it from angina. The pain is persistent and is not relieved by rest or vasodilators, often accompanied by nausea and vomiting or they frequently follow the onset of the pain. The pain may be precordial, in left arm, left side of neck, right side of chest or epigastric. In severe cases we get symptoms of shock and collapse, i.e. ashen pallor, cold sweats, clammy skin and rapid, feeble pulse. It is rare that occlusion occurs without any definite symptoms but sometimes we get a vague sense of substernal or epigastric pain or discomfort. In some cases symptoms of shock and collapse are the only ones present or may have pulmonary oedema. The mind is usually clear.

The above are the immediate symptoms, but a little later, i.e. in from a few hours to a few days, we get a low fever, moderate leucocytosis with the increase in the polymorphonuclears. Blood pressure may be elevated or depressed at the onset but generally falls fairly rapidly during the first few hours and the fall may be moderate or quite marked and usually progressive. The heart is usually enlarged, sometimes very markedly, but often apex beat cannot be felt. The pulse is small, rapid, and often irregular, but in cases where the upper part of the septum is involved we get heart block and slow pulse. The heart sounds are usually feeble especially first sound at the apex and gallop rhythm is the rule. Pericarditis, which develops over the infarcted area, manifests itself by a friction rub and when present is a valuable diagnostic sign.

Electrocardiographic records when available are of great help in confirming the diagnosis in doubtful cases.

Complications: Mural thrombosis over infarct occurs sometimes and gives rise to emboli. Rupture of ventricle with prompt death is common mode of termination and occurs most often towards end of first week when softening on infarct occurs, but may take place any time from fifth day to end of fifth week. Paroxysmal auricular fibrillation frequently occurs but does not seem to affect the prognosis. Paroxysms of ventricular tachycardia while not so common are more serious.

Course and Prognosis: Death may be instantaneous, or occur within a few minutes, often thought to be due to "acute indigestion" on account of epigastric pain, nausea or vomiting. Other cases may last for a few days with lessening of symptoms and their death. If they live a week then recovery is fairly probable, but it may be so incomplete as to leave them invalids for months and then succumb to heart failure. Recovery may be complete enough to allow them to lead a restricted life for a few years or may be to all intents and purposes complete. Subsequent attacks are frequent. Following an attack in a person who has had angina previously, may have no further attacks of angina. However favourable progress may seem to be, there is serious

danger for about five weeks after the attack as at any time during this period the heart may rupture or have fatal attack of ventricular tachycardia. From 60% to 75% of cases are fatal.

Diagnosis: 1. Heart failure with pain. This is usually due to effort, not so lasting, and is relieved by rest and vasodilators; no evidence of shock or rapidly developing failure.

2. Upper abdominal conditions; e.g. perforated ulcer, acute pancreatitis, biliary colic, etc. Mainly by history and evidence of heart failure in the one and of the development of peritonitis in the other. Electrocardiogram is sure diagnosis.

Treatment: Treatment of so severe and serious condition is slight. Absolute physical and mental rest. Morphia at first in amounts sufficiently large and frequent to ensure freedom from pain, restlessness and ensure sleep. Later on the morphia may be replaced by other sedatives such as bromides, chloral or barbiturates. External heat, liquid food is given only at first in small amounts and frequently, enemata to keep the bowels open. Circulatory stimulants are of doubtful value early, but digitalis may be given cautiously sometimes with apparent benefit. If after a few days heart failure develops then to receive usual treatment for the condition. Rest and convalescence to be continued for several weeks to allow firm healing of the infarct. Where paroxysmal tachycardia is suspected or can be definitely determined then use of Quinidine may be life saving and it is also of value in cases showing flutter or fibrillation.

Case No. 1. CORONARY THROMBOSIS.

Male, 56 years, 5'6½", 180 lbs.

May 1st, 1931. Severe cramp-like pains in both sides of chest and left shoulder with shortness of breath. Symptoms came on suddenly with no warning this day, although the day preceding the attack he felt vague pains in his chest while working in his garden. He was carried to his home. When first seen he was cyanosed, pulse rate 35, suffering severe dyspnoea and apparently in great pain, which by this time was radiating down his left arm, and all over his chest, front and back. Small frequent doses of morphia were given which was later replaced by codeine as he tolerated morphia very poorly. The severe pain remained for two weeks. His blood pressure at this time was 90-60—three months previous it was 180-100.

The following day his temperature was 100°F., with a leucocytosis of 14,000, pulse weak and irregular, and rales at both bases with a friction rub over lower portion of precordium. For the next two weeks signs of cardiac failure persisted, then his pain suddenly left him.

Two weeks later the above symptoms again presented themselves, lasting about eight days. For the next two months his progress took a very stormy course, pulse usually weak and irregular varying in rate from 40-55, temperature as high as 101.6°F. He was confined to bed for eighteen weeks. At present he is in fair health probably due to the fact that he is very careful of his mode of life.

The diagnosis here was later confirmed by electrocardiograph.

Case No. 11. CORONARY THROMBOSIS.

Male, 35 years.

February 17th, 1932. Seized with sudden severe pain in his left chest while sitting at work in his office, thought it was indigestion and took a dose of brandy; pain continued in severity radiating to shoulder and down the left arm; he was taken home in a car and the doctor called. When first seen he was lying on a bed, respiration slow and shallow, ashen grey colour, lips slightly cyanosed, pulse regular, very weak, with a rate of 30 and temperature 97°F. It seemed as though he were going to die. His only complaint then was "a pain in the heart."

Treated the case with morphia, heat, etc. A few hours later his blood pressure was 95-70.

February 18th, 1932. Pain less severe; temperature 99°F.; pulse 35.

February 19th, 1932. Rales at both bases, slight cyanosis, temperature 100°F. pulse 40; pain very slight.

February 21st, 1932. Leucocytosis 12,000; pulse 40; temperature 100°F.

The condition remained much the same for a week, temperature gradually falling to normal. A sense of discomfort, rather than pain, persisted in his chest for three weeks, especially on any exertion, e.g. turning over in bed. He was confined to his bed for six weeks and made an uneventful recovery.

The diagnosis was confirmed by electrocardiograph.

Case No. 111. CORONARY THROMBOSIS.

Male, 45 years, 5' 10'', 220 lbs.

November 13th, 1932. Was called out in the country to see a man who was said to be suffering from a severe attack of acute indigestion. Found him on the kitchen floor, lying across a chair in a state of shock and collapse. His pulse was very weak, rate about 35, and at times almost unpalpable; he had vomited twice before I arrived; he complained of pain in the epigastrium and especially in the tip of the left shoulder. He was put to bed, given morphia, external heat, etc. for shock.

On examination slight tenderness was noted in the epigastrium, abdomen moved freely with respiration and there was no rigidity; he could only lie on his right side, as pain in the left shoulder was most severe while lying on his back.

November 14th, 1932. Temperature 100°F.; pulse, 45; B. P. 100-70. The pain was very severe during the night in the left shoulder; epigastric pain was moving around the left costal margin and at the end of three days was centered in the precordial region. At the end of the week the pains had all disappeared and the temperature was normal. He was confined to his bed three weeks, at end of which time his blood pressure was 120-75.

His recovery was uneventful.

A Series of One Hundred and Sixteen Cases of Labor

Using Hyoscine-hydrobromide and Nembutal to Produce Amnesia.

A. B. CAMPBELL, Bear River, N. S.

"**T**HREE blessed is that sleep, which in its scope, includes forgetfulness of pain." This quotation seems to embody the idea which activates us in giving drugs to produce amnesia and analgesia in labor. In writing up this series of cases for the BULLETIN I realize fully that the subject is not a new one, and also that many doctors in the province have much more experience in the use of drugs of this kind than I have. The chief interest in this series lies in the fact that 106 of the cases were confined in their own homes, and their nurses, in practically all of these cases, were women of the neighbourhood, so-called "practical nurses".

This series of 116 cases is divided into two groups—

- 1st—From June, 1931 to August, 1932—55 cases who received hyoscine only.
- 2nd—From August 1932 to Jan., 1934—61 cases who received nembutal and hyoscine.

Previous to September, 1930 I had used only chloroform and ether as analgesics in labor. In many cases during the first stage I gave chlorotone, grs. 5, in capsules, up to 15 or 20 grains. The chlorotone seemed to be more helpful as a sedative than as an analgesic. Following the 1930 Refresher Course, when Dr. E. K. Maclellan gave us the full technique for using rectal ether, I attempted to use that method. I found it impossible to get even fair results unless I had a trained nurse on the case, or else went early and stayed with the patient until labor was terminated. In my few cases either labor stopped and the patient went to sleep, or they expelled the rectal ether, and had little or no result.

In June, 1931 I read an article by Dr. Ashbury Somerville, (1) on the use of hyoscine-hydrobromide alone to produce amnesia in labor. He quoted Van Hoosen (2) Jennings (3) and also Krebs (4) to prove that the use of hyoscine alone is comparatively harmless, but the use of alkaloids of opium combined with it is likely to interfere with the prompt establishment of respiration in the new-born child. His directions were to give hyoscine-hydrobromide, grs. 1/100th S.C. at half-hour intervals for three doses, and then every two hours even if birth be imminent. In primiparae the hyoscine is started as soon as the pains are five minutes apart, or sooner if the patient is complaining; while in multiparae it can be started as soon as labor is definitely established. In this series I have never given more than three doses; the ordinary directions of absolute quiet and darkness were not followed, but I kept the room as quiet as possible and conversation at a minimum.

A few days after I read Dr. Somerville's paper, I used his method. The patient, age 29, multip. 3, was definitely in labor when I saw her, os $\frac{1}{2}$ dilated, pains every 4 or 5 minutes, fairly well borne. The first hypodermic relieved—

the second produced sleep between pains, and the third one complete sleep with a slight amount of restlessness and mumbling during a pain. Labor progressed normally, and the baby was born fifteen minutes after giving the third hypo. The baby cried lustily on birth—the third stage was normal and there was no post-partum haemorrhage. The mother awakened four hours later with complete amnesia following the second hypo. She felt rested and refreshed and had a perfectly normal puerperium. I took this case as a standard and classed it "Good".

Of this group of 55 cases, 28 were just as successful as the case described. Seventeen were incomplete, owing to birth taking place within a few minutes after giving the second hypo. Eight were very restless and were controlled with difficulty. Two were pre-eclamptic cases which had premature labors and I used no hyoscine. Twelve were primiparae, and of these, ten had good results—two were restless. In the restless cases, and those in which amnesia was incomplete, I used a small amount of chloroform. I also used chloroform for deeper anaesthesia in suturing any perineal tears. I did not require any in cases classed as "Good", and a comparatively small amount in any case.

Of the babies, 51 were perfectly normal:—one was still-born after a long labor with the cord shortened by being twice around the neck; two died shortly after birth, seven month's premature labors (eclamptic cases) and one a five month's premature labor. Eight cases were instrumental, and in these I gave a small amount of chloroform.

Just at the end of the series I had a result which I ascribe to various causes—nervousness of the patient, dread of labor, fear of hypos, and a possible idiosyncrasy to hyoscine. The patient, primip., age 17, was making good progress when first seen; pains 3 to 4 minutes apart, os $\frac{1}{3}$ dilated. After the second hypo. she became very restless, which I ascribed to the rapid progress of her labor, for the os dilated rapidly and the head descended to the perineum readily. After the third hypo. she became more restless and I gave her inhalations of chloroform. In spite of these, about ten minutes after the third hypo., with the head on the perineum, she had a convulsion, which I controlled by increasing the chloroform and delivered her instrumentally. She had no more fits—was perfectly quiet after delivery, and awakened six hours later with complete amnesia. The baby was normal. She had a normal puerperium. Her blood pressure was normal before and after labor, and she had no albuminuria. I do not know what caused that convulsion.

At this time, and because of this case, I decided to use nembital (pentobarbital-sodium) grs. $1\frac{1}{2}$, in capsules. After a few cases I found that by using four or five capsules, and hyoscine grs. $1/100$ th, I was able to get more complete amnesia, less restlessness, and better co-operation from the patient. The average case required no other anaesthetic, instrumental cases and suturing perineal tears generally required some inhalations of chloroform or ether. I found that they took ether readily, and I used it excepting in rooms where light was provided by oil lamps. I tried to take as many blood pressure readings as possible, and have observed no marked fall. The pulse rate was generally quickened, but not over 95 in this series. The foetal heart beats I observed as often as I could, and I could detect no change from the usual case. All babies began to breathe normally but were very sleepy. They showed no ill effects.

The second series consists of 61 cases—20 primiparae, 41 multiparae. In primiparae I found it best to be as early as possible, and as soon as the pains

were four to five minutes apart, or sooner if the patient seemed to be suffering, to give one capsule. The patient then went to bed, after a preliminary enema, and making sure that they had voided. The capsules were given slowly during the first stage—not oftener than one each hour unless their progress was rapid and painful, in which case I gave two every hour. I only found it necessary to give five capsules in one case (a primiparae with a prolonged first stage). All others received four. One hour after the last capsule, and generally at the latter end of the first stage, I gave hyoscine 1/100th S.C.

In multiparae, if labor was well established, pains regular, and 3 to 4 minutes apart, os $\frac{1}{2}$ to $\frac{1}{2}$ dilated, I gave four capsules at once, followed in one hour by hyoscine grs. 1/100th S.C. They all complain at first of being dizzy, then sleepy, and soon they only mumble when spoken to—complain incoherently and moan during a pain. In some cases they are quite restless and hard to control during a pain.

In the first stage I noticed very little difference in the force and frequency of the pains. The os seemed to dilate more readily and the patients were more comfortable. Occasionally the pains were decreased in frequency, but lasted longer and were stronger.

The second stage seemed to be shortened, and most patients co-operated well. Pituitrin, when given, acted the same as in the usual case. The third stage was normal, with no increase in post-partum bleeding. I had two retained placentae, which I removed manually, after giving deeper anaesthesia with ether. The puerperium in each case was normal, and the mothers awakened refreshed with a feeling of well-being. Of the 61 cases, 43 could be classed as "good"—13 had islands of memory and were restless—5 were noisy and wanted to get out of bed with each pain. These latter cases were making rapid progress and their restlessness seemed to indicate rapid descent of the head. Eight cases were instrumental, with a small amount of ether as an extra anaesthetic.

I have been interested to find that those women who feared labor most, were the ones most likely to be restless and hard to manage. Conversely, I am finding that those who have had a second labor with the help of amnesiacs, seem more willing to co-operate, and have better results. Even those who have had poor results say it has helped them and they would like to have it at future confinements.

Contra-indications—It would seem to be wise to withhold nembutal and hyoscine in all gross mal-presentations, placenta praevias, and cases of cardiovascular and renal damages.

Disadvantages—Restlessness of patient may make it necessary to have more help and one must stay with the case after the treatment is started. It is also harder to observe the usual sterile precautions.

Advantages—The Nembutal and hyoscine are easily given—it does relieve the pain of labor, with little risk to mother or child, and with no apparent interference in the course of labor. It makes obstetrics more interesting and it seems a safe and fertile field of research for the general practitioner.

References:—

- (1) C. M. A. J. 1931, June p. 818.
- (2) Anesth. & Analg. 1928-7 p. 151.
- (3) B. M. J. 1929-2-801.
- (4) J. Miss. Med. Assn. 1929-26-485.

Historical Section

AUGUSTUS ROBINSON, M.D., M.R.C.S., L.S.A.

By A NEAR RELATIVE

A BRASS tablet in the Town Hall, Annapolis Royal, speaks more forcibly of the life work of Dr. Robinson than anything I can say. The simple inscription reads:

AUGUSTUS ROBINSON

1836-1926

Beloved Physician, Sometime Mayor
of Annapolis Royal.

Tablet erected in his memory by friends
in town and countryside.

This memorial, together with the fine portrait which hangs above it, and sufficient money to insure perpetual care of the lot in St. Alban's cemetery where he was laid to rest, was paid for by unsolicited subscriptions from friends and patients. Sixty-seven years of faithful attention to his profession is a record which few can surpass. Although financial rewards were small he considered himself well paid if he could bring relief to a sufferer or arrest the hand of death. In endeavouring to write a short account of his medical career I find that, although I remember dozens of the stories which he told of his experiences, they are almost without exception of a humourous nature. He said little of success, loved a joke, and was so quick at repartee that he could usually go one better than any shaft of wit that was aimed at him. I once heard a small boy say, "Doctor, what makes you whistle?" "Wind on my stomach, I suppose," was the reply.

Augustus Robinson was a son of Lieut. George Robinson of the 60th Royal Rifles. Most certainly he seems to have made choice of a profession for which he was peculiarly fitted. It may be said that this was to a large extent in the blood. His maternal grandfather was Dr. Henkel who came to Annapolis Royal as an army surgeon in 1804. Two of Dr. Robinson's brothers were also medical men—Edward, who practised in Jamaica, B. W. I., and Frank, of Annapolis Royal—while a nephew is a retired specialist in diseases of women, now a consultant, living in Cambridge, England. Not only did he seem naturally to grasp the principles of medicine and surgery, but his influence on the minds of his patients seemed very helpful and his cheerful smile and greeting to a sufferer often did as much to benefit as his treatment or prescriptions. His life was a ministry of healing. In this connection it may be said that he was a man of great reverence for the Divine and of a childlike faith. Especially in his later years, patients would discuss with him not only the ailments of the body, but of the spirit. One is reminded of the lesson from the Apochryphal Book, Ecclesiasticus, appointed by the Church which he loved for the day of St. Luke, "the Beloved Physician,"—

"The Lord hath created the Physician",—as is implied also, "The Lord hath given him his skill",—"pray unto the Lord," then, "Give place to the physician, for the Lord hath created him". In this spirit he was in close harmony with his intimate friend Dr. John Stewart.

Dr. Robinson received his M.D. from the University of Pennsylvania in 1857, taking four years work in three, his M.R.C.S. and L.S.A. in London, and "walked" the London General Hospital as offering superior opportunities in surgery. A friend, who was medical officer on a large passenger ship, wished to have a holiday and Dr. Robinson made two trips around the world in this capacity, going via the Cape of Good Hope and returning to England by way of Cape Horn. While in Melbourne Harbour, Australia, on one of these voyages, he was the means of saving a lady friend of his family from becoming an innocent bigamist. At luncheon one morning, when several Melbourne men were present, the conversation turned to big game hunting and one of the strangers mentioned having shot moose in Nova Scotia. When Dr. Robinson said that his home was in Annapolis Royal, and they came to compare notes, it was found that the gentleman was a New Brunswicker who had disappeared years before and was considered dead. His supposed widow was about to be married to a clergyman holding an important position in the Church of England, and Dr. Robinson's home letters broke off the engagement which could only have ended in tragedy.

Melbourne Harbour is noted for its wonderful beaches. While strolling along there one morning Dr. Robinson, always very fond of animals, saw an old woman coming towards him with a small monkey in her arms. She was whipping the animal and threatening to break its neck. In a few moments he had bought the monkey for half a crown and started to return with it to the ship. Just as the old woman was disappearing from sight far along the beach the little creature gave the doctor's hand a vicious nip, jumped from his arms, and scampered off to rejoin his mistress and await the next gullible stranger who came his way.

Before settling in Annapolis Royal, Dr. Robinson spent some time at Meteghan, Digby County. Here he so endeared himself to the French people that for many years they came to him for advice when serious ailments overtook them and it frequently saddened him to be obliged to weaken their faith in his skill by telling them that he could do nothing to help them. I have often seen his offices filled with French men and women when a holiday excursion train offered an opportunity to consult him and return home the same night. English was little used in Meteghan in those days and sometimes very funny mistakes were made in conversation with the doctor. On one occasion he gave a man medicine, carefully explaining what its effect would be, but the patient returned in a few days to ask for a different dose. Said he, "Doctor, I cannot keep doze vometic on my stomach." Another man, whose experiences with residents of Sandy Cove must have been unfortunate, declared, "I would rather have four Yarmouth mans come to my house than one Sandy Cove people!"

A lad of about twelve, not particularly bright, who visited the doctor in Meteghan, learned one phrase in the Acadian patois. It was "Vous êtes un fou," (You are a fool) and he used it on every occasion, entirely ignorant of what the meaning was and regardless of the fact that he was always knocked down by the other fellow.

These French people were not satisfied to have treatment without medicine, and the more disagreeable the dose the more confident they felt of its

efficacy. The doctor often resorted to bread pills or a noxious mixture coloured with cochineal. An aged woman had been supposedly bed-ridden for twenty years. Other members of her family knew that she often visited the pantry at night, or wandered about a bit, so when Dr. Robinson found that one of her grandchildren had diphtheria he thought he would see what a bad scare would do for the old woman's limbs. Keeping one eye on the grandmother, he explained to the mother that her boy was very ill—that he had the "black sore throat". Quietly, without a word, the old woman slipped out of her bed in the kitchen, threw a quilt about her shoulders, and departed for the next house which was some distance away.

While at Meteghan Dr. Robinson removed the larger bone from the leg of a woman whose husband said that he had no money to pay for the operation, but promised a cow in lieu of cash. The patient was afterwards able to go about as usual, but the animal could almost have been carried under the arm of an average-sized man.

(To be Continued)

RHEUMATISM

Inflammatory conditions are by no means confined to the winter months, and rheumatism does not govern itself by the calendar. So Antiphlogistine is an all-year therapeutic agent, indicated for and often affording the most grateful relief in the treatment of articular and non-articular rheumatism.

The moist heat which it maintains for more than 12 hours, reinforced by the osmotic and phagocytic actions of its chemical constituents, tends to improve the local metabolism, promote absorption of the swellings in and around the muscular fibres, helps to restore movement in stiffened joints and muscles and to bring relief from the pain.

Antiphlogistine is indicated for the majority of inflammatory lesions, whether deep-seated or local and those physicians who are not conversant with its use, or who may wish to give it further clinical trial, are invited to write for samples and literature. The Denver Chemical Mfg. Co., 163 Varick Street, New York, U. S. A.

NEWS FROM KOREA.

Dr. Florence J. Murray, medical missionary stationed for the last six years in Hamheung, Korea, is expected home on furlough early next week. Dr. Murray, who is a graduate of Dalhousie University and very well known in the province, plans to travel by way of the United Soviet States of Russia. Dr. Murray states that economic conditions are dreadful in Korea, and that an exceptionally severe winter has caused untold privations among the inhabitants.

Besides the scientific programme there will be fun and frolic; music and mirth; games and gaiety—what a meeting! We'll be seeing you in Yarmouth, July 4th and 5th.

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

Published on the 5th of each month and mailed to all physicians and hospitals in Nova Scotia. Advertising forms close on the 15th of the preceding month. All Mss should be in the hands of the Business Editor on or before the 10th of the month. Subscription Price:—\$3.00 per year.

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VOL. XIII.

JUNE, 1934

No. 6

THE NEW GRADUATE—BON VOYAGE.

“IT happens to us, as it happens to wayfaring men, sometimes our way is clear, sometimes foul, sometimes down hill; we are seldom at a certainty; the wind is not always at our backs, nor is everyone a friend we meet in the way.”—Bunyan’s Pilgrims’ Progress.

When the new graduate begins practice he is also making a journey. There are many things which make it a successful undertaking. He has already found during his college years that *work* is the master word in medicine—“With it Pasteur, Virchow opened up to us a new heaven and a new earth in medicine and surgery. The stupid man it will make bright, the bright man brilliant, and the brilliant student steady.” If he is to succeed it will always require hard work throughout his medical career. After graduation there is always dangerous period when he may forget that having received a degree in medicine, he has only reached a point from which to begin a life long process of education. It is a fortunate thing for the young graduate if he is slow in building up a practice. Many a good man has been ruined by rushing around making too many calls in his career.

A medical diary is an excellent undertaking at this time, it should be a record, carefully taken, of all his important cases. He will find it worth while if well done. It will help to imprint his various activities on his mind. It implants in him the orderly recording of his observations which will in time build that invaluable fund of medical and surgical experience. How difficult it is to carry on a well written history of his work over a course of years, he will not know until he attempts it. Sometime ago the writer looked over the case book of a practitioner, in a town of this province, who had died in his early forties. It was excellent, and to me refreshing to read. Thirty years of such a diary would be priceless.

Our young medical man, early in his career, should be determined to go to his nearest medical centre as often as possible. He will need it; learn something, and find the dust shaken off him mentally and physically. There will be some financial difficulties in the way for a time; but if practicing in N. S., the Refresher Course will meet his needs in many ways and the expense is

not heavy. Like the Jews who went up to Jerusalem every year for the Feast of the Passover, every medical man should make a yearly pilgrimage to this course.

Yearly visits to larger Canadian and American centres should also be kept in mind as something to work for as soon as expenses permit. The Medical Society should be considered important and great efforts made to attend all its meetings. When asked for contributions to the programme he should be willing to take as active a part as possible in all its deliberations.

It is a good thing to have some time every day in which there is nothing medical or professional. Osler advises the daily practice of taking a half hour browsing in the classics, from a bedside table on which are Marcus Aurelius, Shakespeare, Macaulay's Essays and others from the great domain of English literature. The self discipline necessary to force one's self to do this over an extended period of years is good for anyone. "The all important thing is to get a relish for the good company of the race in a daily intercourse with some of the great minds of the age. Now in the springtime of life pick your associates among them." The literary background thus acquired is valuable because it broadens one's outlook; makes judgment better, and aside from the mental pleasure aids in getting the best out of life.

The financial condition of the new graduate is important. He is often in debt for college expenses and feels he must earn something at once. He should be a careful bookkeeper, many are not, and render his bills at regular intervals; but forget about becoming prosperous or even out of debt for ten years. He is engaged in a calling which may give him a comfortable living after a while, but his first thought should be to make himself as efficient a servant of the public as is possible to become by hard work and the brains he has. If he keeps up his studious habits he will acquire a professional knowledge and efficiency which the public will appreciate, and which will contribute, more or less, liberally to his support.

Much is said nowadays about hobbies for the professional man. It is good for anyone to keep in mind and develop some interest or accomplishment for which he has an inclination. The exhibition of the artistic work of medical men at the last Canadian Medical Association meeting was said to be a revelation,—musical instruments, golf sticks, fishing rods, carpenter's tools represent other hobbies possible and profitable for the medical practitioner who can plan his time so that he can enjoy them.

The new graduate will be called upon in many ways, especially in the small towns to help in the various community activities, and he should be generous in giving as much time as possible to everything for the good of the community.

Then after years of hard work and patient development of his mental powers as a member of the medical profession, he, at last, becomes what we shall call a successful practitioner. We wonder if he will say after some long weary day or night, with one of Oscar Wilds characters: "There are only two tragedies in life, not getting what you want and getting it?"

Possibly when he thinks that after all, he is doing useful work in his corner of the world he will be a little more cheerful and say with Robt. Louis Stevenson "To travel hopefully is better than to arrive, and the true success is in labour."

L. R. M.

THE ANNUAL MEETING

"Let us hold fast the profession of faith without wavering...not forgetting the assembling of ourselves together as the manner of some is." Heb. Chap. X.

THE announcement respecting the meeting at Yarmouth in July stimulates some thought with respect to medical societies in general, and provokes the question which seems to crop up perennially, especially when the drafts go out, *cui bono*? In other words, what value is there *for me* in medical organization? Has it enough of value to command my interest and support?

An investigation into the question would discover that it is one which, like most others, has its pros and cons, and that these may be set on opposite sides of an account and a balance struck. To its debit side we should have to put

- (1) The loss of time required and cost incurred in attending meetings.
- (2) The cost of supporting the various societies.
- (3) The burdens which come upon those who accept office in them, as most must do in turn, and upon those who must contribute to the programmes.

To the first of these the greatest value would probably have to be assigned, for the doctor's income is cut off the moment he leaves his practice, and if, as has been known, undesirable rivalry exists, the main effect might well be worse than that. Where more than one man is practising in a community however, they might well take turns in getting away, then one year with another this feature would lose its importance. Regarding item (2) while this cost is not great in consideration of the value which accrues, it represents a sum which might appear too great in times of economic depression. Item (3) must vary in importance with the activity of the particular society, being greater as it attempts to develop greater good.

Now what is there to be shown *per contra*—on the credit side of the account? The fact that perhaps should first be stated is that the organization tends to preserve a purity and loftiness of ideals from which—human nature being what it is—the individual tends to fall away. Individual cases of breach of ethics may and will from time to time appear, but the standard as preserved in our societies stands between us and the world as a great fortress. It is our profession's greatest insurance effort against loss of public confidence and should be so evaluated. The good from this is immeasurable, and accrues to all doctors alike whether they subscribe to its cost or do not. This would seem to be another case of "causing the rain to fall upon the just and on the unjust".

Then there is the educational value of the medical society. Osler, speaking on this subject thirty years ago said:

"There are many problems and difficulties in the education of the medical student, but they are not more difficult than the continuous education of the general practitioner... The university and the state board make it certain that the one has a minimum at least of professional knowledge, but who can be certain of the state of that knowledge of the other in five or ten years from the date of graduation?... The medical society helps to keep a man 'up to the times' and enables him to refurnish his mental shop with the latest wares... It keeps his mind open and receptive, and counteracts that tendency to premature senility which is apt to overtake a man who lives in a routine."

Nor is it only for the G. P. that it has value in this regard, for we have plenty of evidence of the interest which men have taken in their societies,

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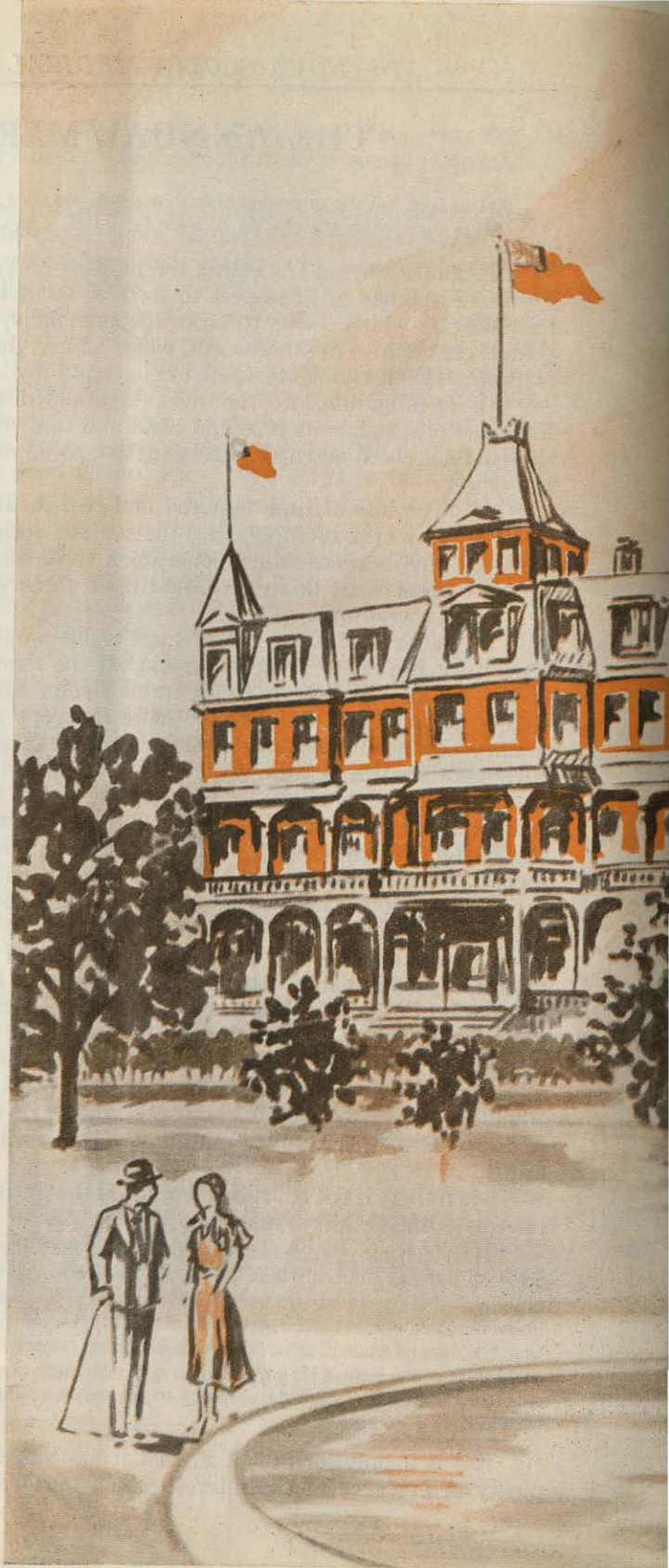
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**July 4th and 5th
1934**



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who for many years were doing special work. Sir Humphrey Rolleston addressing a medical group in London a couple of years ago said: "No medical meeting was said to be missed by the three G's, Goodhart, Gowers and Greenfield who reached the highest places in General Medicine, Neurology, and Pathology respectively".

But the Medical Society has another function. Osler thought it in some respects, its most important function. It is "To lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the profession". This is something which should begin in the local society and be carried through the provincial and into the federal, the keynote of all. It should constitute a very heavy entry to the society's credit. To many constant attendants at meetings it means a great deal now, and may indeed be the deciding factor in their attending so regularly; but we should see more of it, and it is from these same old stagers that we expect more—more of the extension of the hand of fellowship to those who have not come so frequently, or who as younger men are just being admitted into the inner temple. They should be given a 'place by the fire' with that courtesy which makes for unity and friendliness.

In this connection our tendency to rely upon our hosts of the occasion for our *joie de vivre* is too pronounced. Our Western Counties confreres will do all in their power this July, we know, but we should realize that we go there not only with all the rights and privileges which appertain to a medical family but also with all its obligations. Surely the outstanding family obligation is that none be sent away empty of that sense of fraternity which should be ours.

Summing up our debits and credits as far as we've gone, the balance is a heavy one to the credit of our societies, a balance that is there for us to collect. One is not surprised that in this province in the past, that fact has been so fully appreciated. (Up to two or three years ago the proportion of members of our profession who were members of our society to those who were not members was very high). Nor should one be surprised that through what is probably a mistaken idea, that appreciation has been somewhat dulled by an unfavorable economic situation, and that in consequence membership should have fallen off. However, the signs point this year to a great return of the wanderers to the family circle, with Yarmouth ready to fall upon our necks with the kiss of greeting, the best robes of Aesculapius being prepared for our adornment and Father Lebbetter itching to kill the fatted calf.

N. H. G.

LADIES' ENTERTAINMENT

- July 4th.** Registration of ladies on arrival with registrars at Grand Hotel and Lakeside Inn.
- 2.30 p.m.** Drive to environs of Yarmouth, visiting "Merrywood" and "Braemar." Afternoon tea.
- 7.30 p.m.** Sail around Yarmouth Harbour.
- 9.00 p.m.** Theatre Party.
- July 5th.** Garden party at home of Mrs. Harry Raymond, Hebron, N. S. Afternoon tea will be served at the boat house on the Estate.
- 7.30 p.m.** Banquet and Dance, Grand Hotel, Yarmouth.

EIGHTY-FIRST ANNUAL MEETING

OF THE

Medical Society of Nova Scotia

Yarmouth, July 4th and 5th, 1934

PROGRAMME

JULY 3rd

7.30 p.m. Executive Meeting, (Grand Hotel).

JULY 4th

9.30 a.m. Registration—Y. M. C. A. Auditorium.

10.00 a.m. Civic Welcome by His Worship J. M. Walker.
Report of Executive,
Routine Business.

12.30 a.m. Adjournment.

2.00 p.m. "Cystocele, Rectocele, and Prolapse of the Uterus, the result of injuries at birth; their anatomy, recognition and treatment" by Dr. L. R. Meech, North Sydney, N. S.

2.30 p.m. "Intracranial Haemorrhage of the Newborn" by Dr. D. W. F. Porter, Saint John, N. B. representative of the New Brunswick Medical Society.

3.30 p.m. Golf and picnic.

7.30 p.m. "The Diabetic of the Future and His Problems" by Dr. Elliott P. Joslin, Boston, Mass. Discussion to be opened by Dr. K. A. MacKenzie, Halifax, Nova Scotia.

JULY 5th

9.30 a.m. To be announced—by Dr. M. J. Carney, Halifax, N. S.

10.30 a.m. "The End Result of Adrenal Denervation in cases of Neurocircular Asthenia, Hyperthyroidism, Peptic Ulcer, Epilepsy and Polyglandular Diseases" by Dr. George W. Crile, Cleveland, U. S. A.
Discussion opened by Dr. J. J. Roy, Sydney, N. S., and Dr. J. J. Macdonald New Glasgow, N. S.11.30 a.m. Presidential address.
Unfinished business.

2.00 p.m. "Entamoeba living in Man" by Dr. E. T. Tanton, Summerside, P. E. I., representative of the Prince Edward Island Medical Society.

3.00 to Symposium in Surgery by Lahey Clinic of Boston.

6.30 p.m. (1) "Peptic Ulcer and Gastric Malignancy" by Dr. Frank H. Lahey. Discussion opened by Dr. J. G. MacDougall, Halifax, N. S.

(2) "Gall Stones and their Complications" by Dr. Howard M. Clute. Discussion opened by Dr. H. K. MacDonald, Halifax, N. S.

(3) "Common Symptoms sometimes indicating Surgical Diseases of the Brain and Cord" by Dr. Gilbert Horrax. Discussion opened by Dr. W. N. Rehfuss, Bridgewater, N. S.

(4) "The Treatment of Fractures of both bones of the leg" by Dr. G. E. Haggart. Discussion opened by Dr. W. Alan Curry, Halifax, N. S.

7.30 p.m. Annual Banquet.

Guests of Honour—Lieutenant-Governor and Mrs. Covert; Premier and Mrs. Angus L. Macdonald; Hon. and Mrs. F. R. Davis. Dancing will follow the banquet. Dress optional.

CASE REPORTS

Haemorrhage into Corpus Luteum Simulating Ectopic Pregnancy.

CALLED at 3 a.m. night of December 6-7, 1933 to see an Indian girl, age 23, complaining of severe pain in the abdomen with vomiting. The day previously she had a similar only not as severe an attack which had eased away after a few hours, and at that time there was no vomiting.

Past History: No serious illnesses. No history Tuberculosis. Had an appendectomy 1927 with good recovery. Menstruation always regular. No history V. D. G.

Present Illness: Patient's last menstrual period October 21 and she admitted the possibility of pregnancy. On December 6 she had a severe cramp-like pain in the left lower abdomen which eased away so that for a few hours she was free of pain. She did not feel faint or dizzy. There was no flowing. The next night the pain became worse and after some hours the patient called the doctor.

Examination: Well nourished Indian girl, obviously in great pain. Definite tenderness left lower quadrant and elongated mass could be felt rising about two fingers breadth above the inguinal Ligament and parallel to it. Temp. 98.0, Pulse 74, Respirations 18. On vaginal examination a tender mass was felt posteriorly and to the left. Leucocytes 7,800. Patient was brought to hospital and on December 8, 9 was quite comfortable, but the night of Dec. 9 the pain returned. Leucocyte count was 11,800 and after consultation the patient was operated on, the pre-operative diagnosis being Ectopic Pregnancy.

Operation: On opening the abdominal cavity more than the usual amount of peritoneal fluid was present. No tubercles seen. There was a mass in the left side of the pelvis. This was explored and found to be the left tube and ovary. There was a cyst containing half a cupful of straw colored fluid and a haemorrhagic mass near the cornu of the uterus where the tube and ovary were adherent and difficult to differentiate. A salpingo-oophorectomy was done and the abdomen closed without drainage. The tissue removed was reported on as follows: The fallopian tube reveals a simple chronic salpingitis; there is no evidence of tubal abortion. The haemorrhagic cystic body is apparently a haematoma of the ovary resulting from haemorrhage into a true corpus luteum. No evidence of chorionic villi is seen in the structure. There is no evidence of malignancy.

Subsequent Progress: Patient did well after operation. On Dec. 13 there was some bleeding from the vagina. On the 14th she passed clots and products of conception following which in a few days the bleeding ceased and she was discharged recovered on December 23.

H. E. KELLEY, Middleton.

Torsion and Leakage of a Small Cystic Right Ovary.

R. M. A married lady, 36 years of age. Has had six or seven confinements the last one a year previous to this last illness.

The chief feature of this condition was the amount of shock or the collapsed state the patient was in when she was admitted or carried to my office by two men. She took suddenly ill on the morning of November 10th, 1933, with a sharp pain in the right lower quadrant which would not respond to ordinary household remedies. She lived out twelve miles in the country. I was called by phone to go and see the case; but hearing of the symptoms and the sudden onset, I advised that the patient be brought to my office to save time, as I suspected an ectopic. The history for an ectopic was against me. Appendicitis was ruled out. Vaginal examination revealed a small mass in the right broad ligament or pelvis.

The temperature was subnormal, pulse feeble and very fast; marked pallor in the face and lips, and the extremities cold.

I advised her to be admitted to the Berwick Hospital at once, which was agreed to. She was prepared for her operation as quickly as was considered advisable. Glucose and saline was started intravenously before the abdomen was opened.

On opening the abdomen by the usual midline route, I found, instead of blood, a moderate amount of clear fluid.

The appendix, fallopian tubes and uterus were normal; but the right ovary was cystic—about the size of an orange with the pedicle twisted two or three times, and a small stream from the cyst as if you had punctured it with a fine round needle.

The cystic ovary and appendix were removed. The patient made a quick and uneventful recovery and was able to go home ten days after the operation. She is in very good health now and has gained 10 or 15 lbs. in weight.

I don't know if there is anything of special interest in this case, but I was rather amazed at the degree of shock with such a small sized cyst and only about half a pint of free fluid in the abdominal cavity.

HUGH MACKINNON, Berwick, N. S.

Ectopic Gestation.

I was called to see Mrs. C. age 39 years, May 10th, 1934, at 1 p.m. She met me at the door of her bedroom fully dressed and gave me the story that she had gotten up as usual around six o'clock, had her breakfast and been working around the house. At nine o'clock she sat down to plan her work for the day. All of a sudden she felt a sharp pain in her left side and began to bloat up. The pain was steady from then on till one o'clock when she called me. When I arrived I found the woman very pale with a definite look of anxiety. Extremities were cold and bloodless. Might say that she always did look very pale with not a bit of colour in her cheeks. Pulse 108°F. and thready. Weight 134 lbs. she gave a history of having missed two sicknesses but explained this by saying she thought she was having change of life. Had two children, a boy and girl, 19 and 20 years of age, and been regular since

until two months ago. Has what she called bilious attacks about every fortnight with severe pain in her neck and head, behind the ears, with vomiting; generally lasts four days; suffers somewhat from indigestion.

On examination I found the abdomen soft but tender on left side. The whole abdomen was too tender to palpate much but no marked rigidity; dull on percussion all over. She complained of a heavy bearing down pain at lower part of abdomen that did not let up. She had had three bowel movements during the morning which were not soft, but natural in appearance. These followed the advent of the pain. Temperature $96\frac{1}{2}^{\circ}\text{F}$. There was no history of any sign of flowing during the last two months. No morning sickness. Said she had felt draggy and had no pep. Made a vaginal examination with negative results.

It looked very much like a ruptured extra uterine pregnancy, but she had not had a child for 19 years. Was approaching the time of her menopause. Had given no history of a show of blood at anytime since she had her regular sickness, and had not suffered from morning sickness apparently, although she had had her regular bilious attack. I hesitated to send her at once to the hospital as her husband was away for the day and knew nothing of her sickness, and I felt her condition was such that I could delay a little; possibly it might be an attack of nervous indigestion so I left her a sedative, and some caroid soda and charcoal tablets; asked her to remain quiet in bed and if the pain did not go away to call me again a little later. At five o'clock the call came again. She was no better, complained of pain in her neck and behind the ears which was as severe as pain in the abdomen. When palpating the abdomen pain was made more severe in the neck. She had fainted several times; felt very restless and nervous; wanted cold fomentations to forehead and face continuously; pulse thin and rapid. Ordered her to the hospital and made preparation for her operation. She had no preparation until she was on the operating table for fear of increasing the haemorrhage if there should be any. Used Ethyl chloride and ether for the anaesthetic. She took her anaesthetic well. I made the incision in midline below the umbilicus 4" in length. On going through the peritoneum blood and clots poured from the incision. I quickly inserted my left hand, located the fundus uteri, followed down the left tube to ovary, introduced clamp with right hand, clamped left tube and delivered same into the incision. The left tube was ruptured. I removed section of tube and ligatured both ends; cleaned out the abdomen of clots and blood and sutured abdominal wall layer by layer. The patient was removed to her room and given saline submammary and to-day is making an uneventful recovery.

The reason why I cited this case is that it was peculiar and a little puzzling in two ways. The regular or ordinary ectopic nearly always before rupturing at sometime makes a show of blood from the vagina. This one did not. This woman had not borne a child for nineteen years and was approaching the change of life. She had no regular morning sickness. However, I decided something definite had gone wrong in the abdomen which called for at least a laparotomy.

W. R. DICKIE, Digby.

CASE I. Acute Spontaneous Subarachnoid Haemorrhage.

H. R. Male, age 23. Had an attack of influenza but felt well enough to be out on Mar. 20th. While walking along the street he suddenly felt faint and went into a restaurant where he fainted. When I first saw him he was lying on the floor, very pale and had vomited a large amount of undigested food. Pulse rate 68, regular; heart sounds normal. He complained only of a severe headache which had troubled him since the 15th. He was removed to his home and kept at rest. Sedative given for headache.

At 8 p.m. temp. 98, pulse 68, Babinski and Kernig negative. No stiffness of neck muscles. No photophobia. Headache still troublesome.

Mar. 21st. Pulse 66, temp. 97.8. Headache persistent. Some nausea. Reflexes normal. At 8 p.m. headache was troublesome. Slight suggestion of stiffness of neck muscles.

Mar. 22nd. Felt much better. Headache was almost gone and reflexes normal.

Saw the patient again on Mar. 23rd. Some stiffness of neck muscles and some photophobia. Kernig doubtful. Lumbar puncture was done and the fluid came out under pressure and contained much blood. Report on fluid was not satisfactory as there was so much blood. Cell count showed some mononuclears but no increase in number. Copper reduction, normal. Chlorides .70% Kahn negative. The photophobia was relieved by the puncture and to some degree, the headache.

Mar. 24th. Temp. 99.6, pulse 72. Patient quite comfortable.

Mar. 25th. L.P. fluid did not contain so much blood. Slight pressure. Headache and photophobia disappeared when the fluid was withdrawn.

Mar. 26th. Patient ran a temp. of 100, pulse 72.

Mar. 27th. Temp. 99.6, pulse 72. slight headache. L. P. fluid clear. Very slight pressure.

Mar. 28th. Headache disappeared. Reflexes all normal. Appetite returning.

Blood Kahn was three plus.

A diagnosis of acute spontaneous subarachnoid haemorrhage was made in this case.

CASE II. Broncho-Pneumonia Complicating Influenza.

F. K. Female, age 14.

Called to see patient on Mar. 22nd. Temp. 102, pulse 90, resp. 30, chest negative. Put patient on treatment for influenza.

Mar. 23rd. Cough troublesome, temp 101, pulse 90, resp, 24. Chest negative for physical findings.

Mar. 24th. Same as above. Cough persisted, temp. ranged from 101 to 103. Pulse never above 90. Resp. around 24.

On the evening of Mar. 28th cough was still troublesome and chest was negative for physical signs.

Mar. 29th. Right lung 5 v.s. and 2. i.s. showers of rales. W. P.+ V. R. + Br. + Temp. 102, resp. 20, pulse 90.

Called in Dr. Beckwith of the Nova Scotia Sanatorium who confirmed the above findings.

Mar. 30th. Rales extended to 7 v.s. and 4 i.s. Temp. 98.8, pulse 78.

Mar. 31. Temp. 99, pulse 72. Rales extended to base with some clearing at apex.

April 1st. Temp. 98, pulse 70. resp. 20. Rales more marked at root of lung. Sputum was negative on repeated tests for tubercle bacilli.

This patient made an uneventful recovery from the above date. The rales persisted for some days—clearing and reappearing again. The last area to clear definitely was at the root of the lung. A plate at a later date revealed a normal chest.

This girl had been plated, in connection with the school survey in Kentville, about two weeks before the start of her illness and at that time her chest was normal.

The striking feature of this case was the absence of physical findings twenty-four hours before the date on which the rales appeared. The diagnosis rested between pulmonary tuberculosis and broncho-pneumonia following or complicating influenza.

Note. Since the above case came under my observation, I have had knowledge of three cases with the same clinical picture. The feature of these cases was the absence of abnormal physical findings twenty-four hours before the rales appeared.

The differential diagnosis between pulmonary tuberculosis and broncho-pneumonia is very difficult and can only be definitely determined by careful and prolonged observation.

T. A. KIRKPATRICK, Kentville, N. S.

Three Cases of Hydrocephalus.

July 6, 1924. Mrs. L. B. Age 30 years. Multipara.

This woman went into labor during the early hours of July 6th, 1924, without any antipartum care whatever. Examination per vagina revealed a breech presenting. The abdomen was somewhat larger than normal, but was considered to be due to excessive amniotic fluid. Labor progressed normally through the first stage. The second stage progressed slowly and it seemed necessary to give some help. Consequently, a foot was brought down and some traction applied. I then found it necessary to go up after the other foot. I could not deliver the child. Both arms were brought down; and as delivery seemed too difficult and contractions were regular and strong, some abnormality was looked for. Over the lower dorsal vertebrae there was evidence of a small spina bifida. The abdomen, with the child delivered with the exception of the head had not reduced in size to any extent. Diagnosis of hydrocephalus with breech presenting was very evident. At the site of the spina bifida the vertebral canal was entered and a hand catheter pushed into the head. Approximately four quarts of fluid were withdrawn before the head could be delivered and labor terminated. There was a normal third stage and no postpartum haemorrhage. Post-partum convalescence was afebrile and quite normal.

October 29th, 1931. Mrs. R. E. Multipara. Age 28 years. This woman went into labour on October 29th, 1931. The examination per vagina revealed a breech presenting. Labor progressed normally throughout the first stage. During the early part of the second stage labor was devoid of any suspicion of trouble. It was found necessary to bring down the feet and the arms. Traction was applied but the child could not be delivered and on examination it was found to be a case of hydrocephalus of moderate degree. The lower dorsal area revealed a small dimple—a slight spina bifida. Through this area a hard catheter was passed into the head and a quart or so of fluid withdrawn before traction could deliver the head. The third stage was normal. Post-partum convalescence was uninterrupted.

Mrs. J. D. Multipara, age 37 years. This woman was admitted to the hospital in labor on April 14th, 1933. Because of the impossibility of delivering the after coming head in an otherwise normal breech presentation the physician called me in in consultation. Examination in this case revealed precisely the condition noted in the two previous cases insofar as the child was concerned. There was a marked spina bifida and hydrocephalus. The condition of the mother was that of oncoming fatigue but contractions still regular and somewhat forceful. A rapid emptying of the head per catheter through an opening made at the site of the spina bifida allowed of easy delivery with slight traction. There was a moderate post-partum haemorrhage, controlled by manual compression together with Ernutin and Infundin. Post-partum convalescence was very rocky. The temperature and pulse rate mounted. On the ninth day post-partum there was a severe haemorrhage per the vagina which was controlled by vaginal packing immediately. A severe laceration of the cervix which had been neglected was noted and it was from this site the secondary haemorrhage had come. Twenty-two days post-partum when I was again called in consultation; the case presented a left broad ligament abscess the result of infection in the cervical tear. The treatment was carried out on expectant lines and the abscess eventually evacuated itself into the vagina. Recovery was prolonged but eventually complete.

A. R. REID, Windsor, N. S.

PARALYZED ENGLISHMAN KEPT ALIVE TWO YEARS.

Chicago, May 29.—A 63-year-old Englishman has been kept alive for two years by a home-made machine for artificial breathing, setting a record for such treatment, the *Journal of the American Medical Association* reported in its current issue.

The patient was the victim of a progressive wasting of the muscles, which eventually paralyzed those controlling breathing.—*Sydney Post Record*.

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 O'Brien, W. C., Wedgeport.
 Fox, C. J., Pubnico (Argyle Mcpy).

Those physicians wishing to make use of the free diagnostic services offered by the Public Health Laboratory, will please address material to Dr. D. J. MacKenzie, Public Health Laboratory, Pathological Institute, Morris Street, Halifax. This free service has reference to the examination of such specimens as will assist in the diagnosis and control of communicable diseases; including Kahn test, Widal test, blood culture, cerebro spinal fluid, gonococci and sputa smears, bacteriological examination of pleural fluid, urine and faeces for tubercle or typhoid, water and milk analysis.

In connection with Cancer Control, tumor tissues are examined free. These should be addressed to Dr. R. P. Smith, Pathological Institute, Morris Street, Halifax.

All orders for Vaccines and sera are to be sent to the Department of the Public Health, Metropole Building, Halifax.

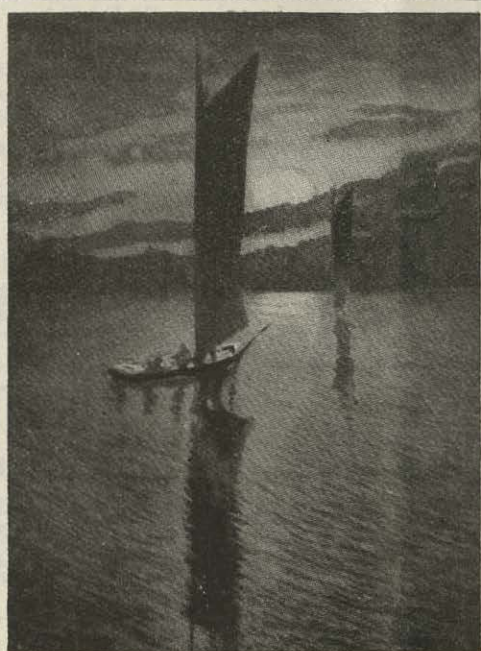
The golf tournament should be bigger and better than ever this year on Yarmouth's outstanding links. Those too fat to play golf can enter the fat men's race at the picnic.

**Communicable Diseases Reported by the Medical Health
Officers for the month of May, 1934.**

County	Paratyphoid	Chicken Pox	Diphtheria	Influenza	Measles	German Measles	Mumps	Pneumonia	Scarlet Fever	Scabies	Tbc. Pulmonary	Tbc. other forms	V. D. G.	V. D. S.	Whooping Cough	Goitre	Pink Eye	Erysipelas	TOTAL
Annapolis				3															3
Antigonish																			
Cape Breton		8			16	11		4	2		2		4		5				52
Colchester				3					1								5		9
Cumberland	1		1	2		4	6		15										29
Digby					4			1							2				7
Guysboro																			
Halifax City		4	5			1			21	1					24			1	57
Halifax																			
Hants					1				8										9
Inverness				2				2	3	5	2					1			15
Kings				11		1		3	1		1			3					20
Lunenburg									5		1		1						7
Pictou						88		1	3				3						95
Queens		7		80					1		1		5	6			30		130
Richmond				4															4
Shelburne								3											3
Victoria																			
Yarmouth				11							2		4	1	16	1			35
TOTAL	1	19	6	116	21	105	6	14	60	6	9	..	17	10	47	2	35	1	475

RETURNS VITAL STATISTICS FOR APRIL, 1934.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis	19	17	9	4	5	0
Antigonish	9	9	5	5	6	0
Cape Breton	108	98	40	56	39	8
Colchester	24	24	14	10	13	0
Cumberland	45	38	21	20	22	5
Digby	12	10	11	10	8	1
Guysboro	11	14	6	10	7	0
Halifax	91	93	62	55	62	16
Hants	16	18	10	15	7	3
Inverness	21	17	5	11	12	3
Kings	16	17	14	4	5	0
Lunenburg	19	23	21	8	12	2
Pictou	25	42	10	20	15	1
Queens	7	8	3	6	3	0
Richmond	6	5	3	4	3	0
Shelburne	9	15	5	8	12	0
Victoria	3	5	1	5	4	0
Yarmouth	21	15	6	12	11	2
TOTAL	462	468	246	263	246	41



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ORTAL SODIUM—the result of ten years of research in the Parke-Davis laboratories—is an effective rapidly-acting hypnotic; it induces sound, restful sleep, so necessary in a wide variety of physical and mental disorders. Ortal Sodium has low toxicity, and its use is free from unpleasant hang-over effect.

The effective hypnotic dose in most cases is one or two capsules.

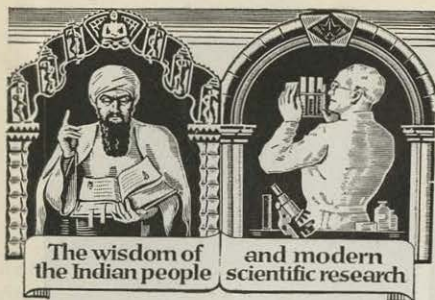
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capsules.*



Parke, Davis & Co.

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THE
ROYAL BANK
 OF CANADA

Branch Societies

CAPE BRETON DOCTORS MEET.

North Sydney, May 30—Members of the Cape Breton Medical Association held their first meeting in Hamilton Memorial Hospital last night. The meeting was well attended and was presided over by Dr. Daniel McDonald, president.

The visiting medical men were extended a welcome to North Sydney by Dr. J. W. McLean, dean of Cape Breton medical men.

The meeting was featured by papers on interesting medical subjects by Dr. A. K. Roy, Dr. J. S. Munro and Dr. L. R. Meech.—*Sydney Post Record*.

LUNENBURG-QUEENS MEDICAL SOCIETY HOLD SESSION.

The Lunenburg-Queens Medical Society met in session May 22 at the Dawson Memorial Hospital. Dr. C. B. Cameron of Petite Riviere, presided, and twelve doctors were in attendance. The meeting was one of the most interesting held for some time. After routine business papers were read by, Dr. C. G. MacKinnon of Mahone Bay on the "Use of Digitalis"; Dr. H. A. Creighton, of Lunenburg on "Cervical Rib"; Dr. J. C. Wickwire, of Liverpool on "Artificial Pneumo-Thorax"; case reports were given by Dr. H. A. Fraser and Dr. C. A. Donkin of Brigewater.

After the business session the Superintendent of the Hospital, Mrs. Margaret Bohner, served refreshments, which were much appreciated by the medical fraternity.

DOCTORS HELD ANNUAL MEET YESTERDAY.

The 27th annual meeting of the Valley Medical Society was held in the parish hall, at Middleton, May 22nd, with the president, Dr. L. B. Braine, of Annapolis Royal, in the chair. The presidential address was given by Dr. Braine in which the progress of medicine in the past 35 years was pointed out. Papers were given by Dr. P. S. Cochrane, of Wolfville; Dr. J. A. Sponagle, of Middleton; and Dr. L. B. Morse, of Lawrencetown. The guest speaker was Dr. E. K. MacLellan, of Halifax, who spoke on "Obstetrics" and showed a film on the subject from the DeLee Clinic in Chicago. Dr. MacLellan stressed the desirability of every woman having her first baby in hospital. Other guests were Dr. Ray Bennett, of St. John's, Nfld.; and Dr. T. H. MacDonald of Somerville, Mass. for many years an active member of the society.

Officers were elected for the next year as follows:

President—Dr. P. S. Cochrane, of Wolfville.

Vice-President for Digby County—Dr. John R. McCleave, Digby.

WHAT WILL RETIREMENT MEAN TO YOU?



NO DOUBT you are looking forward to retiring when you reach the "Sixties". In many institutions retirement is optional at 60 but Compulsory at age 65.

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Vice-President for Kings County—Dr. F. F. Chute, Canning.

Secretary-Treasurer—Dr. H. E. Kelley, Middleton.

Members of Executive of Medical Society of Nova Scotia—Dr. L. J. Lovett, Bear River; Dr. H. E. Killam, Kinsman's Corner.—*Digby Courier.*

HALIFAX PHYSICIANS SELECT OFFICERS.

The Halifax Branch of the Medical Society of Nova Scotia met Wednesday, April 25th, at the Nova Scotian Hotel. Election of officers resulted in the following: President, Dr. F. V. Woodbury; Vice-President, Dr. H. W. Schwartz; Secretary-Treasurer, Dr. C. W. Holland; Members of the Executive and representatives on the Executive of the Medical Society of Nova Scotia, Dr. J. W. Reid, Dr. G. R. Burns, Dr. F. F. P. Malcolm, Dartmouth; Dr. R. H. Stoddard and Dr. S. J. MacKenzie. Following the business session dinner was served.

OBITUARY

The death occurred at the Yarmouth Hospital on May 13th of Dr. Alice Symonds Churchill, of Darling Lake. The deceased, who was a daughter of the late Thomas and Hannah Symonds, of Darling Lake, and the widow of the late Gilbert Churchill, who died in 1927, had for many years followed the practice of medicine in Haverhill, Mass.

Mrs. Jennie F. Ross, wife of Murdock W. Ross, and for thirty years a resident of Sydney, died in the Victoria General Hospital, Halifax, on May 5th, after a lingering illness. She was in her 62nd year. Beside her husband three sons survive, Dr. Robert F., Elmsdale; Dr. Arthur W., Souris, P. E. I.; and Donald M., Halifax, member of this year's Dalhousie University Science graduating class.

There passed away at Kentville on May 31st, Wilhemina Lyons, wife of Postmaster J. R. Lyons. Mrs. Lyons was a daughter of the late Mr. and Mrs. John Risser of Lilydale, Lunenburg County. Dr. Hubert Lyons of New York city, is a son of the deceased.

Personal Interest Notes

Yarmouth, July 4th and 5th, 1934. "We'll be seeing you."

DR. GEORGE COX of New Glasgow recently returned from St. Petersburg, Florida, where he spent the Winter.

Dr. and Mrs. Dan Murray of Tatamagouche are leaving this week by motor for Calgary to attend the annual convention of the Canadian Medical Association.

Dr. and Mrs. Daniel MacDonald of North Sydney left May 31st for Toronto, where they will attend the convocation at Toronto University at which their son, Neil Alexander, will receive his degree in medicine, Dr. and Mrs. MacDonald will be away about two weeks.

Dr. and Mrs. M. J. Wardrope and son James of Springhill, after spending the winter in Arizona and California, motored back to Nova Scotia arriving home about the first of June.

Quack doctor found guilty by Nova Scotia Jury. Frank MacDonald of Sydney, N. S. alias "Dr. W. R. McCumber", alleged fake eye specialist, was convicted May 29th by a Supreme Court Jury of obtaining \$987.00 under false pretences from Enos Dares, aged Lunenburg farmer.

Dr. D. A. McLeod of Sydney, who has been in ill health for some little time, left last month, accompanied by Mrs. McLeod on a trip to Montreal, Boston, New York and Los Angeles. After spending some weeks in the south Dr. and Mrs. McLeod are returning home via Vancouver and Winnipeg.

Dr. W. W. Bennett, Caledonia, Queens County, has been visiting in Sydney, the guest of Mr. and Mrs. Lyman Jackson, Winifred Square.

The marriage was celebrated on June 2nd at Montreal of Miss Theresa Macneil, Montreal, daughter of the late Mr. and Mrs. Joseph Macneil, Reserve, N. S., to Dr. Lewis W. Johnstone of Sydney Mines, Member of Parliament for Cape Breton, North Victoria. Dr. and Mrs. Johnstone will spend their honeymoon at Seignory Club, Quebec, and after the end of the parliamentary session in Ottawa will take up residence at Sydney Mines, N. S.

Dr. G. A. Winfield, son of Mr. and Mrs. J. H. Winfield, of Halifax, has been appointed Assistant Urologist of the Victoria General Hospital, Halifax.

Miss Frances W. Morrison, daughter of Dr. and Mrs. M. D. Morrison of Halifax, has obtained the diploma of A.R.C.M. from the Royal College of Music, London, England. Miss Morrison is a graduate of the Halifax Conservatory of Music and a Bachelor of Music, Dalhousie University.