

MANDELIC ACID B.D.H. and **SODIUM MANDELATE B.D.H.**

For the treatment of urinary infections

The introduction of mandelic acid into modern therapy as a substitute for a ketogenic diet in the treatment of urinary infections is the outcome of an investigation the results of which were reported in *The Lancet* of May 4th, 1935, p. 1032. Results of further clinical cases reported (*Brit. Med. Journ.*, December 7, 1935, p. 1096) would seem to suggest that '.... in mandelic acid a really efficient urinary antiseptic has been found, confirming the original claims made for the drug....'

In the original investigation upon the treatment of urinary infections with mandelic acid, the acid itself (dissolved in water and neutralised with sodium bicarbonate) was administered; latterly the administration of the pure sodium salt has been found to be the more convenient form of treatment.

Mandelic Acid B. D. H. and Sodium Mandelate B. D. H. are available in various standard packages from one ounce to seven pounds.

For successful treatment it is necessary to maintain the pH of the urine at 5.3 or lower, which is effected by regular daily tests of the pH of the urine followed by the administration of appropriate doses of ammonium chloride.

MANDELIC ACID B.D.H. OUTFIT

To facilitate the practice of mandelic acid therapy and to ensure optimum effects the Mandelic Acid B. D. H. Outfit has been designed. The outfit contains the necessary materials for fourteen days' treatment, and there are included also the accessories for controlling the pH of the urine.

*Stocks are held by leading druggists throughout the Dominion,
and full particulars are available from*

THE BRITISH DRUG HOUSES (CANADA) LTD.

Terminal Warehouse

Toronto 2, Ont.

Of Interest to the Profession

Physicians of Nova Scotia will be interested to know that the Anglo-Canadian Drugs of Oshawa, Ontario, have opened an office and stock warehouse in Halifax. The Nova Scotia office is located in the Roy Building, Suite 137-138, second floor, Halifax, from which premises we will endeavor to serve the Profession. Realizing the necessity for the cutting down in time of delivery of many items used by the profession the Anglo-Canadian Drugs Limited will from now on give physicians of this Province a better delivery on many of their needs. Anglo-Canadian Drugs is an ethical Manufacturing Pharmaceutical organization, Directorate and all Staff Canadians, and made possible by Canadian capital. Detailists and salesmen will visit the Profession in the near future and explain more fully the policy of Anglo-Canadian Drugs. A complete Maritime staff has been engaged to meet requirements of these Provinces understandingly. Complete stocks of Pharmaceuticals, Chemicals and other Medical Sundries will be available to meet demands. An inspection of our facilities will be invited.

ANGLO-CANADIAN DRUGS

R. G. BLAIR, *Maritime Manager*

FOR SOUND INDUSTRY

Industry and trade are the means by which a country makes effective use of natural wealth. The Royal Bank has always been ready to encourage sound Canadian enterprise. It has maintained this attitude through many years of varying conditions.

THE

ROYAL BANK

OF CANADA

CONTENTS

SCIENTIFIC:

Diverticulitis—E. David Sherman, M.D. - - - - - 171
 Dystrophia Adiposo Genitalis.—B. C. Archibald, M.D. - - - - - 177

HISTORICAL:

Reminiscences.—Dr. A. S. Kendall - - - - - 180
 Notes from Glace Bay.—Dr. J. F. Bates, M.D. - - - - - 184
 Reminiscences of an old time Practice and Practitioner.—A. W. Miller, M.D. - - - 186
 A Trek from Cheticamp to Pleasant Bay.—L. J. LeBlanc, M.D. - - - - - 190

EDITORIAL:

A Fraternal Greeting in Kindly Gaelic - - - - - 193
 A Modern Alliance - - - - - 194
 The Dalhousie Medical Journal - - - - - 195

CASE REPORTS:

Arsenical Dermatitis with Exfoliation.—Dr. F. T. MacLeod - - - - - 196
 Some Unusual Complications in a Case of Chronic Alcoholism.—Dr. B. F. Miller - 197
 Report of Cases of Trichinosis.—Dr. A. Gaum - - - - - 199

A Financial Consideration of the Proposed Federation With the C.M.A. - - - - - 201
 DEPARTMENT OF THE PUBLIC HEALTH - - - - - 203
 OBITUARY - - - - - 206
 PERSONAL INTEREST NOTES - - - - - 210
 Early Adventures with Chloroform in Pictou, N. S. - - - - - 214

URASAL

AN EFFICIENT

URINARY ANTISEPTIC

COMPOSITION:

Hexamethylenamine 7½ grs.
 combined with Piperazine
 and Lithia Benzo-Citrate.

INDICATIONS:

● CYSTITIS - PYELITIS
 RHEUMATISM, Etc.

Manufactured by

FRANK W. HORNER LIMITED
 MONTREAL » » CANADA

For the treatment of

**RHEUMATOID ARTHRITIS
LUPUS ERYTHEMATOSUS
PULMONARY TUBERCULOSIS**



For intravenous
administration.

Gold Sodium Thiosulphate.

In ampoules of 0.05 Gm., 0.10 Gm., 0.20 Gm., 0.25 Gm., and 0.50 Gm.
In Rheumatoid Arthritis—First inject 0.05 Gm. every five days, then 0.10 Gm. to 0.20 Gm. per week till the total dose of 2 Grams is obtained (Forestier).

In Lupus Erythematosus—An initial intravenous dose of 5 milligrams. Subsequent injections given at weekly intervals may be increased to 5 and 10 mill. per dose up to 50 mill.

(Bibl. reference: "The use of Gold and Sodium Thiosulphate in the treatment of Lupus Erythematosus", by J. S. Chamberg and C. S. Wright, Arch. Dermat. & Syph. 15: 119-137, 1927).

In Pulmonary Tuberculosis—In a report of 43 cases of pulmonary tuberculosis treated with CRISALBINE, an eminent American phthisiotherapist states:

"The benefits derived from the use of gold salts should encourage its wider absorption in suitable cases until a more effective remedy is discovered."



For intramuscular
administration

Sodium Aurothiomalate.

In aqueous solution or in oily suspension in the following dosages: 0.01 Gm., 0.05 Gm., 0.10 Gm., 0.20 Gm., 0.30 Gm., and 0.50 Gm.

In Pulmonary Tuberculosis—Recommended in cases where patients appear to be particularly sensitive to gold and where intravenous injection seems to complicate treatment unnecessarily.

In Rheumatoid Arthritis—Weekly injections of 0.1 Gm. to 0.2 Gm., the total amount for one series should be between 1.5 Gm. and 2 Gms. (Rheumatoid Arthritis and its treatment by Gold Salts," by Jacques Forestier, M.D., The Lancet, September 22, 1934, p. 646).

LABORATORY POULENC FRÈRES OF CANADA LIMITED

Distributors: ROUGIER FRÈRES - MONTREAL

Diverticulitis

E. DAVID SHERMAN, M.D.
Sydney, N.S.

DIVERTICULOSIS is a condition marked by the formation of small pouches or sacculae along the lumen of the bowel. These sacculae represent hernial protrusions of mucous membrane through a defect in the musculature of the bowel, so that it consists only of two layers in its wall, namely the peritoneum and mucosa. The diverticula may be localized or scattered diffusely throughout the length of the bowel. On account of obstruction or other factors, stagnation and retention may result causing a condition termed diverticulitis.

In the examination of portly, well fed patients, more than forty years of age, one often discovers diverticula through a Gastro-Intestinal Roentgen examination, but in about 75% of such cases the diverticula are in the nature of anatomic anomalies and are not related to any symptoms of which the patient may complain. The correct descriptive term for the condition in which diverticula are present is Diverticulosis. It should be born in mind that any of these people with diverticulosis are potential candidates for diverticulitis: nor on the other hand that a patient may have had mild attacks quite suggestive of diverticulitis and yet at the time of examination present evidence solely of diverticulosis.

In 1888 Jones described a case of a patient who suffered a fistula between the bladder and bowel, secondary to an inflamed and ulcerated diverticulum of the sigmoid. Graser and Fischer in 1898 established this condition as a definite clinical entity. Since then Mayo, Cecil, Erdmann, Judd, Moynihan, Beer and others have made striking contributions to this subject.

Diverticulitis is a rather uncommon condition. Larimore reported the incidence of diverticula as 1.24% in a series of over 4000 roentgenoscopic examinations. Rankin and Brown at the Mayo Clinic, noted that in a series of 24,620 roentgenographic examinations of the Colon, a diagnosis of diverticula was made in 5.67% of the cases. (1398 cases)

Most observers agree that the disease occurs chiefly over the age of 40, although cases have been reported in children by Erdmann, Ashhurst, and others. The majority of the patients appear to be males. The condition affects the sigmoid principally, but the remaining Colon maybe involved, usually with decreasing frequency from the right to the left side of the bowel. (Judd and Pollock, Masson).

To judge from the literature it would appear that diverticulosis of the small bowel is rather uncommon. Spriggs found 0.7% of Jejunal and Ileal diverticulosis in 1000 consecutive cases. Rothschild in 1925 was able to collect only 33 cases of Jejunal diverticulitis from the literature.

Etiology.

The mode of causation of diverticulosis still remains unsettled and controversial. The different theories evolved fall into the following groups. (1) Increased abdominal pressure; (2) Weakness of the musculature of the intestinal wall; (3) Traction on the intestine by mesenteric vessels; (4) Traction following adhesions.

From a study of the experiences of many observers it is apparent that no one factor causes or produces diverticula. The outstanding features in their formation seems to have to do with inherent weakness of the wall of the bowel, in addition to increased intracolonic pressure. The majority of workers favor congenital predisposition in most cases, and obesity, venous stasis, and constipation undoubtedly are accessory factors.

The presence of gas and the effects of constipation and straining at stool cause these diverticula to increase in size, and their fecal contents stagnate and form hard inspissated concretions. There is consequent inflammatory change secondary to obstruction and stagnation and the rather constant pathologic picture.

The Mucosa and Submucosa extend through a point where the muscular weakness is localized. (Beer) Arriving at the longitudinal coat, the growing diverticulum either breaks through it or carries it in front of it.

The longitudinal coat of musculature may be intact in some cases, but ultimately undergoes pressure atrophy from the continued growth of the diverticulum. The end result, in most cases is a diverticulum of the false type, lacking the muscular coat. Beyond it extends and fills an appendix epiploica.

Pathology.

The pathologic change is a process of chronic inflammation progressing both in the wall of the bowel and in the mesentery itself, producing symptoms of inflammation and obstruction according to the amount of encroachment on the lumen from the inflammation, perisigmoiditis, and mesenteritis. This gives rise to the deposit within the bowel wall and surrounding tissue of large masses of fibrous tissue. After some time this may give rise to a large, hard, sausage-shaped tumor, the bulk and contracting scar tissue of which produces gross stricturing and narrowing of the gut for some inches; this tumor resembles a carcinoma.

Perforation of the diverticulum may produce local abscess or fistula, external or internal. Formation of abscess, with localized peritonitis is the commonest complication of this disease.

The diverticular mass becomes adherent to surrounding structures and lying on the left side of the pelvis it is especially liable to become adherent to the bladder. When this occurs the spread of inflammation and the onset of ulceration not infrequently will give rise to a vesico-intestinal fistula.

Diverticulitis with Carcinoma: Rankin, Borgen, and Buie conclude that the association of these lesions are uncommon. From a study of 227 cases of diverticulitis, co-existing carcinoma was found only in four cases and during the course of operation for carcinoma of the bowel in 679 cases, diverticulitis was only present in four.

Clinical Features.

The clinical features of this condition are fairly definite: (a) In the Acute condition they almost exactly resemble those of appendicitis on the left side as e.g., pain, localized tenderness and rigidity, increased temperature and pulse, leucocytosis, etc. (b) In the chronic type the symptoms very closely simulate those of carcinoma of the pelvic colon. There is thus increasing constipation and the onset of griping pains and the abdominal distension in a stout, middle aged patient. After a long period the condition may terminate in acute obstruction.

On examination a hard, tender, sausage-shaped mass may be felt in the left iliac fossa or on rectal examination lying in the pouch of Douglas. Rankin, Barga, and Buie state that tumefaction was noted in 30% of their cases. Blood is as a rule not found in the stool.

Many cases may be symptomless, except for repeated attacks of pain and fever.

According to many writers, the clinical history is vague and indefinite in diverticulosis of the small bowel. A review of various case reports, however, shows that the symptoms, particularly of the jejunal type; in the presence of inflammation, resembles those of peptic ulcer. In the absence of inflammation the history is vague and indefinite, and the finding of the diverticulum is accidental.

Diagnosis.

Roentgenologic examination is the principal procedure for establishing the diagnosis in these cases through a Barium Enema or a Gastro-Intestinal series. The Barium Enema is the more important aid in diagnosis.

Proctoscopic examination is of relatively little value except when the lesion is very low.

Roentgen Features:—In diverticulosis of the multiple type rounded areas of density varying in size from a pea to a five cent piece are observed throughout the abdomen. They are manifested as knob-like projections from the lumen. Less frequently, diverticula occur singly the pouch varying in size from a five cent piece to that of a plum. Stasis may be present from 24 to 48 hours.

The degree of retention in the diverticula should be determined by examinations at intervals, as stagnation increases the possibility of infection. Diminished mobility and localized tenderness over the region of the pouches on Roentgenoscopic palpation is significant of the presence of inflammatory changes within and around the diverticula, causing a diverticulitis.

Diverticulitis is encountered practically only in the region of the sigmoid. The filling defects produced by this disease is the result both of spasm, which may be so marked as to produce complete occlusion of the lumen, and of the encroachment of the pericolic inflammatory tissue on the lumen of the bowel. It is usually possible to visualize diverticula in the more proximal uninvolved segments, as rounded knob-like projections from the lumen of the colon. Differential diagnostic points from carcinoma are the concentric serrated contours of the affected segment contrasted with the sharply irregular and eccentric contours of carcinoma; the maintenance of flexibility in the former compared with the stark rigidity in the latter, and the long segment involved with diverticulitis as opposed to the relatively short segment which carcinoma usually occupies.

Treatment.

The treatment of diverticulitis is chiefly medical, although when complications arise surgical intervention should be considered.

Rest in bed: As rest of a diseased part is obvious in treating inflammation, the most satisfactory method of obtaining as much rest of the colon as possible is by keeping the patient in bed. The period of rest must be adequate in order to permit complete resolution of the chronic process.

Ice bag to abdomen.

Residue-Free diet, increasing the diet gradually as the process subsides, but the patient should be instructed as to the avoidance of foreign or unnatural substances, as e.g., bran, whole wheat foods, popcorn, and coarse berries such as blackberries or raspberries.

Brown and Logan question the wisdom of giving hot rectal irrigations usually prescribed. The mechanical distension associated with the irrigation may be more harmful than helpful, despite the value of heat and cleansing. They prefer the low, warm (112 F) saline, rectal enema.

Mineral oil may be given several times daily. Some writers have objected to mineral oil because in many cases it leaks through or makes pellet-like stools which are annoying to the patient.

Brown and Logan in a recent review of the treatment of diverticulitis, have suggested returning to the old remedy, olive oil, which tends towards a soft type of fecal mass. They also recommend the retention enemas of olive oil, providing minimal exertion is involved in having the patient assume the knee-chest position.

Tinctura Belladonna may be given to relax the intestinal spasm, but its value is questionable.

Surgical treatment is imperative for the complications of diverticulitis. The surgical risk is increased by reason of extensive inflammation and the operative procedure may be a long and drawn out affair; hence it is desirable to obviate the need of surgical treatment if possible.

The following two cases of diverticulitis are reported: first, to illustrate the features of this disease, a comparatively uncommon clinical condition; second, to draw attention to a definite clinical entity that should be more frequently considered in the diagnosis of abdominal conditions of a complex nature, if the diagnosis is to be formulated correctly in more cases which at times may save an unnecessary laparotomy.

Case Reports.

Case 1. History: A fifty-two year old housewife was admitted to the Hospital. For two days prior to admission the patient complained of pain in the left lower quadrant, constipation, nausea and vomiting. The pain was sharp in character, and radiated to the back and was constant. It was somewhat relieved by hot water bottles. The patient stated that she had had several similar attacks lasting for two to three days during the past year.

Examination on admission:—Temp. 102. Pulse 90.

Eyes:—pupils equal and regular, reacted to light and accommodation.

Ears, nose and throat:—Negative.

Chest:—Configuration was normal. Retromanubrial dulness normal. Percussion note was resonant. Breathing was vesicular. No rales audible.

Cardio-Vascular System:—Blood Pressure 170/90, Pulse was increased, of good quality, No obvious sclerosis. The heart was not enlarged to percussion. Sounds were regular and of good quality. No murmurs.

Abdomen:—The abdomen was not distended and moved freely on respiration. There was an indefinite mass, about the size of an orange in the left lower quadrant. It was not movable and yielded a dull note to percussion. The mass was tender to palpation. There was rigidity of the left rectus muscle. Liver and spleen were not palpable.

Vaginal examination:—The cervix was normal in appearance and position. The uterus was anteverted and anteflexed, and not enlarged. In the left fornix was felt a mass tender to palpation.

Reflexes:—Normal.

Urine examination:—Negative.

Blood examination showed:—hemoglobin, 80%; red blood cells, 4,320,000; white blood cells, 18,000; polymorphonuclear neutrophils, 75%; lymphocytes, 25%.

A tentative diagnosis was made of Ovarian Cyst with a twisted pedicle. After consultation it was decided to perform an Exploratory Laparotomy. Operation revealed a sausage-shaped, inflammatory mass which extended from the sigmoid downwards and was adherent to the surrounding structures. There were noted several flask-like processes extending from this mass which resembled diverticula. It was felt that resection was not indicated on account of the patient's condition.

The patient made an uneventful recovery. She was treated medically with a low residue diet, olive oil, retention enemas, low rectal enemas, etc. The patient was in bed for over five weeks and disappearance of the abdominal mass was noted.

Several days before discharge the patient was examined by means of a Barium Enema.

Report of examination of Barium Enema:—A filling defect was noted in the distal half of the sigmoid both fluoroscopically and on the films. The contours of the filling defect were serrated in character. There was no obstruction to the passage of the Barium. Many diverticula were noted in the sigmoid and descending colon. There was no tenderness to palpation.

Case 2. History:—A 56 year old steelworker was admitted to the Hospital. He stated that one day before admission he was seized with an attack of abdominal pain in the left lower quadrant, accompanied by nausea but no vomiting. The pain was sharp and boring in character and lasted for several hours. An enema was effectual and relieved the pain.

The patient claims that for the past year he had been complaining of increasing constipation and griping pains in the abdomen which gradually were becoming more severe. He had never noticed any blood or mucus in the stool or tarry stool. His appetite was good. There was no loss of weight or weakness.

Past History:—Bronchial Asthma for several years.

Physical examination:—

Eyes: Pupils:—round, regular, equal, and react to light and accommodation.

Ears and nose:—Negative.

Mouth:—Mucous membranes are well colored. Teeth are in poor condition.

Pharynx:—Negative. Tonsils are present and show no evidence of infection.

Lymphatics:—Negative.

Chest:—The chest was emphysematous in character and moved freely on respiration. The percussion note was hyper-resonant. Tactile and vocal fremitus equal. Breathing vesicular. No rales were heard.

Cardio-Vascular System:—Blood pressure 150/80. The pulse was regular in rate and rhythm. Moderate volume and tension. Artery wall not palp-

able. Heart sounds regular in rate and rhythm and of good quality. No murmurs.

Abdomen:—The abdomen was obese and moved freely on respiration. There was tenderness in the left lower quadrant. No masses were palpable. No rigidity. Liver and spleen not palpable.

Rectal:—Negative.

Genito-Urinary System:—Negative.

Reflexes:—Negative.

Urine examination:—Negative.

A blood examination showed: hemoglobin, 85%; red blood cells, 4,000,995; white blood cells, 10,950; polymorphonuclear neutrophiles, 68%; large lymphocytes, 10%; small lymphocytes, 13%; monocytes, 5%; eosinophiles, 3%; basophiles, 1%.

Stool examination:—Negative.

A diagnosis was made of Diverticulitis and a Barium Enema was performed.

Report of Barium Enema:—There was no obstruction to the flow of barium. The barium filled the entire colon from the rectum to the cecum. An irregular filling defect was noted in the entire sigmoid fluoroscopically; there was flexibility of the affected segment and tenderness on palpation. This filling defect was demonstrated on the roentgen plates. The edges of the filling defect were concentric and serrated with numerous diverticula. Several diverticula were seen in the distal portion of the descending colon.

This patient was also treated medically with bed rest, olive oil orally, olive oil retention enemas, irrigations, low residue diets, etc. There was a complete amelioration of symptoms.

Follow up:—Both patients on discharge were instructed in detail as to diet and care of bowels. It is interesting to note that both patients have been free from attacks for several months.

Summary.

- (1) Two cases of Diverticulitis are reported.
- (2) The various aspects of the disease are discussed briefly.
- (3) Roentgenologic examination holds first place amongst diagnostic procedures in the establishment of an accurate diagnosis of this disease.

Dystrophia Adiposo Genitalis

B. C. ARCHIBALD, M. D.

FROHLICH'S Syndrome or Dystrophia adiposo genitalis is a symptom complex of deficient activity of both the thyroid and adrenals as a result of destructive or inhibitive disease of the pituitary body or of its efferent channels. Signs or symptoms are namely, headache, hemianopsia, vertigo, vomiting, anomalies of taste, tinnitus aurium, loss of memory, melancholic tendencies, polydipsia, polyuria, excessive sweating, which, in progressive cases, are due to pressure by the diseased pituitary body, etc. The phenomena denoting thyroid insufficiency are often very clearly defined. Thus, besides the obesity, which may be very marked, the tissues may become myxedematous, hard and tense to touch, infantilism is a prominent feature in most young subjects, and the rheumatoid pains of hypothyroidism are not infrequent. The menstruation is irregular or inhibited though metrorrhagia is sometimes witnessed. The intelligence is dulled and mental disturbances are frequently noted. The patients are potbellied and moon faced. The symptoms of insufficiency of the adrenals are no less prominent. We have seen that excessive activity of these organs gives rise to premature development of genital organs and excessive growth of hair. In the deficiency of the adrenal activity which occurs in Frohlich's disease we have opposite conditions. The genital organs remain infantile while there is absence of hair in the pudendal and axillary regions.

Cases developed after puberty show hypothermia and progressive loss of hair and sexual characteristics, besides the symptoms of hypothyroidia enumerated. The lesion need not be located in the pituitary itself but anywhere along the path of fibres it sends via its infundibulum, basal tissues, bulb, etc. and the sympathetic or autonomic system to thyroid and adrenals. This explains why tumors located almost anywhere in the base of the brain may cause the disease.

Case History.

Patient admitted to hospital on various occasions since 1928 with numerous complaints, namely, hemicrania, hemianopsia, vertigo, vomiting, anomalies of taste, tinnitus aurium, loss of memory, melancholic tendencies, polydipsia, polyuria, excessive weight, rheumatoid pains in different regions, amenorrhoea, mal development of the external genitalia, absence of pubic and axillary hair.

Family History.

- Mother died from acute alcoholism.
- Father killed overseas.
- One sister died from a cerebral condition.
- Eleven brothers died in infancy.
- One sister living and healthy.

Previous History.

Patient had syphilis four years previous to admittance to hospital. Received intensive treatment, 606 Mercury and Bismuth, the Kahn test remaining positive + + at the time of admittance in 1928.

History of Present Condition.

When seen by me in 1928 the patient complained of severe attacks of pain in lower right abdominal quadrant accompanied by vomiting. Patient had never menstruated but seemingly passed blood per rectum at periodic intervals at which time her breasts swelled and become very tender. Appendectomy was performed, the appendix, full of concretions, was bound down by adhesions and kinked in the middle portion. Ovaries and uterus seemed infantile in size. She made an uneventful recovery with exception of a slight infection in incision which cleared up in due course. A Kahn test was + in June 1929 followed by spasmodic arsenical and pot. iodide treatment Myalgic complaints were becoming more numerous and as there was considerable pyorrhea present all her teeth were extracted in the hope that the myalgia would clear up. Tonsils were also septic. She was advised to have them enucleated but refused operation.

March 1931. The patient was seized with severe attack of pain in right lumbar region accompanied by scanty and bloody urine simulating renal colic. Cystoscopic examination was made of the kidney at this time. Nothing abnormal could be found and her condition cleared up after several week's time. In June 1931, the patient drank creoline trying to commit suicide but was not successful. Later on patient suffered from attack or pain in the gall bladder region radiating through to the back between the scapulae. X-Ray examination was undertaken to visualize the gall bladder. Nothing abnormal could be seen. A Kahn test became negative at this time and she developed varicosity of the right leg which was treated with urea and quinine hydrochloride injections. As it was thought her condition was of glandular origin, she was given gland treatment with very little result. She was also given Theelin, Thyro Ovarian (P. D. & C.) Hormotone, and other glandular products. The attacks of rheumatoid pain were becoming more severe and frequent. Her weight also was increasing to enormous proportions. There also developed a slight incisional hernia which bothered her somewhat at times. In October, 1934, she was sent to the Victoria General Hospital in Halifax with my provisional diagnosis of dystrophia adiposo genitalis. This diagnosis was corroborated by Dr. Atlee.

Examination.

The patient is an obese negress; thirty-five years of age. Married. Lateral rectus incision scar with small hernia visible. Tender areas under right costal margin and over the recti muscles. Also tenderness in the lumbar region on movement. Absence of the pubic and axillary hair, breasts small, external genitalia infantile. Respiratory system is negative; circulation system, negative; digestive system, negative; central nervous system, negative; blood pressure and blood picture both normal.

Differential Diagnosis.**Acromegaly**

Headache.
 Face egg shaped.
 Jaw bone increased in size.
 Hands and feet increased in size.
 Eye lids, nose, ears and tongue increased giving leathery speech.
 Increase of hair, moist skin and spine kyphotic anemia.

Myxedema

Headache.
 Face broadened.
 Cheeks flushed.
 Hand and feet increased in size.
 Lips thick.
 Leathery speech.
 Decrease of hair.
 Skin dry. Anemia.

Addison's

Muscular and vascular asthenia.
 Pigmentation of the skin.
 Gastro intestinal symptoms.
 Anemia and low blood pressure.

Treatment.

Thyroid gland extract, Theelin.
 Hormotone, Thyro Ovarian.
 Prognon.
 Reducing weight.
 Pituitary gland is ineffectual.
 Thyroid gland extract.

Historical Section

REMINISCENCES

Sydney, N. S., March 16, 1936.

A. S. KENDALL.

MR. PRESIDENT, the Members of the Cape Breton Medical Society have requested me to convey their congratulations and very best wishes to the members of the Senior Society of the Province now celebrating your Seventy-fifth birthday. Both Societies are animated with the same intent—to keep the ethical standard of the medical profession above reproach and to maintain connection with scientific and clinical centres in order that our practice may be in the front line of progress.

Our Society celebrated its Fiftieth birthday two years ago, so the older Society was Twenty-three years old when the younger was established at Sydney in 1876. The names of the first members of our Society were:

Dr. Lewis Johnstone, father of Dr. E. J. Johnstone, and Dr. Lewis Johnstone, M.P., and the son of Honourable Justice Johnstone, the formidable opponent of Joseph Howe.)

Dr. Duncan McLarty, Sydney Mines.

Dr. Millage Oakes, Sydney.

Dr. A. D. McGillivray, Sydney.

Dr. H. B. McPherson, North Sydney.

Dr. William McKay, Reserve Mines.

Dr. McKeen, Baddeck. (He walked over the frozen Bras d'Or Lake ice on snowshoes to get to the first meeting.)

Dr. Marcus Dodd, Bridgeport and Lingan.

Dr. William McKay McLeod, Ex. M.P., Sydney.

Dr. McKay was at one time leader of the Conservative opposition in Halifax and was later elevated to the Canadian Senate. In the Assembly of 1887-1890 Dr. McKay cooperated with Dr. Farrel in constructing or recasting our Provincial Health Act, since amended in accord with recent advances.

This occasion being a historical incident, the writer has ventured to describe some incidents and conditions of his observation during the last sixty-one years, a recital of which may make some of us feel very old and others stand aghast at the Egyptian darkness of half a century ago and wonder why the discoveries of Pasteur and the discoveries and proclamation of Lister did not immediately revolutionize Surgery and Preventive medicine.

In the summer of 1867, the writer then six years old, received a great cut on the front outer aspect of the leg from the swipe of a scythe. A young Doctor fresh from Harvard, Dr. Lewis, later of Dartmouth, whom some present remember with affectionate regard, gave chloroform and stitched the big flap back to its site. The wound suppurated, the flap 'mortified,' and the battle against "proud flesh" began. All dressings failed, including poul-

tices of bread and milk, and the sun cure was tried. On hot days when parents were satisfied that the wound would not suffer from cold, the patient was wheeled to the garden and the wound exposed. The family dog took a kindly interest and wanted to lick the sore. The Doctor encouraged the dog and for several days he gave his services with appetite for his job, but the wound did not make headway though the pus was said to be of the good variety. (Gentlemen, young gentlemen, I have seen gallons of "laudable pus", have notes taken of lectures of a great Surgeon in 1884 describing the characters of good, sweet, creamy, laudable, pus that accompanied constructive granulation, and the thin, sanious, sour, article that noted caseation). A change of air was advised, and the patient was moved to Mira, twelve miles from Sydney, where he was to enjoy the advantage of the oversight of two loveable old persons, brother and sister, noted for their "skill". Their consultation ended in a difference of opinion. One was determined on a turnip poultice, the other insisted that carrot poultice was the quicker cure for a cut from a scythe. Both were tried and both failed. The last resort was a cow dung poultice. This was applied for several days and nights. Eventually the wound healed aided by hot vinegar dressings. The part that apples, fresh milk, cream and Cape Breton Oatmeal played in turning the tide after six weeks ebb was not recognized. In the early stage borax, alum and white sugar had been used in vain.

In 1867 Lister proclaimed to the profession at large for the first time his confidence in the value of his practices, and his discoveries based on the discoveries of Pasteur.

In March, 1863, be it noted, Pasteur after conversation with Louis Napoleon, the third, remarked, "I assured the Emperor that all my ambition was to arrive at the knowledge of the causes of putrid and contagious diseases".

Just here let it be noted that in 1870 when the Franco-Prussian war broke out, a young assistant French Army Surgeon who had just witnessed and studied Lister's procedure, ordered several casks of carbolic acid for the Field Hospital in which he was not the Chief. His superior officer ordered the stuff sent back. As late as 1885 the writer saw the Surgeon of a French Admiral's flagship open a pateller bursal abscess with the actual cautery knife. This surgeon bore a decoration for distinguished service. Opposition to Lister was bound to continue down to 1887, or until advanced age or death of opponents removed criticism.

Let me note conditions at the Halifax Medical College in 1879 to 1881, at Bellevue, New York in 1882, and at Guy's Hospital, London, in 1882 to 1884.

At Halifax, Anatomy was the strongest feature. Dr. Sinclair was a lecturer of exceptional effectiveness. Dr. D. A. Campbell and Dr. Lindsay, the latter recently returned from Edinburgh, were at that date establishing a reputation as demonstrators of Anatomy. This work was infinitely more thorough than at Bellevue, New York, in 1881 and 1882. At Bellevue, Dr. Joseph Bryant, was a very great teacher as lecturer to a class of seven or eight hundred students. But the dissecting room work was weak compared with that in the little school at Halifax, while compared with the practical teaching of Anatomy at Guy's it was in a deplorable state of backwardness. Dr. F. S. Dennis, a young London graduate had just begun to jack up the teaching of Anatomy and modern Surgery, and his friend and companion Dr. W. H.

Walsh, just back from London and Continental schools, opened in a new way to American students the study of pathological Anatomy.

The microscope was not used in teaching in Halifax or Bellevue and had only been introduced at Guy's about 1880.

All know that Lister acknowledged his debt to Pasteur. Many do not know that had it not been for Lister's father, J. J. Lister, there might have been no one with the reputation of Pasteur. Lister, the father, away back in 1830 had contributed knowledge which led to a great increase of power in the microscope. Without this increased power, Pasteur and some of his fore-runners would not have made their discoveries.

It is flattering to ourselves to note that the opposition to Lister, which, in 1879 and much later, was vehement in London, (the attitude in New York may be described as that of cynical curiosity), was not existent in Halifax. On the contrary the three operating surgeons Farrell, John Black and Lawson were following Lister as closely as the local limitations permitted with results most gratifying to themselves and onlookers. The old time men Parker, Jennings and Black, Senior, looked on, not with cynicism or hostility as prevailed the world over—with, of course, outstanding exceptions. These old surgeons were amazed, gratified, and satisfied, that the Listerian procedure was a valued contribution. The writer remembers Dr. Farrell's first outstanding successes were in several excisions of the knee joint for caseating tubercular disease. Dr. John Stewart, was at this time also at work in Pictou. This statement will not be challenged that of all men in America at that time, he was the best qualified to demonstrate Listerism.

In New York in 81-82, ditactic teaching was of high order, clinical teaching very, very scant.

Thousands graduated (M.D.) without having attended a single case of midwifery; thousands graduated with scarcely an idea of hospital ward work, many had never been inside a ward, many had never examined urine by chemicals or microscopes.

In London the reverse prevailed. Ditactic lectures continued and a percentage of attendance was obligatory. The great work was in the dissecting room, dead house, laboratories, museums, wards, operating theatre and outpatient departments. There was a surfeit of clinical material including obstetric work all the time. The different hospitals contended against each other to secure the highest percentages of "passes", before the examination boards. The examinations at the College of Surgeons were mostly practical.

One subject was tabooed as late as 1884, how much later the writer does not know. That subject was Lister and antiseptic surgery; not a question was put on the treatment of wounds. At one of the several tables of examiners—Viva-Voce—sat Sir Wm. Savory, Bart., surgeon in ordinary to Queen Victoria; he a vehement opponent of Lister and his methods, alongside Sir Wm. sat Mr. John Lund, of Birmingham, one of Lister's first disciples whose word was of great authority throughout the surgical world. The only way to prevent a storm was to let the students through without ascertaining what they did or did not know about treating wounds. Fortunately then and for several years previously, the clinical teaching was mostly in charge of the younger surgeons who were uncompromising proclaimers of the undoubted value of antiseptic methods. Space does not allow me to describe some interesting clashes between the new and old orders. Hostilities did not cease until 1890

or perhaps later, when not conviction but death brought the principals to their finish.

And what have we of the older generations seen in Nova Scotia?

In 1884 there was only one Hospital in Nova Scotia, the Victoria General, then only half its present size and there were no trained nurses. The hospital beds now number 1480 and are occupied up to 60 per cent capacity. Imagine no Infirmary, no Children's Hospital, no Lying-in Hospitals except the horrible "poor houses" in Halifax, and a few large centres such as Pictou and Cape Breton. Imagine the sudden closing of all the Hospitals from Yarmouth to Glace Bay save the Halifax Victoria General, and from Springhill to Halifax, and the loss of all our splendid associates, the trained nurses. Imagine Diphtheria taking its old time toll unchecked by antitoxin, where in some districts every second young mother was weeping for her children and could not be comforted.

In 1887, the writer lost every one of a family of six children within a week. By 1902 the parents had raised another family of three. Diphtheria struck them again, killed the first but the other two were saved by antitoxin.

In the autumn of 1894, Roux demonstrated antitoxin value before his beloved Master, a few months before Pasteur passed over.

In Sydney Dr. McGillivray and the writer stocked up without delay and waited our turn which came on April 30th, 1895. A young woman had a sore throat, was sick but gave her husband and children their dinner. At two o'clock she choked to death. Dr. McGillivray was called, found she had died of Laryngeal Diphtheria and found several children in this and the next door family sick with Diphtheria. In all 18 persons had been exposed. Between us we had 14 doses. Each patient with the disease got the full dose. The rest was given in divided doses to others who had been in close contact. In twenty-four hours our satisfaction was supreme. The accounts in medical papers of three preceding months were confirmed in our experience. Since then only in two cases have I known two children die in the same family, and in these two cases there was unavoidable delay in getting antitoxin. And now we are beginning the use of toxoid.

Just two years ago in 1926 in Cape Breton County we began the use of antiscarlatinal serum. In several hundred cases there was only one failure. No untoward effects have come to the writer's notice.

During the Autumn of 1928 Doctor McKeigan of Dominion No. 6, Glace Bay and the writer and Miss Kerr, County Nurse, administered Diphtheria Toxoid to 337 school pupils. In all about 800 hypodermic injections were made. Not one of the children under 12 years suffered anything worth noting. Several 13 to 18 years old, experienced distinct reactions, some severe. Most of them about equal in severity to the onslaught of measles.

That nearly all the youngsters first inoculated came back as to a frolic for their second and third doses shows how little disturbance resulted from their first and second contacts.

Epidemics of Puerpural Fever have disappeared. In the 70's of last century there was an epidemic in Cape Breton of awful consequence. Its contagious nature was not recognized. The disease was supposed to travel 'in the air.' In my time there have been two appearances of Puerpural Fever when four and eight women died,—the source in each was virulent Erysipelas. Its sporadic appearance is still too common. In short, in 50 years we have seen Diphtheria, Scarletina, Typhoid and Puerpural Fever, "Hospi-

talism," reduced in frequency and mortality, in some instances next to banished.

Myxoedema and other manifestations of gland disturbance can be recognized and modified in their course. Knowledge in regard to lesions due in first place to Pyorrhoea of gums is bringing relief and prolongation of life to multitudes. So is the knowledge that only reached us a few years ago in regard to the value of food-stuffs such as, liver, cod-liver oil, yeast and raw fruits and vegetables.

Cancer still marches on with all the horrible sequelae. We seldom see as formerly we saw families wholly or in large part wiped out by consumption of the lungs; but general results of treatment of other manifestations of tuberculosis are far from satisfactory. We appear to be awaiting a death-dealing cyclone to arouse our urbane population to a sense of their danger from typhoid, T.B., and Diphtheria, which lurks in their supplies of water and milk.

NOTES FROM GLACE BAY

J. F. BATES, M.D.

THE Town of Glace Bay has two standardized hospitals with a total capacity of two hundred beds. These hospitals serve the surrounding districts of Reserve Mines, Port Morien, and Dominion, as well as the town of Glace Bay; the combined population being in the vicinity of thirty-five thousand. These institutions contain all the latest and best in hospital equipment, are self-supporting, free from debt, and are supported mainly by a weekly payment from the miners. This weekly fee provides not only for hospital treatment to the miner himself but also to all the members of his family. The doctor is paid under the same system and the service includes medical and surgical treatment as well as drugs, etc. This system has been in operation very many years and has proved its merit to all parties concerned. During the year 1935, there were 6,937 admissions to the hospitals. Surgical operations numbered 1,417, of which 480 were major.

Both hospitals maintain training schools for nurses, a system we think too universally prevalent in this province as well as in other parts. It is a system no doubt very beneficial to the hospitals from the point of view of economy, but we cannot help opine that a system which permits a better class of young women with good educational qualifications to give three or four years of their lives to hard work and study in return for a very meagre recompense, and a diploma which entitles them to join a host of unemployed graduate nurses, is nothing but a highly specilized form of exploitation that should not be permitted.

Our hospitals have not availed themselves of the offer of the Provincial Government to erect annexes for care of tubercular patients. The medical men here believe that this work should be done in a central institution. We feel in the light of present day knowledge that the tubercular patient should be under continual and direct supervision of a staff specially trained in this phase of medicine. In spite of the anti-tuberculosis campaign of the last ten years, tuberculosis is yet all too prevalent. The Provincial Government has recently carried out a very extensive survey in this district. Findings have not yet been published, but we await the result with a great deal of interest.

Our hospitals each maintain a maternity department. In 1935 there were 658 births in the two institutions. This number is but a modest percentage of the total number of births in this prolific district, from which may be gathered that the practice of obstetrics is a major part in the routine of the colliery doctor. While on the subject of obstetrics, we beg to offer a few observations. We have noted in the last four or five years that considerable prominence has been given to the use of various forms of anaesthesia and analgesia at child-birth. In fact, it is not uncommon to see articles in popular magazines and periodicals written by laymen on this subject, which emphasizes the fact that a wave of this sort of propagand a has swept the country. The general practitioner almost feels that unless he employs some sort of rectal, intervenus or intermuscular anaesthesia, he is not taking advantage of the things which would at least classify him as humane. Recent discoveries and research have brought to light some valuable and excellent aids along this line, and they are untold blessings under certain circumstances, but we feel that there has been created a tendency for their indiscriminate use. It is likely to bring about an unnecessary fear of child-birth, and throw an additional responsibility on the attending physician and create the feeling that child-birth is all the business of the doctor, with the patient a passive agent. We still consider that "the mother of to-day is as fully equipped mentally and physically to undergo the hardship of labor as was the mother of yesterday", and try not to "belabor the expectant mother with heavy artillery where diplomacy will serve better". In this family doctor type of practice, our experience even with prinniparie is that with Reassurance at onset of labor, Patience during labor, with occasional use of hypodermic of morphia, chloroform or ether anaesthesia at the end of the second stage, the major requirements are fulfilled.

In this area, we have seven large collieries which employ about six thousand men. Coal mining is still a hazardous occupation, despite the active and intensive safety first methods and propagand a. Last year, fractures alone to the number of one hundred and fifty were admitted to our institutions, fifteen of which were compound. The majority of these were industrial and are usually accompanied by marked contusion and laceration. It is our experience that the majority can be treated without too great an array of mechanical gadgets, and with the advent of Kirchner wire, appliances even in most severe cases are reduced to a minimum. The comfort of the patient and the function of the neighboring joints is better assured by simple, practical splints. Early active movement is always insisted upon. It is interesting to note that in the coal mine even the badly lacerated wounds very rarely become infected.

We appreciate and read with great interest the Nova Scotia MEDICAL BULLETIN. It is hardly necessary to emphasize that the general practitioner looks upon the Medical Journals and Periodicals to which he subscribes not as a medium of pasttime but fundamentally as a source of aid in the many problems that confront him in his routine work. And, after all, the general practitioners comprise the bulwark of the medical profession. We feel that there is a tendency in the majority of the Medical Journals to give too much prominence to the highly specialized items, to feature the remote, the peculiar, or what you will. In any one issue, too many articles tending to biochemistry, biology, etc., and long tables of labratory findings and observations tend to foster a lack of interest on the part of the general practitioner. In a word, we sometimes feel that too much space is allotted to those engaged purely in

scientific research. That this work is highly important and essential, we agree, but there should not be undue emphasis to a point of unbalance. At least, they should be presented in such a way as to be complementary to the major subject; the human being, the patient, for whom the medical profession exists.

In the Nova Scotia MEDICAL BULLETIN we have a place—a forum—for correspondence from members of the profession on subjects that concern the profession. We hope that interest in this phase of your work can be further stimulated. It is not only useful but very refreshing. We think a good, level, commonplace tone is maintained with topics of the general rather than the particular type. Let us hope the endeavor can be increased without altering the tone. Let's not go Hollywood.

REMINISCENCES OF AN OLD-TIME PRACTICE AND PRACTITIONER

A. W. MILLER, M.D., C.M.

New Waterford, N. S.

ON January 13, 1906, I harnessed old Dobbin to my riding sleigh, already loaded with two large bags of medicine and left my quiet and peaceful office in Margaree for parts, to me, unknown.

I say quiet and peaceful office advisedly, for there was not enough money taken in to purchase flour for my flap jacks and tobacco for my pipe.

I had heard that in the northern part of Cape Breton there was considerable need for a doctor.

Proceeded as far as Baddeck the first day. While there I met Mr. McLeod, Councillor for one of the districts to which I was heading. He was attending the Municipal Council then in session at Baddeck. Next morning I started out on my long trek of over one hundred miles. Arriving at English-town I thought it an act of courtesy as well as diplomacy to call on the late J. G. Morrison, then local member for Victoria.

While there Mr. McLeod telephoned from Baddeck inquiring if Mr. Morrison knew whether I had gone by or not. It seems that Mr. McLeod had received a telegraphic message from South Harbour asking him to send a doctor as soon as possible. Knowing that I was on my way North, he asked me if I would attend to the call. I agreed, and advised Mr. McLeod to wire them to have a team meet me at North Bay.

My first problem was to get across the ferry at Englishtown. The day was stormy and the ferryman did not feel inclined to risk the crossing. Telling him I was a doctor and on a sick call, he changed his mind. Calling his son to his assistance, he soon had myself, my horse and sleigh, safely landed on the other side. I made him accept twice the amount of the fare. Later I was informed that a glass of whiskey was a passport to his good will. So next time I came to his ferry I was armed with a flask of whiskey. Gave him one drink before starting. On landing and paying the fare, asked him if he would have another "Smile". Passing back the flask after helping himself, he exclaimed: "Dr. M. you may come here in the day or in the night, in storm or in sunshine, and all you'll have to do is to let me know and I will do the

rest". I passed over the flask to him as a reward for his good will. And he was as good as his word. On several occasions later I came to his ferry and he was always most kind and considerate.

Leaving him, I kept plodding along the road on the North Shore and arrived at the foot of Smokey in a downpour of rain, just at dark. Smokey at that time was a name to make the bravest shudder. Knowing that the horse's eyesight was better than mine, I remained seated in the sleigh and allowed the horse to navigate the hill as best he could.

Well, about 8 p.m. I arrived at South Ingonish and called upon a firm friend of mine—Father LeBlanc. After partaking of a hearty supper, I drove to North Bay to the place I was supposed to meet the messenger. None had arrived. Waited two hours and then concluded the patient had died and no messenger would come. Returned to Father LeBlanc's. Next morning, however, about 11 a.m. the messenger arrived. He had an ordinary wood sleigh. No wraps of any kind. Tied my bags to the stakes of the sleigh and seating myself on a beam, we got under way. We had not proceeded much over a couple of miles when the old horse became dead lame. He was twenty-eight years old. The driver informed me that if we could get two or three miles farther, we might be able to hire a horse. None were available. The best I could do was to send back to South Bay for my own horse. It was 5 p.m. before we got started from North Bay. It had rained considerably the night before and froze just sufficient to bear up a horse, if he walked, but at the least attempt at a trot, down he would go. Well, we walked the horse for ten miles over the mountain till we finally came to the Half Way House kept by a Mr. McPherson. Ordered supper for ourselves and a feed for the horse. While supper was being prepared, Mr. McPherson found out I was a doctor and might probably remain in the North for a time. Asking for the bill, he refused to render any. I protested. But he said, "There are two classes of people from whom I will not accept money—clergymen and doctors. We find it hard enough to get them here, and the least we can do when we have them is to treat them decently so that they may stay for a while with us". And on many occasions afterwards, I had meals for myself and feed for the horse and never would he accept a cent of payment. He was one of Nature's Noblemen.

Continuing our journey, we arrived at our destination at 3 a.m. and found the woman unconscious and practically moribund from Puerpural Septicaemia. Could do nothing for her. There was no barn available to shelter my horse, but at last a fish house was found into which he was forced and a neighbor kindly brought him an armful of hay. There was no bed in the house except the one on which the dying woman was lying. Wrapping myself in my overcoat, I laid down on the floor, by the stove, and was soon sleeping soundly. And what remuneration did I receive for all this hardship? Believe it or not, not one black cent.

Next day, drove to Neil's Harbor and was soon located in a house and office, previously used by my predecessor, Dr. Cochrane.

Had many experiences, some serious, some amusing, during my two and one-half years sojourn in this district.

One of the first was that of a man who waylaid me on the road and asked me to visit him at his house, claiming he had "something wrong with his behind". Examination disclosed that he was suffering from hemorrhoids. Gave him a box of suppositories and instructions as to their use. Did not see the man again for two weeks, when I happened to meet him on the road. "Well,

how are you getting along?" I asked. He scowled at me and replied, "Doctor you are no dom good". "Hello, what's the matter now," I replied. "Matter," he growled, "I ate every one of them dom little candles you gave me and my behind is as bad as ever".

A case of dire possibilities but absolutely necessary was called to my attention. I was called upon to attend a woman who had a three month's abortion. The foetus had been expelled but the placenta was retained and bleeding was profuse. Tried to remove it with my fingers but failed. Then in a small room, six by seven, lighted only by two panes of dirty glass, and absolutely unaided, I performed a curettage. Gave the woman chloroform and then with a blunt curette, removed the placenta and packed. Result, O.K.

Another rather serious case—I was called upon to confine a woman, but the way was long and the roads were bad. With the result that the child was born and the placenta expelled before I arrived. Entering the door a woman in attendance yelled, "Good God, Doctor, she's bleeding to death". One glance was sufficient. The blood was pouring away as from a pitcher. Without waiting even to remove my overcoat, I plunged my right hand into the uterus, and with my left hand on the fundus, vigorously kneaded the uterus. The hemorrhage stopped in ten or fifteen seconds. Gave her a douche and packed. Recounted the incident to the visiting doctors at Mayo's Clinic some years later. They were horrified at my action. At last one of them recovering from shock, asked me if I were not afraid of causing infection. I replied that owing to profuse hemorrhage infection was improbable, but that even if it did occur, I still had a chance of saving the woman's life; but none at all if the hemorrhage continued as it was a minute or two longer. They considered the matter and at last agreed that my action was not only justified but life saving. I was heartily commended, where at first I was condemned.

Was called one night to visit a woman twenty-five miles away, who was suffering from a severe pain in the stomach. After ploughing through many seemingly impassable snow-banks, I arrived at the house. The woman gave me no indication of the cause of the pain. Her stomach was distended and I could feel a crepitant tumor. Gave her chlorodyne to ease the pain. Before leaving the house, a neighbor asked me if the woman had told me about eating stones. She had not. Returning to the woman's room, I questioned her. She admitted that the day before, walking along a road, she had picked up a large number of small stones and swallowed them. One of the idiosyncrasies of pregnancy. A rather drastic purgative was my treatment with good results.

A few experiences with bichloride of mercury tablets may be interesting:

CASE NO. 1. A young man, not too bright, applied to me for treatment for an ulcer on his leg. I gave him six bichloride tablets, some ointment and dressings with instructions as to their use. Did not see the man for several weeks. On meeting him inquired how he was getting along. "Doctor," he said, "I ate every one of those tablets you gave me and all they did for me was to make me sick and vomit." A life-saving sickness, was it not?

CASE NO. 2. Called to a house to see a man suffering from an ulcerated leg. Gave him some bichloride tablets to wash the ulcer and cautioned him particularly to keep the tablets out of reach of a seven year old boy in the house. While I was still in the house, he went to the kitchen to obtain a basin of warm

water, placing one of the tablets on the kitchen table. The young boy appeared, saw the tablet and swallowed it. The alarmed yell of the father frightened every one in the house. Grabbing the boy, I forced the end of a broom-handle between his teeth and ran my finger down his throat, with the result that the tablet was expelled.

CASE NO. 3. But perhaps the most drastic treatment I ever handed out for bichloride poisoning was given to a woman. She and her husband were not getting along well and she became tired of life. One day passing her house, a man, not her husband, came rushing out calling me to come quickly as the woman had swallowed poison. Hurrying up to the house, I inquired from the woman if she had swallowed any poisoning. She denied having done so. "But, yes," the man exclaimed. "I saw her swallowing poison tablets." "Oh, the man is crazy," the woman replied. "Crazy, I'll show you," he yelled. And rushing to another room he soon appeared with a box of which traces of bichloride were plainly seen. "I saw her swallow five tablets from this box," he said. I was convinced. Had no emetic with me. Asked the man if there was any milk in the house. "Not any." Any eggs? "No, but I can get you some." "Do so quickly," I replied. In a minute or two he appeared with eggs and as luck would have it they were thoroughly rotten. Forced her to swallow two of these. And it was not long till there was profuse vomiting. Whipped up my horse to my office and soon returned with a tube of apomorphine. Gave her a hypo of this and I venture to say never before or after did she have such a cleaning out of her stomach. She never took any more poison.

How a kindly Providence watches over us puny mortals was forcibly called to my attention by a pregnant woman. She was suffering from a most exaggerated leakage of the heart. I had kept her in bed for six weeks but allowed her to get around about two weeks before the expected confinement. Hoping to be able to give her some stimulation to help her through her ordeal, I cautioned her to let me know at the first approach of labor pains. She lived only about two hundred yards from my office. Several weeks later, her husband came running to the office saying the woman had a bad labor pain. Grabbing my bag and leaving without even closing the door, I hurried to the house. But just as I was entering, another pain came and a beautiful boy was born. Placenta came away easily and no bad effects on her heart were noted.

A new treatment for diphtheria. Our Professor, the late Dr. D.A. Campbell, in treating diphtheria, cautioned us that the treatment for diphtheria was anti-toxin given early and given freely. "But," he continued, "Some of you young men may find yourself in the country where anti-toxin is not readily available. If so I would give you a tip. There is in the City of Halifax, an old practitioner, very successful in his treatment of diphtheria. And his treatment consists in getting his patient under the influence of alcohol. He reports that there is a natural antagonism between the diphtheritic germ and alcohol. It requires a large amount of alcohol to get the patient under its influence. But once under, he considers that he has the disease conquered."

I was called to South Harbor to see a patient and found his throat completely covered. An adherent membrane covered the fauces extending also over the uvula. Diphtheria. I had no anti-toxin and it would require at least two days before I could get any. I thought of Dr. Campbell's tip. Asked if there were any whiskey available. "Can get some on your order,"

he replied. "Very well, get two bottles and hang your hat on the bed-post and drink until you see two hats." Next day I was unable to see the patient, being called a long distance in the opposite direction. On the second day, however, I visited him, and found him up and feeling "unco happy." Inquired as to how he felt. "Never better in my life. Drank the two bottles of whiskey and feel fine." Examination revealed that the membrane had almost completely disappeared. I considered him well on the road to recovery. "Doctor," he said, "Was it really diphtheria I had?" "There is no doubt in my mind that it was," I replied. "Well, doctor, under similar circumstances, I would not mind having diphtheria once a week. "

Many more interesting experiences occur to me, but as I have already far surpassed my limit of space, I must perforce say, "Au Revoir."

A TREK FROM CHETICAMP TO PLEASANT BAY

L. J. LEBLANC, M.D.

AT 9 a.m., February 21st, as I was preparing to make a call some four mile south of my home, and debating with myself whether I should take a wagon or a sleigh, a phone call came from Mrs. MacIsaac, the nurse, in attendance at the Fraser home, Pleasant Bay Interval, some thirty-two miles away. All I could make out on the phone was that the little patient, a child three years of age, was running a temperature of 103°F, with considerable abdominal distention. Patient had suffered with a severe pain in the region of the 11 rib (left side) the last two days. Called the day before I had ordered a treatment but with no relief. From the description given by the nurse I feared an abdominal condition so I asked for a few words with the father, which request was granted. I told the father, over the phone, to have the nurse carry on another treatment and to call me by phone at 11 a.m.; I expected then to be at home.

At twelve (noon) I was called; the message had come before my arrival home. The father gave me to understand that the treatment had given no relief to the abdominal distention. I then said, "Call a medical man," and the answer back was, "Will you come?" I pondered for a few minutes and then decided on going, for although my home had been saddened by the tragic death of our dear baby Gerald, an inspiring message seemed to say, "Here is an only child ill thirty miles away seeking medical relief." I told my family, "I am going to try and help that child, happen what may."

Leaving with my team at 2 p.m. I travelled to Cape Rouge, seven miles north and stabled my horse at Edward LeBlanc's. Then, with a guide, at lunch and show-shoes we left Cape Rouge at 3.30 p.m. I decided to take it easy at first, for not being used to walking, I feared my poor muscles. I walked to the top of French Mountain, a distance of over two miles, a rather icy walk, and rested there waiting for my guide, who was plodding his way up the steep trail with my medical case and lunch. Before my guide arrived I decided to don the snow-shoes, and try my luck on them. Reaching Jumping Brook I waited for the guide who was trailing his way behind. I asked of him to walk faster. It was then 5.30 p.m. He, unconcerned, replied, "You must not rush yourself." Then I spurted along on my snow-shoes and reached Camp No. 1. Waiting for the guide I said to him, "We must hurry." He replied,

"I am taking it easy, so you had better keep ahead and I'll overtake you." Thinking he was sincere I kept on. At the South-Branch of the Fishing Cove River darkness had overtaken me and in making the turn (or horse-shoe curve) it was impossible to use snow-shoes. Crawling on my hands and knees for about a quarter of a mile I got to the other side. There I waited for the guide, but after half an hour's wait (I was getting cold), I called out his name a few times but the only reply was my own echo. What was I to do then? I decided to rush to the Half-way-house and I arrived there at 7 p.m. (It was some three miles from the dangerous curve at the Fishing Cove River). I sent one of the men from the Half-way-house to meet the guide. A good fire was on so I had a hot lunch. At 7.30 no guide yet. The second man had to go and meet the other two while I remained in the dark. During my anxious hour of waiting I telephoned Mrs. Aka MacLean, Pleasant Bay, and asked her to send men to meet me at MacKenzie Mountain with lights, for my flash-light was about all in. At 8.15 p.m. leaving George MacLean with my tired guide at the Half-way-house I set out with Herbert MacLean for MacKenzie River. We made good time for in an hour and thirty minutes we were at the Pleasant Bay Lookout. There we were met by Rod Fraser and Dougald Fraser, and good lights. Taking my show-shoes off I took to running down the Mountain Trail, but I accidentally twisted my left knee in a furrow. Later I accidentally fell on my stomach, which fall did not suit my poor knee. Reaching MacKenzie River Bridge, Duncan Urquhart was in waiting there for us with his team. I donned two overcoats, covered myself with rugs and the team slid away. After travelling some ten miles I reached Intervale Bridge, a quarter of a mile from the Fraser home. Duncan Urquhart said, "You will have to get off the sleigh." I did, and I was almost a frozen corpse, but I managed to crawl out, and well I did. Then the horse took a plunge, throwing the driver against the railing of the defunct bridge. I was too cold to laugh. Then I decided to crawl on my hands and knees to pass this bridge which had been carried under by the weight of snow. Reaching the home I was in order to warm myself and ask for a cup of good Scotch tea.

After warming myself I went to see my little patient. The temperature was 103°F. The distention had gone due to the treatment ordered before my leaving home, and a good bowel movement had resulted. I found after a careful examination that the child was suffering with Pleuro-pneumonia. Gave the treatment and remained at the home until 2 a.m. Then I said, "Men I am going." We then left to make that long trek. It wasn't very enticing, but I had to get back, (a thirty-two mile walk returning). Larry Fraser, Duncan MacLean and Malcolm MacLean were ready then to accompany me. At 3.30 a.m. we were at the MacKenzie River Bridge. Leaving Malcolm MacLean to take the team back we set out for the Mountain top. It was then that I felt my left knee to give way, and after a trek of some two miles I could not bend the knee. Determined to make the Half-way-house I had a hard task to keep up to my two guides though they walked slowly. I was often wishing myself at the wheel of a Ford V8. We got at the Half-way-house at 6.30 a.m. to find my old guide and George MacLean happy and a hot cup of tea ready. My guide said, "I can walk to-day." I smiled and said, "I am crippled up, so call for your dog-team," which he did. After an hour's rest my old guide and I left for the Cape Rouge Trail, while the other men left for their respective homes.

At the No. 1 Camp, I was met by the dog-team and it was time. I could hardly crawl on account of my sore knee. It was then blowing a westerly gale and snowing, which made walking heavy. Then I sat on the dog-sled and the dogs trotted along, but coming down the French Mountain it was icy and dangerous, also I suffered discomfort from my knee. I reached the Bourgeois home at 9.45 a.m. It was then snowing heavily and a westerly gale was raging. I rested myself and had a good hot lunch, prepared for me by Mrs. Bourgeois, then I telephoned for my team. Making one call on my way home, I landed at my office at twelve noon. It was then quite rough and stormy. I rested until 4 p.m. when another call was sent in, but luckily it wasn't far. At 8 p.m. having a nice sleep the telephone again gave me a call, but this time it was only news from my little patient at Pleasant Bay, reported as resting easy. The next day I was well "all-in."

This is, I think, some of the true hardships of the country practitioner, and to those who have experienced similar treks of sixty-four or more miles in less than nineteen hours, let me repeat the promise of the poet:

"He that ever following her commands
On with toil of heart and knees and hands,
Thro' the long gorge to the far light hath won
His path upward and prevailed,
Shall find the toppling crags of duty scaled
Are close upon the shining tablelands,
To which our God Himself is moon and sun."

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.

Editorial Board, Medical Society of Nova Scotia

DR. N. H. GOSSE, Halifax, N. S.
Editor-in-Chief

DR. J. R. CORSTON, Halifax, N. S.

DR. A. L. MURPHY, Halifax, N. S.

and the Secretaries of Local Societies

It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors, except those which may be expressed in this section.

VOL. XV.

APRIL, 1936.

No. 4

Failte Bhrathaireil Ann An Gaidhlig Ghasda.

THA sinn 'am barail gum beil e ro fhreagarrach failt' a chuir oirbh ann an Gaidhlig ghasda—canain a tha gle mhiosal aig moran do lighichean na dutcha, 's tha 'ga labhairt le miltean sluaigh ann an taobh-an-ear Alhainn Nuaidh agus gu h-araid' ann an Eilean Cheap Breatuinn. 'Si Ghaidhlig cainnt dhaoine mhor-inntineach agus bhlath-chridheach, ainmeil airson an dilseachd, am misneach, 's an coibhneas. Bha na lighichean riamh miosail aig na Gaidheil. 'Siomadh sgeul a thainig a nuas bho shean, ann am beul-aithris an t-sluaigh, air an euchdan 's an eolas. Anns an duthaich so fhein, 's na ciad laithean, b'ann ris na pearsachan-eaglais 's na lighichean bha'n sluagh a' coimhead airson soilleireachadh 's stiureadh ann an nithean spioradail is saoghalta—airson math is feum anna is choluinne. Gun teagamh, mar a laghdaich carrantachd 's a mheudaich droch-bheirt, thoisich luchdlagha air adhartas mor a dheanamh, ach cha do chaill sinn ar greim buileach fhathast. Tha driachd mor againn ri choimhlionadh, agus cothrom againn air seirbheis mhath a dheanamh. Tha e ri aithris gu firinneach gum beil lighichean na dutch' a' cumail an coir air cliu 's air onair bho'n t-sluaigh. Gu ma fad' a' chumas sinn e. 'Se sin teisteanas is fherr a ghabhas fhaotainn, agus dearbhadh cinnteach gu bheil ar saothair feumal is torrach.

(TRANSLATION.)

A Fraternal Greeting in Kindly Gaelic.

We are of opinion that it would be very appropriate to greet you in kindly Gaelic—a language greatly esteemed by many of the physicians of our country, and which is spoken by thousands of people in eastern Nova Scotia, and particularly in the island of Cape Breton. Gaelic is the language of a high-minded and warm-hearted people, famous for their loyalty, their courage, and their kindness. Physicians were always held in high repute among the Gael. Many a tale of their deeds and their skill has come down to us from

olden days, in the traditions of the people. In this country itself, in the early days, it was to the clergy and the physicians the people looked for light and guidance in spiritual and worldly matters—the good both of soul and body. Undoubtedly, as charity weakened and wickedness increased, the legal profession began to make great progress, but we have not entirely lost our hold yet. We have great duties to perform and an opportunity to render good service. It must be said, truly, that the physicians of our country are holding their claim to good repute and honour among the people. Long may we hold it. It is the best testimony that can be given, and a certain proof that our work is both useful and fruitful.

A Modern Alliance

To even the average lay mind the physician exists, not purely as a unit in the hustling work-a-day world, but as an outstanding personality, always more than a mere accessory in the processes of civilized society. This ordinary attitude is quite natural. From the very threshold of life, when the infant is as yet unborn, to the very threshold of eternity, when the grave invites, and all the times and seasons in between, in the daytime and in the darkness of night, the physician hovers like a ministering angel around the lifetime of mankind.

As one engaged scientifically in the preservation of health and the prolongation of life, the medical or surgical practitioner has never been a drab factor in the world, but it is only in comparatively recent years that he has been presented as a heroic and romantic figure in the world of art and literature. One is naturally reminded of that thrilling conception of an English painter, "The Doctor," which is not as often seen now as it was in the early days of last century, yet never loses its dramatic appeal. Then there is that fine story by Sinclair Lewis, "Dr. Arrowsmith," with its implications of the surgeon's sovereign duty to his patient, be he friend or foe. In the realm of the cinema there have been portrayed "Magnificent Obsession," "Louis Pasteur," and others developing the story of adventure and discovery in the field of science.

But the rarest event of all within our immediate memory is the romance of the Dionne "Quins" and the obstetrical triumph of Dr. Dafoe. This almost direct association of science, literature and art, could not possibly, it may be safely assumed, have transpired in any by gone era of which we have knowledge, although the story of medical and pseudo-medical science, from the alchemic Dr. Faustus down to the present, is crowded with incidents of abiding interest.

We often refer, with wonder and admiration, to the mechanical marvels of this age—the telephone, automobile and radio, among others—but here, in the little Canadian town of Callendar, we have seen one of Nature's marvels, which might not, of course, have been brought to perfection and fruition without the aid of medical science.

There you have it, medicine, literature and art, an invincible alliance in these latter days.

And, to paraphrase Hamlet, "There are still more things . . . on earth than are dreamt of in our philosophy."

THE DALHOUSIE MEDICAL JOURNAL

(A Student Publication.)

The Dalhousie medical students have just undertaken a venture of faith in the publication of a students' medical journal and we are happy to be able to compliment them on their enterprise and industry and to congratulate them upon the high quality of their first number.

The theory that work increases the capacity for work finds further support here. The medical course commands most of the time of the average conscientious student, yet the group responsible for this venture are able to keep up their end of the plank in the realm of regular study and to find the very considerable time necessary for this further exercise.

We cannot but feel that their industry should be commended and encouraged, not only for the virtue that accrues to them, but for the benefit which it offers to the future of Medicine. How many of us wish that in our undergraduate days some provision had been made for us to wade a little into medical writing? We would be so much more capable and so much less timid about it now. The objection may be advanced, and with much reason, that already we have too much medical "literature", but because ability to write has as its first pre-requisite ability to read, in which quality the greater benefit to Medicine resides, we think the objection loses force.

Enterprises of this kind need encouragement and we understand that the students are seeking that in the support of their university's medical alumni. There is evidence that that support is forthcoming, not only from members of the Dalhousie tribe but from graduates of other schools as well. In this the BULLETIN wishes them every success and hopes that they may reach the goal to which they aspire.

CASE REPORTS

Arsenical Dermatitis with Exfoliation.

Male, Single, Mechanic, aet. 40.

Case No. 15542.

Family History.

The family history is irrelevant to present condition. Both parents, two brothers and three sisters are alive and in good health. There is no tuberculous or venereal history.

Personal History.

The patient has never had any serious illnesses. The right index finger was amputated in 1914 following an accident. The patient has used alcohol fairly freely, especially over week ends, for more than twenty years. He was never treated for alcoholism, but he took no precautions with the drinking vessels used, the sources of his supply, nor the quantity or quality of the beverages he consumed.

In September 1935, an hypertrophied bone was removed from the left nasal fossa. The operation site did not heal. Two weeks later a profuse foul smelling discharge was issuing from the nasal fossa. There was an ulcer on the soft palate to the left of the base of the uvula, and another on the left tonsil. These ulcers as well as the nasal discharge were so highly suggestive of specific infection that antiluetic medication was started immediately, arsenic and bismuth concurrently, by the usual routes. The result was very satisfactory, the lesions clearing up completely after the second treatment. The Kahn reaction being highly positive-four plus—the patient continued the treatment, receiving six injections of arsenic and bismuth without any additional medication.

Present Illness.

In November, patient sought treatment for intense itching of the scalp, face, forearms, both surfaces of the hands, lower limbs, dorsum and sole of the feet, accompanied by hoarseness, an irritating cough without expectoration, dimness of vision, weakness, loss of weight and muscular atrophy. Specific treatment was discontinued, and the patient admitted to the hospital with a moderate systemic upset indicated by chills, lassitude, headache, muscle pains and gastric irritability. Routine examination on admission, exclusive of the skin condition, revealed no gross pathology in the organs of the thoracic or abdominal cavities. There was a slight elevation of temperature, a rapid pulse of low tension. The heart was normal in size and no murmurs were detectable. The blood pressure was low, 100-70. Dry rales were present in both lungs, but no consolidation or congestion. The kidneys were functioning well, the output of urine varying from 45 to 60 ounces daily, and negative for albumin, renal epithelium, casts, blood and pus. The Kahn reaction was negative.

The skin was the seat of an intense and wide-spread dermatitis presenting few of the features usually found in the dermatoses ordinarily met with in general practice or those accompanying or following eruptive fevers. Some

areas of the skin were dry, others were moist with serous exudates, vesicles, pustules and encrustations. There were numerous cracks of the cutis vera, in the skin folds and along the joint lines. Oedema of the non-pitting type was prominent on the face and limbs, and extending to the mucous membrane of the nose, mouth, pharynx and glottis. There was a purulent conjunctivitis in both eyes with marked oedema of the eyelids, and a purulent discharge from both ears, but no middle ear infection. The lymphatics were very sharply defined seemingly by the deposition of some metallic-like substance inside the vessels and giving the skin a peculiar dusky mottled appearance which was most striking. Pruritus was intense, most aggravating and painful. Desquamation was profuse and wide-spread. The epidermis fell off in showers of coarse scales, while that of the palms of the hands and soles of the feet were almost casts of these areas. Even the hair and nails did not escape. In fact the entire skin condition was one more easily remembered than described.

Treatment.

The treatment consisted of active purgation with calomel and salines, cardiac stimulation with digitalis and strychnine. Local treatment of the skin condition was very unsatisfactory. Bland ointments and lotions were of very little value. Balsam of peru gave some relief of the pain, burning and pruritus. Carbolic baths, alcohol sponging and moist compresses added much to the patient's comfort, besides their value in combating secondary infection.

Sodium thiosulphate intravenously in doses of .5gm. to 1 gm. administered on alternate days proved specific in this case, about 60 grams the drug being used over a period of two months. There were forced intermissions, as the drug was not available at all times. These intermissions were invariably marked by exacerbations of the skin condition. No untoward effects were noted from the administration of the drug, the patient frequently expressing a feeling of improvement both during and following injections.

Results.

The results obtained from this case were very satisfactory. The patient returned to his work on March 15th. feeling in the best of health, except for some lassitude and a sensitiveness to cold. The Kahn reaction is negative. Whether this means that the original specific infection is cured, remains to be seen. If not, further treatment is a matter for future consideration.

F. T. MACLEOD.

Some Unusual Complications in a Case of Chronic Alcoholism.

J. C. Age—35 Years.

Had been on a drinking bout two weeks previously. About ten days before I saw him he began tapering off, and was only getting small amounts of alcohol, doled out to him, by his wife.

She states that he was very nervous and she had been giving him luminal and paraldehyde to control his "jitters".

There was also a history of an injury to the back of the neck, about one month previous, which dazed him at the time and bothered him ever since.

On the evening of January 15th. 1936, he was given luminal gr. $1\frac{1}{2}$, later paraldehyde, drams 2, which was again repeated. He went to sleep and his wife was not alarmed until morning when she could not arouse him.

When seen, at his home, about 9.00 A.M., January 16/36, patient was stuporous, deep reflexes could not be elicited and there was a generalized fibrillary twitching of muscles. Pupils were equal and regular and reacted to light. There was an odor of paraldehyde on the breath and it was thought that the patient was suffering from an overdose of that drug, and I had him removed to hospital about 11.00 A.M.

On admission, the physical findings were as follows:—Patient in coma. Can not be aroused. Pulse is fast and extremities cold. Purposeless movements of both arms and fibrillary twitching of muscles, particularly in arms and shoulders. There is considerable neck retraction. Pupils equal and regular and react to light. There is some divergence at times. Knee jerks cannot be elicited. Kernig's sign is negative. No Babinsky. No ankle clonus. Abdominal reflexes absent. Heart, chest and abdomen—normal. Patient is voiding involuntary and the urinalysis is normal.

External heat was applied, an enema given, with good result, and patient was stimulated by hypodermic medication.

Seen again about 2.30 P.M. The paraldehyde odor had disappeared from the breath, but patient was still in coma. Saline and glucose ordered, by rectum.

About midnight, his condition was very poor and lumbar puncture was done. The fluid was clear and not under excessive pressure. Stimulation was continued and his condition began to improve.

Next day he was conscious, but confused. He had visual hallucinations, at times, and symptoms of peripheral neuritis began to appear and the neck retraction to disappear.

His physical condition continued to improve. On Jan. 21st. the deep reflexes were normal and he appeared rational, except that he was disoriented and he still had occasional hallucinations. A steel hand would appear over the top of the screen and menace him and the foot of his bed would rise straight in the air and nobody would help him get it down, he complained.

On Jan. 23rd. he appears quite rational, but on questioning him, he has no memory of any of the events of the past ten days, but for about one hour, he gave me a detailed description of his doings and adventures, (which he made up, to fill in the gap in his memory). He told me that he was sent to a military hospital in England, where he was treated for war disabilities and eventually had half of his stomach removed by operation. The lower half was wooden. He was then invalided home, to the Moxham hospital in Sydney, N. S., (now non-existent), and something hard began to grow out of his forehead. He reached up and broke it off, and apparently that settled that. From the Moxham, he then went to a private home at Waterford Lake, etc. etc.

The interesting thing to me was the wealth of detail with which he embellished his story. He had all the appearances of telling the truth, the whole truth and definitely nothing but the truth.

The peripheral neuritis was also becoming more evident. He had definite wrist drop, particularly of the left hand and complained that his arms were numb from the elbows down, and the legs, from the knees down, and that his head felt too heavy for his neck.

I allowed him to go to his home on January 26th., fairly clear mentally, but with the peripheral neuritis still much in evidence.

The symptom complex of loss of memory for recent events and the fabrication of detail to fill the hiatus, along with the peripheral neuritis is quite characteristic of Korsakow's syndrome, but I was at a loss to account for the initial coma. I finally concluded that it was either due to an overdose of paraldehyde, or more probably, to the condition known as "wet-brain".

B. F. MILLER.

Report of Cases of Trichinosis.

Trichina spiralis was first named by Richard Owen 100 years ago. Leidy of Philadelphia first found trichinillae in pork in the year of 1847. In 1897 hematologic examination of an afflicted patient revealed an Eosinophilia. Osler as a student observed the parasites. He states that he found "159 Cysts in a single drachm of one of the muscles of the arm".

In this particular disease, man serves as the host through the medium of meat from an infected animal, usually the hog. The gastric juice digests the wall of the ensysted larvae, in which form they deposit themselves in the hog's muscles. The parasites mature, copulation occurs, and the female deposits the embryos in the intestinal wall, whence, by means of lymphatics they gain the thoracic duct and the blood stream. The majority of the larvae reach the voluntary muscle where they initiate inflammatory reaction which leads to their encystment.

The trichinia have been found in various parts of the body for e.g. the brain simulating encephalitis, in the ocular muscles, in the hear muscles, liver, and in the pancreas and in the intestinal wall etc.

The symptoms of Trichinosis are very complex. The diarrhea and vomiting of this disease has led one to think of food poisoning. The unexplained fever has been called influenza. The abdominal pain is very suggestive of an inflammatory condition of the appendix, intestine or gall bladder. Edema of the eyelids necessitates ruling out acute nephritis or frontal sinusitis.

Diarrhea, somnolence and fever suggest typhoid. This suspicion may be strengthened by the finding of typical rose spots or splenomegaly. Pain and tenderness in the muscles causing an acute myositis may simulate peripheral neuritis. Pneumonia and myocarditis are the most serious complications. Phlebitis of the femoral veins have been noted.

The severity and prognosis of a case is directly proportional to the number of organisms ingested in the food.

CASE REPORTS.

Mr. Tony J. age 22, an Italian laborer was admitted to the hospital complaining of epigastric pain, vomiting and diarrhea. He had general weakness and was complaining of a soreness in his muscles. He stated that he had been ill for eight days prior to his admission.

On admission his temperature was 101F. Blood pressure was 92 S—60 D. The heart and lungs were normal. In the abdomen there was tenderness over the gall bladder area, but otherwise negative. Knee jerks were absent. The urine analysis was negative. Kahn negative. The leucocyte count on admission was 16,800. 84% neutrophils and 3% eosinophils.

Typhoid was suspected but cultures of the urine, stool and blood were negative for the typhoid group.

Four days later his wife was also admitted. Three days before admission she likewise suddenly became ill with the diarrhea and black stools. At the time of admission her diarrhea had improved but she had grown very weak and sleepless. Urine analysis showed a slight trace of albumin. The leucocyte count was 18,300 with 75% neutrophils and 1% eosinophils. She had a low grade fever. On the fourth hospital day she developed rose spots. Strangely enough ten days after admission they both showed a positive test for typhoid in a 1-80 dilution. The next day their blood counts showed a marked eosinophilia as high as 35%.

During this time four other members of the same family were also afflicted and investigation revealed the strong possibility of a food poisoning. It appears that the family purchased a small pig, fed it until it reached such proportions as warranted its slaughter. Homemade sausages were then manufactured and in their raw state the sausages were consumed. Sections of the pork sausages were taken and stained and the trichinae were found to be present.

A piece of muscle tissue was then removed from the biceps of Tony J. and trichinae were demonstrated. The other four members of the family mentioned were also admitted and one of these, Alonzo J. became delirious. An indirect blood transfusion of 500 c.c. was given. Glucose and saline were also administered freely, but it was of no avail, the patient died of what was believed to be Toxemia. A post-mortem examination was not performed. Two days later another member of the family lapsed into coma and never regained consciousness.

Mrs. Anna F. developed an enormous swelling of the right thigh of the leg, a condition simulating elephantiasis, as the result of obstruction in the lymphatics by the trichinae. The other patients recovered.

From a diagnostic point of view it would seem that the criteria in the determination of positive cases are an eosinophilia, biopsy and a positive intradermal test. (Dried larval powder is used as an antigen for the skin test). There is no specific in the treatment. Prophylaxis in the proper cooking or refrigeration of pork. Catharsis is useful in the initial diarrhoea. Calcium and glucose are advocated.

A. GAUM.

A Financial Consideration of the Proposed Federation with the Canadian Medical Association.

The Medical Society of Nova Scotia

The Year 1932-33.

Number of members.....	210
Profit and Loss Statement:	
Fees Collected	\$1,955.53
Interest in Savings Bank.....	19.66
	\$1,975.19

Costs

Medical Bulletin.....	\$ 262.66
Travelling Expenses.....	104.75
Salaries.....	1,200.00
Sundry Expenses	492.80
Rent of offices.....	330.00
	\$2,390.21
Net loss for the year.....	\$ 415.02

The Year 1933-34

Number of members.....	233
Profit and Loss Statement:	
Fees collected.....	\$2,330.51
Interest.....	11.23
Medical Bulletin.....	222.60
	\$2,564.34

Costs

Salaries.....	\$1,250.00
Sundries.....	578.81
Rent.....	100.00
Taxes.....	70.73
	\$1,999.54
Net Profit for the year.....	\$ 564.80

The Year 1934-35

Number of Members.....	233
Profit and Loss Statement:	
Fees collected.....	\$2,275.50
Interest.....	11.17
Medical Bulletin.....	430.84
	\$2,717.51

Costs

Salaries.....	\$1,600.00
Travelling expenses.....	116.05
Sundry Expenses.....	211.02
	\$1,927.07
Net Profit for the year.....	\$ 790.44

Taking the year 1934-35 as a basis to work on there were 233 paid members, and the amount received from dues, less bank commission, was \$2,275.50. One hundred and fourteen of our members were also members of the Canadian Medical Association. One hundred and nineteen were members of the Medical Society of Nova Scotia, but *not* members of the Canadian Medical Association. If the Medical Society of Nova Scotia becomes a division of the Canadian Medical Association there will be one fee which the Medical Society of Nova Scotia will collect, and from this send \$8.00 for each member to the Canadian Medical Association.

If the combined fee were \$18.00, working on the 1934-35 basis, it would mean that the Medical Society of Nova Scotia would receive 114 times 10, or \$1,140.00 in fees, instead of the \$2,275.50, the amount collected for 1934-35, a difference of \$1,135.50. To make this up it would be necessary to bring in to the combined scheme at least 115 of the 119 members who now belong to the Medical Society of Nova Scotia alone.

There was, however, in 1934-35, a net profit of \$790.44. If the Society were satisfied with putting by \$290.00 as a reserve, \$500.00 of this profit could be applied to expenses. If this were done it would only be necessary to bring 64 of the 119 into the proposed federation.

If the combined fee were \$15.00, the Canadian Medical Association would receive \$8.00, leaving \$7.00 per member for the Medical Society of Nova Scotia. The 114 members who now pay fees to both Societies would pay 114 times 7, or \$798.00 to the Medical Society of Nova Scotia, or a difference of \$1,477.50 (\$2,275.50 minus \$798.00), from the income from fees of 1934-35. At \$7.00 a member it would take 211 members; that is, all of the 119 members who now belong to the Medical Society of Nova Scotia alone, and 92 of the 171 practitioners who now belong to no Society to make up this difference. In this comparison, if it were decided to apply \$500.00 of the profit to expenses it would only be necessary to get in 140 new members, or the 119 who are now members of the Medical Society of Nova Scotia alone, and 21 additional.

Recapitulation.

With a Combined Fee of \$18.00:

The 114 members who now pay fees to the Medical Society of Nova Scotia and the Canadian Medical Association would undoubtedly come into the combined scheme. To secure the same income from fees as in 1934-35 it would be necessary to secure 115 new members. In other words it would be necessary for practically all of the 233 members of the Medical Society of Nova Scotia to join the new division.

If \$500.00 were applied to expenses there would have to be secured 65 members in addition to the 114 who now belong to both Societies.

With a combined fee of \$15.00. The 114 members who now pay fees to the Medical Society of Nova Scotia, and also the Canadian Medical Association would pay the combined fee. To make up the same income from fees as in 1934-35 it would be necessary to secure 211 additional members.

If \$500.00 were applied to expenses it would be necessary to secure 140 additional members instead of 211.

The only other thing to be considered would be the lessening of expenses. It is not felt that the expenses of the BULLETIN could be decreased. Last year it declared a profit of \$430.84. The Society does not pay any rent for its office; the salary of the Secretary is \$1200.00 a year, the clerical secretary \$480.00 a year; incidentals last year were \$327.07.

The Committee on Federation is strongly impressed with the desirability of a \$15.00 combined fee, but since they realize that this will necessitate a considerable increase in membership, they recommend that the executive of the Medical Society of Nova Scotia draw up plans whereby this increased membership may be secured.

Committee: G. H. MURPHY, K. A. MACKENZIE, G. R. BURNS,
H. B. ATLEE, J. R. CORSTON, (Chairman).

Department of the Public Health

PROVINCE OF NOVA SCOTIA

Office—Metropole Building, Hollis Street, Halifax, N. S.

MINISTER OF HEALTH - - - - HON. F. R. DAVIS, M.D., F.A.C.S., Halifax

Chief Health Officer - - - - DR. P. S. CAMPBELL, Halifax.
 Divisional Medical Health Officer - - DR. C. M. BAYNE, Sydney.
 Divisional Medical Health Officer - - DR. J. J. MACRITCHIE, Halifax.
 Director of Public Health Laboratory - - DR. D. J. MACKENZIE, Halifax.
 Pathologist - - - - DR. R. P. SMITH, Halifax.
 Psychiatrist - - - - DR. ELIZA P. BRISON, Halifax.
 Superintendent Nursing Service - - - MISS M. E. MACKENZIE, Reg. N., Halifax.

OFFICERS OF THE PROVINCIAL HEALTH OFFICERS' ASSOCIATION

President - - - - DR. F. F. EATON - - - - Truro.
 1st Vice-President - - DR. P. E. BELLIVEAU - - - - Meteghan
 2nd Vice-President - - DR. H. J. TOWNSEND - - - - Louisburg
 Secretary - - - - DR. P. S. CAMPBELL - - - - Halifax.

COUNCIL

DR. F. O'NEIL - - - - Sydney
 DR. G. V. BURTON - - - - Yarmouth
 DR. R. M. BENVIE - - - - Stellarton

MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

ANNAPOLIS COUNTY

Hall, E. B., Bridgetown.
 Braine, L. B. W., Annapolis Royal.
 Kelley, H. E., Middleton (Mcpy. & Town).

Murray, R. L., North Sydney.
 Townsend, H. J., Louisburg.
 Gouthro, A. C., Little Bras d'Or Bridge, (Co. North Side).

ANTIGONISH COUNTY

Cameron, J. J., Antigonish (Mcpy).
 MacKinnon, W. F., Antigonish.

COLCHESTER COUNTY

Eaton, F. F., Truro.
 Havey, H. B., Stewiacke.
 Johnston, T. R., Great Village (Mcpy.)

CAPE BRETON COUNTY

Tompkins, M. G., Dominion.
 Morrison, J. C., New Waterford.
 Martin, H. J., Sydney Mines.
 McNeil, J. R., Glace Bay.
 McLeod, J. K., Sydney.
 O'Neil, F., Sydney (County), South Side.

CUMBERLAND COUNTY

Bliss, G. C. W., Amherst.
 Drury, D., Amherst (Mcpy.)
 Gilroy, J. R., Oxford.
 Stewart, Chas. E., Parrsboro.
 Eaton, R. B., River Hebert (Joggins).
 Walsh, F. E., Springhill.

DIGBY COUNTY

DuVernet, Edward, Digby.
Pothier, H. J., Weymouth, (Mcpy.)
Doiron, L. F., Little Brook.

GUYSBORO COUNTY

Chisholm, A. N., Port Hawkesbury, (M.H.O. for Mulgrave).
Sodero, G. W., Guysboro (Mcpy).
Moore, E. F., Canso.
Monaghan, T. T., Sherbrooke (St. Mary's Mcpy.)

HALIFAX COUNTY

Almon, W. B., Halifax.
Forrest, W. D., Halifax (Mcpy.)
Glenister, E. I., Dartmouth.

HANTS COUNTY

Bissett, E. E., Windsor.
MacLellan, R. A., Rawdon Gold Mines (East Hants Mcpy).
Reid, A. R. Windsor (West Hants Mcpy.)
Shankel, F. R., Windsor, (M.H.O. for Hantsport.)

INVERNESS COUNTY

Chisholm, A. N., Port Hawkesbury.
Boudreau, Gabriel, Port Hood, (Mcpy. and Town).
MacLeod, F. J., Inverness.

KINGS COUNTY

Bishop, B. S., Kentville.
Bethune, R. O., Berwick (Mcpy.)
de Witt, C. E. A., Wolfville.
Morash, R. A., Berwick.

LUNENBURG COUNTY

Marcus, S., Bridgewater (Mcpy.)
Rehfuss, W. N., Bridgewater.
Morrison, L. N., Magone Bay.
Zinck, R. C., Lunenburg.
Zwicker, D. W. N., Chester (Chester Mcpy).

PICTOU COUNTY

Blackett, A. E., New Glasgow.
Chisholm, H. D., Springville, (Mcpy.)
Bagnail, P. O., Westville.
Crummey, C. B., Trenton.
Dunn, G. A., Pictou.
Benvie, R. M., Stellarton.

QUEENS COUNTY

Ford, T. R., Liverpool (Mcpy.)
Smith, J. W., Liverpool.

RICHMOND COUNTY

Digout, J. H., St. Peters (Mcpy.)

SHELBURNE COUNTY

Brown, G. W. Clark's Harbour.
Fuller, L. O., Shelburne. (Town and Mcpy).
Wilson, A. M., Barrington, (Barrington Mcpy.)
Lockwood, T. C., Lockeport.

VICTORIA COUNTY

MacMillan, C. L., Baddeck (Mcpy.)

YARMOUTH COUNTY

Hawkins, Z., South Ohio (Yarmouth Mcpy).
Burton, G. V., Yarmouth.
Lebbetter, T. A., Yarmouth (M.H.O. for Wedgeport).
Chiasson, B. I., (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.

Report on Tissues sectioned at the Provincial Pathological Laboratory from March 1st, 1936, to April 1st, 1936.

During the month, 215 tissues were sectioned and examined, which with 27 tissues from 5 autopsies, makes a total of 242 tissues.

Tumours, malignant.....	23
Tumours, simple.....	16
Tumours, suspicious.....	2
Other conditions.....	174
Tissues from 5 autopsies.....	27
	—242

Communicable Diseases Reported by the Medical Health Officers
for the month of March, 1936.

County	Chickenpox	Diphtheria	Infantile Paralysis	Influenza	Measles	Mumps	Paratyphoid	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. Pulmonary	Tbc.-other Forms	V. D. G.	V. D. S.	Whooping Cough	Pink Eye	German Measles	Septic Throat	TOTAL
Annapolis.....	22	..	..	..	1	1	..	1	..	..	..	..	1	..	..	..	1	..	28
Antigonish.....	1	..	..	..	..	..	..	..	..	..	1
Cape Breton....	8	7	..	..	..	..	..	..	11	..	..	..	..	..	3	..	..	..	29
Colchester.....	12	..	1	..	..	..	..	..	..	..	1	13	..	34	..	61
Cumberland....	1	..	..	..	..	..	..	..	..	..	1
Digby.....	5	..	..	..	..	..	..	..	..	..	..	7	..	12
Guysboro.....
Halifax City..	3	6	..	..	24	..	..	..	43	..	2	..	..	..	3	..	..	..	81
Halifax.....	2	..	..	..	..	..	..	..	..	..	..	..	..	..	2
Hants.....	6	..	..	..	..	..	..	..	..	..	6	..	..	..	12
Inverness.....	..	1	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	..	3
Kings.....	..	1	..	12	11	5	..	..	4	..	..	1	..	1	5	..	24	1	65
Lunenburg.....
Pictou.....	10	..	..	..	..	2	..	..	..	..	..	8	..	..	..	20
Queens.....
Richmond.....	2	..	..	..	..	..	..	..	..	1	..	20	..	..	..	23
Shelburne.....	5	..	..	..	..	5
Victoria.....
Yarmouth.....	..	1	..	..	..	..	..	..	6	..	..	..	..	..	..	..	50	..	57
TOTAL.....	33	16	..	36	44	12	..	1	69	..	4	1	2	2	63	..	116	1	400

RETURNS VITAL STATISTICS FOR FEBRUARY, 1936.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis.....	9	8	13	5	2	0
Antigonish.....	10	5	3	8	2	2
Cape Breton....	45	46	60	19	19	6
Colchester.....	18	23	11	16	14	1
Cumberland....	43	22	18	25	14	1
Digby.....	23	15	5	13	8	4
Guysboro.....	9	10	5	7	2	0
Halifax.....	101	86	72	62	43	5
Hants.....	13	9	3	7	6	2
Inverness.....	16	18	3	11	12	2
Kings.....	22	19	13	10	11	3
Lunenburg.....	12	18	10	13	7	1
Pictou.....	29	19	27	17	19	1
Queens.....	7	4	3	3	2	0
Richmond.....	6	6	6	10	8	0
Shelburne.....	6	10	1	6	4	1
Victoria.....	5	8	8	2	5	0
Yarmouth.....	17	16	9	12	5	2
	391	342	270	246	183	31

OBITUARY

DEATH has again struck down one of the most beloved medical men in the Province in the person of the late Dr. John W. McLean, of North Sydney, where he had practised his profession for well nigh half a century. This is the third death in the profession during the past month and in the days to come Cape Breton will feel the effects of this great loss.

Only a month ago Dr. Lewis Johnstone, of Sydney Mines, passed from us and two weeks after Dr. Bayne, and now the Dean of the profession in Cape Breton has passed to his reward. Death occurring after a short illness on Saturday, March 28th.

Dr. McLean was born at Lake Ainslie about 80 years ago and attended Pictou Academy followed by a medical course in McGill University, Montreal, and later did post graduate work in that old and famous medical centre Edinburgh. After graduating, for a short time he practised in Port Hawkesbury, but on his return from Edinburgh settled in North Sydney where he lived and practised for about fifty years. He soon became firmly established as one of the most successful practitioners in the province, and his practice extended to all parts of the northern end of the county.

He was interested in every forward movement that meant for the welfare of his adopted home, and the town of North Sydney has every reason for gratitude that a man of Dr. McLean's integrity, foresight and outlook became one of its citizens.

Rarely has a physician been so beloved and respected by those to whom he ministered for so many years—a physician whose personal concern was for the welfare of his patients. He has set an example to all those who enter the medical profession.

Besides his work as a physician he was a member of the Royal Albert Lodge A.F. and A.M., the Oddfellows, as well as a great worker in all town organizations that made for the improvement of the town.

The funeral took place from St. Giles Presbyterian Church of which he was a devout member and elder. It was perhaps the largest seen in North Sydney, attended by all classes who showed their respect for one who served them so faithfully for so many years.

DR. CHARLES MACDONALD BAYNE.

It is with profound regret that one refers to the death, on Thursday, March 19, 1936, of Dr. C. M. Bayne, in his 41st year. Dr. Bayne, eldest son of the late Andrew N. Bayne of Halifax, was born in the city of Halifax and received his medical education at Dalhousie University, whence he graduated in the year 1920, with the degree M.D.C.M.

Shortly after graduation the doctor joined the staff of the Nova Scotia Sanatorium, serving on it for upwards of 8 years, during the last five of which he acceptably filled the position of Assistant Superintendent. Here his wise counsel and equable temper, coupled with an exceptional knowledge of his special

subject, frequently helped to smooth out difficulties and to increase the popularity and reputation of the institution. At the Sanatorium he was universally loved by patients and staff alike, and many a discouraged tuberculous sufferer was given new hope and a changed outlook, as the result of his special adaptability for giving the proper advice in his own characteristic kindly and cheerful manner.

Early in 1930 Dr. Bayne became attached to the Department of the Public Health, as Divisional Health Officer and tuberculosis travelling diagnostician, for the eastern division of the province. This position he filled with conspicuous success, due to his resourcefulness and enthusiastic interest. As an authority on clinical tuberculosis and tuberculosis control, Charles Bayne had few equals, consequently his advice was continuously sought by medical associates and others. To patients and colleagues he was at all times a model of courtesy and helpfulness.

Although not enjoying good health for some months, his spirit was undaunted and he continued to shoulder the duties of office, right up to the end. Those intimate with him, however, were aware that the burden was becoming too great for his strength and it seemed that only his will and devotion to duty kept him going.

By the death of Charles MacDonald Bayne, the medical profession has lost a worthy representative and I have had brought to an end, a warm friendship, extending over thirteen years. He was a man of sterling qualities, making and retaining friends wherever he went. Quiet and unassuming, he won the affection of all with whom he was brought in contact, and in his dealings with others he was always a gentleman. In his leisure moments, which were few, he was an ardent sportsman, being a good boatsman, an enthusiastic angler and an excellent shot. He loved the country and always looked forward to life in the open.

Dr. Bayne is survived by his widow, a son, a daughter, his mother and four brothers. In extending sincerest sympathy to the members of his family, I am expressing the feelings not only of his medical brethren, but of a host of other friends and acquaintances as well.

The funeral service was held on Saturday, March 21st, and was attended by many of his medical confreres and a large number of others, the large concourse giving further evidence of his wide popularity. Interment took place at Camp Hill Cemetery.

Word has been received of the death of Dr. Frank Woodland Taylor, of Oakland, California. Dr. Taylor was born at Port LaTour, Shelburne County, sixty-four years ago. He graduated in 1900 from Dalhousie Medical School, and first started practising at Wood's Harbour. Later he went to the Hawaiian Islands, but on account of ill health was forced to leave and finally settled at Oakland.

The BULLETIN regrets to hear of the death of Dr. Albert Ernest Forbes, of Moncton. Dr. Forbes had been ill for two weeks and although his condition was serious his death came as an unexpected shock to his immediate family and friends. Dr. Forbes was born at Loch Katrine, Antigonish County, N. S., a son of the late Rev. John Franklin Forbes. He graduated in medicine

at Dalhousie University in 1900. After serving some time at the Victoria General Hospital he located at Sydney. Leaving Sydney he practised in Upper Stewiacke for five years, and then moved to Maccan where he stayed for a period of eleven years. In 1920 Dr. Forbes moved to Moncton and was very successful in practice in that city. He leaves to survive him his widow, two sisters and three sons.

The BULLETIN extends sympathy to Dr. T. F. Meahan, of Glace Bay, on the death of his mother, Mrs. (Dr.) J. C. Meahan which occurred on Tuesday, March 24th, at Bathurst, N. B.

If there is any doubt why clinics flourish—why patients do not hesitate to pay large fees to these institutions—why patients accept the verdicts of even inexperienced internes—the answer is obvious! The patient wishes to be examined completely, carefully. The person who to-day accepts anything but most meticulous examination for even a minor illness is a rare bird—and an ignorant one!—one who has remained untouched by the propaganda waged by organized medicine, insurance companies, public health agencies, and newspapers for careful periodic medical examinations.

As we have said before, the American public wants *quality* medical care.
—*Detroit Medical News.*

DIAL "CIBA"

(Diallylmalonylurea.)

Dial calms excited, irritated nerves, and for such occasions as nervous insomnia, mental and traumatic agitation, preoperative restlessness, etc., it will fulfil all the requirements of a good hypnotic.

AMPOULES - TABLETS - ELIXIR

CIBALGINE "CIBA"

(A combination of dimethylamino-phenyl-dimethyl-pyrazolone and Dial.)

Cibalgin is indicated in the treatment of pain of every description, febrile manifestations, nervous excitement, insomnia due to pain, dysmenorrhoea. Cibalgin represents a non-narcotic analgesic and antipyretic *worthy of the physician's confidence.*

AMPOULES - TABLETS - ELIXIR

**CIBA COMPANY LIMITED,
MONTREAL**

Sole Representatives

for

Androstine "CIBA"

Personal Interest Notes

Bathing Beach an Issue at Sydney.

DR. J. K. McLEOD, City Medical Officer of Sydney, in an address before the Rotary Club on March 3rd, made the announcement that a request will shortly be made to the Provincial Health Department to send a sanitary engineer to survey the harbor front for the purpose of selecting a safe place for bathing. The Kiwanis Club have also interested themselves in this matter and are behind the movement to have a clean place for bathing at Sydney. Sydney is to be congratulated on this forward step; a good many other towns could profit by their example.

Dr. A. Philip Magonet, formerly located at Mulgrave, has moved across the Strait, and is now fitting up an office at Port Hawkesbury.

Dr. E. B. Hall of Bridgetown has returned from a trip to Boston and New York where he went to take a post-graduate course in Surgery.

Dr. Gerald R. Burns of Halifax recently lectured to the pre-medical class at St. Francis Xavier taking as his topic "Mediaeval Medicine."

Dr. G. A. Dunn of Pictou addressed the quarterly meeting of the Women's Council on the subject of "Cancer" on March 16th.

Dr. and Mrs. A. F. Miller, of Kentville, left recently by the S.S. "Lady Hawkins" for Barbados. Returning, Dr. Miller plans to visit some of the chest clinics in New York.

Dr. Ralph P. Smith, Provincial Pathologist, addressed the Kentville Rotarians on March 9th, taking as his topic the medico-legal aspect of his work.

Dr. and Mrs. D. A. Campbell, of Bridgewater, have left for a visit to Boston.

Dr. Donald Rankine, who has been practising in New York City for the past few years, has located at Halifax.

Dr. W. A. Hewat of Lunenburg addressed the Women's Institute on March 5th on the subject of "Public Health."

Dr. S. Marcus, of Bridgewater, has returned from a recent visit to New York and Boston.

Dr. and Mrs. L. M. Silver, of Halifax, have returned from a visit to Charleston, South Carolina.

PETROLAGAR

FIVE TYPES

"Delightfully Palatable"

Your patients will co-operate willingly when delightfully palatable Petrolagar is prescribed in the treatment of constipation. We suggest that you taste Petrolagar and note the pleasant flavor. Petrolagar is a mechanical emulsion of liquid petrolatum (65% by volume) and agar-agar.

Samples free on request

Petrolagar Laboratories of Canada, Ltd.

364 ARGYLE ROAD

Walkerville

Ontario

DIGESTOPHOS

(E. B. S.)

Each fluid ounce represents:

Calcium Glycerophosphate.....	12 grs.
Sodium Glycerophosphate.....	8 grs.
Iron Glycerophosphate.....	2 grs.
Manganese Glycerophosphate.....	1 gr.
Quinine Glycerophosphate.....	1/2 gr.
Strychnine Glycerophosphate.....	1/16 gr.
and the Digestive Ferments—Pepsin, Pancreatin and Diastase.	

Dose: One to two fluid drachms.

A valuable Reconstructive Tonic in Neurasthenia, General Debility and in Functional Nervous Disorders.

Free on Sugar.

Clinical Sample on request.

Specify "E.B.S." on your Prescriptions.

The E. B. SHUTTLEWORTH CHEMICAL CO., LTD.

MANUFACTURING CHEMISTS

898 St. Clair Avenue, West

TORONTO, 10, Canada

Sales Representative for the Maritimes

F. R. CLAYDEN, 58 John St., Moncton, N. B.

Dr. C. S. Morton, of Halifax, sailed on March 15th on the Duchess of York for a six weeks' visit to England.

Dr. C. A. S. McQueen, of Amherst, has returned from a trip to the West Indies.

Dr. Fraser MacGregor, of New Glasgow, is spending a few weeks in Montreal in post-graduate study.

Dr. Hugh F. MacKay, of New Glasgow, has returned from a visit to Montreal and Toronto. At Montreal Dr. MacKay took a six weeks' post-graduate course at the Royal Victoria Hospital.

We are pleased to hear that Dr. H. B. Whitman, of Westville, who was recently a patient at the Halifax Infirmary, has improved and is now on his way to recovery.

Dr. A. R. Cunningham, of Halifax, is enjoying a holiday in Bermuda.

Dr. W. R. Dunbar, Truro, left on Sunday, March 29th, for Montreal to attend a reunion of the Medical Class of 1896 of McGill University. Graduates of forty years ago are expected from all parts of Canada.

Dr. Daniel Hoare, of Philadelphia, was recently called to his former home at East Mountain, near Truro, owing to the death of his father, Joseph Hoare, a highly respected citizen of that community. Dr. Hoare, who was well known in Halifax, has been for several years with the Mutual Life Assurance Company of Philadelphia, and among the many floral tributes was one from this Company. Dr. Hoare had to at once return to his duties in Philadelphia, but will return later to discharge his duties as executor of his father's estate.

The Secretary has had an inquiry from one of the graduating students for a locum for the month of June. Any Doctor requiring a locum for that period will please apply to this office.

Dr. W. Ross Wright of the Eye, Ear, Nose and Throat Department, Montreal General Hospital, who this spring will have completed three years internship, is anxious to relieve a general practitioner for six weeks to two months beginning the middle of July. Following this, he plans to return to the Montreal General for further work in his specialty.

Dr. T. F. MacLeod of New Waterford wants a physician to take charge of his practice during the month of June. Full particulars may be had by applying directly to Dr. MacLeod.

Practice Vacant.

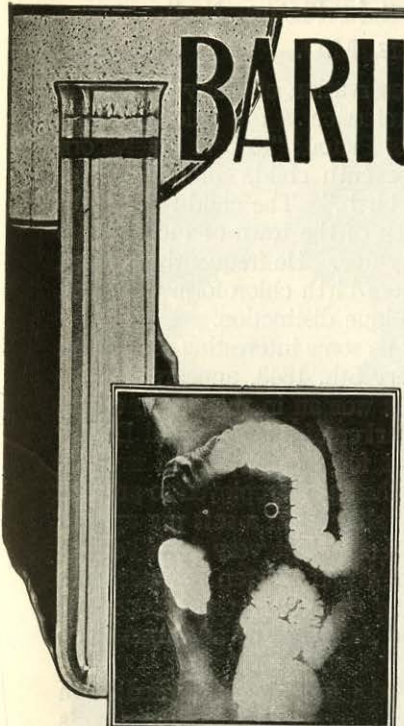
Due to the death of Dr. M. E. Commins at Bath, Carleton County, N. B., there is an opening there for a medical man. A Roman Catholic would be preferred on account of the high percentage of Catholics in the population. Further particulars may be obtained from Mrs. M. E. Commins at Bath, N. B.

BARIUM SULPHATE

Mallinckrodt

Unexcelled Shadow Forming, Perfect Suspension. No hardening and retention of excreta. Satisfactory for oral and rectal use.

Gives Best Results—Least inconvenience to physician and patient when Mallinckrodt Barium Sulphate is used because it is made by the precipitation process, the only method that gives a uniform fine powder remaining satisfactorily in suspension



Write for folder on
Suspension and
residue tests.

Mallinckrodt

CHEMICAL WORKS

Makers of Fine Medicinal Chemicals

378 St. Paul St. W., Montreal

TORONTO

ST. LOUIS

NEW YORK

Early Adventures With Chloroform in Pictou, N. S.

By K. A. MACKENZIE, M.D.

The family Bible is responsible for the preservation of many interesting records. Of special interest to the medical profession is the following from the family Bible of the late Mr. R. P. Fraser of Pictou: "Robert Peter, born March 22nd, 1848. At the birth of this, the seventh child, chloroform was used for the first time in Canada during child birth." The child referred to was Mr. R. P. Fraser, a highly respected citizen of the town of Pictou, who died on August 30th, 1923, at the age of seventy-five. He frequently boasted to his friends that he was the first child at whose birth chloroform was used in Canada, and was evidently proud of this unique distinction.

The *Presbyterian Witness* has preserved for us some interesting records on the use of chloroform. In the copy of February 5th, 1848, appears the following: "Dr. Almon amputated the thumb of a woman in the Poor Asylum Tuesday morning, in the presence of Doctor Parker of this city, and Doctor Brown of Horton. This case is published, not for the purpose of inviting attention to the operation, but to the effects of the agent employed to prevent pain. The chloroform was administered by inhaling from a soft rag applied to the nose and mouth for a few minutes. The patient very soon became insensible to pain, and the operation, occupying perhaps ten minutes, was finished before sensibility returned. On waking the poor woman expressed her gratitude in the warmest form, and in the judgment of all present the success of the operation was complete."

In the same paper of March 11th, 1848, the following appeared: "An operation was performed on Friday last, by Dr. Almon at the Halifax Poor's Asylum, in the presence of many of the medical men of the city, upon a poor woman, under the influence of chloroform. The patient upon first inhaling, the chloroform was a little excited, but after a short time became more tranquil and finally sank into a state of partial lethargy. The operation, (amputation of the leg above the knee) was then commenced. Before it was completed she so far came to herself as to sing and converse, though rather incoherently, with those about her. When the operation was finished and the stump partly dressed, on being asked if she was ready to have her leg taken off, she gave her assent, and, for some time, could not be persuaded that it had already been done, as she had experienced no pain. The medical men present expressed themselves satisfied with the result of the chloroform which quite equalled their expectations.

"The chloroform made use of on this occasion (on the purity of which the producing of its characteristic effect depends) was manufactured by J. D. B. Fraser, Esq., Chemist of Pictou."

Both of these antedate the date of Mr. Fraser's birth. At this point, one should recall that Sir James Young Simpson first administered chloroform in childbirth on November 4th, 1847, and published his notes about one week later. The news of this wonderful discovery had barely reached this side of the Atlantic when a modest chemist in a small shop in the town of Pictou began experiments with chloroform under conditions which to us appear truly remarkable. He found the formula in a London medical journal and set to work to produce the substance himself. He prepared it, purified it, and supplied it to doctors in Halifax. This was less than four months after Simpson's first administration. Two weeks later he had the courage to administer it to his wife for the relief of labor pains.

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in *Maclean's* and other leading magazines.



This man is Medicine's greatest problem

THIS man is Medicine's greatest problem. He is not the victim of a strange or baffling disease. He is just the *average* man.

The greatest problem Medicine faces today is to get the average person to take advantage, *in time*, of the help it has to offer him.

One need not look far to find proof of this statement—tragic proof.

A child lies ill with diphtheria, a disease which practically never occurs in children who have been given immunizing treatment and tested for immunity.

A pretty young girl sits, day after day, in her wheel-chair, far away from the parties and fun that are every girl's right. She has tuberculosis, which could have been arrested without difficulty if the family physician had been consulted when her first symptoms appeared.

An elderly woman comes to the doctor with something that has been troubling her for some time. He shakes his head sadly as he discovers

an advanced cancerous growth. She would have had good prospects for cure if she had come to his office when her suspicions were first aroused.

A business man in the prime of life dies in his office. His heart had been giving him warnings for more than a year, but he was "too busy" to heed them.

Yes, Medicine's greatest problem is to get people to take advantage of the help it can offer them. And *you* are the only one who can solve that problem. When something is wrong within your body, you are usually given some warning signal. *Act* on that warning by consulting your doctor without delay.

PARKE, DAVIS & COMPANY

WALKERVILLE, ONTARIO

*The World's Largest Makers of
Pharmaceutical and Biological Products*

Mr. J. D. B. Fraser was born in Pictou on February 11th, 1807. He established his drug business in 1828 and carried on his business until his death in 1869. He was a man of more than ordinary ability. He was a chemist in the true sense, and represented a type not usually found in a modern drug business. In his day, drugs were manufactured locally. The large manufacturing house had not appeared. Besides his early adventures with anaesthesia, he was interested in other new features, especially antiseptics, and his wisdom and achievements are still discussed by his admirers in the old town. His name still adorns the shop window, although the business has passed out of the Fraser family.

In 1853, Mr. R. P. Fraser had an operation on his eye under chloroform, but this was five years subsequent to his birth, and anaesthesia had ceased to be a novelty. His father for a considerable time supplied chloroform for use in Nova Scotia.

(Canadian Medical Journal, Vol. 14, 1924).

PHYSICIAN WANTED

A physician is wanted to take over a good general practice in Cape Breton. Further particulars may be obtained from the Secretary, or from Dr. H. A. Grant at Big Bras d'Or, Cape Breton, N. S.

MARITIME SURGICAL SUPPLIES

OWNED AND CONTROLLED IN THE MARITIMES

AGENTS FOR:—Bard Parker Blades, Davis & Geck Sutures,
Operating Room Lights, Blood Pressure Apparatus
and all Hospital Equipment.

IMPORTERS OF:—Surgical Instruments, Suction and Pressure
Apparatus, McKesson Gas 2 Apparatus

28 Spring Garden Road, Halifax, Nova Scotia

AS YOU LIKE IT—

SO we can do your printing! Whether it be prescription or hospital forms, letters— or bill-heads, something in the way of social printing—we are here to serve you with an unusually wide selection of type faces, unique experience in layout and design, and a friendly understanding service gained in more than thirty years' experience. We will gladly quote prices on any sort of printing you may require.

IMPERIAL PUBLISHING CO., LTD.,

614 BARRINGTON STREET, HALIFAX, N. S.

The Story of MEAD'S OLEUM PERCOMORPHUM

A NEW, ECONOMICAL, POTENT SOURCE OF NATURAL VITAMINS A AND D

OLEUM PERCOMORPHUM, or Percomorph Liver Oil, is the achievement of an intensive, 10-year investigation conducted in the research laboratories of Mead Johnson & Company to find a natural oil more potent in vitamins A and D than cod liver oil and less expensive to the patient.

The U. S. Pharmacopoeia (IX, 1916, and X, 1925) recognized cod liver oil as the oil from the livers of fishes of the family *Gadidae*. There being some 50 species in this family, in addition to the type species, *Gadus Morrhua*, our first studies were directed at the examination of the more important species classed as cod. It occurred to us that somewhere in nature there might exist a species, or a family or an order of fish, the liver oil of which would make possible a mixture comparable with Oleum Morrhuae but higher in vitamin potency.

The study was then directed to other species. By 1927 we had quantitatively compared the anti-ricketic value of oils from 15 species of fish and 11 other oils and fats. This was the most extensive survey of vitamin D sources reported up to that time. Outstanding in this list was puffer fish liver oil with a vitamin potency 15 times that of cod liver oil. Puffer fish were not available in commercial amounts, but the fact that one species of fish yielded so high a vitamin store provided great stimulus to investigators.

We discovered that the potency of fish liver oils increases with the leanness of the livers. With this revelation, we began a survey of all available commercial fish, as well as of rarer species. Collectors were sent to distant continents and to the islands of the Pacific and Atlantic oceans. From ports which never before knew cold storage we arranged to obtain refrigerated livers for our experiments. This ichthyological survey was interrupted (1928) at the time we introduced activated ergosterol.

In 1929 the Norwegian investigator, Schmidt-Neilsen, reported halibut liver oil to be superior to cod in vitamin A. Upon investigating, we felt then, as we do now, that while halibut liver oil marked a distinct advance

it left much to be desired since it was perforce an expensive source of vitamin D. Hence it came to be used chiefly to supply vitamin A as a vehicle for viosterol.

Continuing the search for fish liver oils, by 1934 our laboratory staff had made thousands of bio-assays of oils from more than 100 species to determine their vitamin characteristics. The results, reported in scientific journals in January and April 1935, were the culmination of a search literally of the seven seas.

With cumulative data on more than 100 species, it became evident that the fish belonging to the order known as *Percomorphi* differ from others in possessing, almost without exception, phenomenal concentrations of vitamins A and D. Thus we find liver oils which contain 50, 100, 500, and even 1,000 times as much vitamin A or vitamin D as average cod liver oil!

Percomorph liver oils are seldom equally rich in both vitamins. By skilful blending of the A-rich oils with the D-rich oils, a mixture is obtained which is about 200 times richer than cod liver oil in both vitamins A and D. As this concentration is so great that an ordinary dose of the oil could not be conveniently measured, we dilute the percomorph oil with approximately one volume of refined cod liver oil.

The resultant product is Mead's Oleum Percomorphum, 50%, which is 100 times cod liver oil* in both vitamins A and D. By a further dilution we obtain Mead's Cod Liver Oil Fortified With Percomorph Liver Oil, 10 times as potent as cod liver oil* in both vitamins A and D. Their respective potencies are 60,000 vitamin A units, 8,500 vitamin D units; and 6,000 vitamin A units, 850 vitamin D units (International) per gram.

Just as Oleum Morrhuae is a mixture of the liver oils of various cod species (cf. U.S.P. XI, 1935, p. 261) so Oleum Percomorphum is a mixture of the liver oils of various percomorph species.** The significant difference is that the improved product is 100 times as potent in both vitamins A and D.

Mead's Oleum Percomorphum, 50%, is available in 10-drop capsules, 25 in a box, and in 10 c.c. and 50 cc. bottles. Mead's Cod Liver Oil Fortified With Percomorph Liver Oil is available in 3 oz. and 16 oz. bottles.

*U.S.P. XI Minimum Standard.

**Principally *Xiphias gladius*, *Pneumatophorus diego*, *Thunnus thynnus*, *Stereolepis gigas*, and closely allied species.

MEAD JOHNSON & CO. OF CANADA, Ltd., Belleville, Ont.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons.



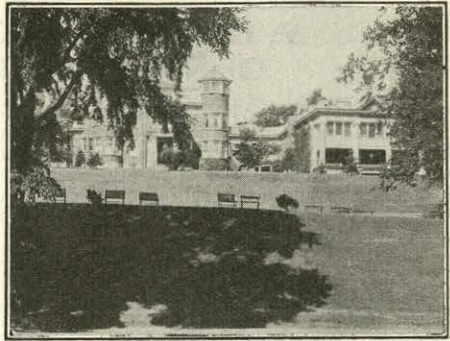
D^R COLLECTEM

Get into the coupon-clipping Class.

Doctor. We can bring you in the money—
from your past-due accounts. Mail a good
big list of them to The Medical Audit
Association, 44 Victoria Street, Toronto.

Homewood Sanitarium

GUELPH, ONTARIO



Nervous cases including Hysteria, Neurasthenia
and Psychasthenia.

Mild and incipient mental cases.

Selected habit cases will be taken on advice of
physician.

For rate and information, write

HARVEY CLARE, M.D.

Medical Superintendent

NEO-Syophrin Hydrochloride

"STEARNS"

EITHER JELLY OR SOLUTION

Vasoconstrictors when applied to Nasal Mucosa

Does not irritate nor cause sneezing.

SAMPLES SUPPLIED

MACLEOD-BALCOM LIMITED
DRUGGISTS

174 SPRING GARDEN ROAD

Bedford

Sheet Harbour

Armdale

Kentville