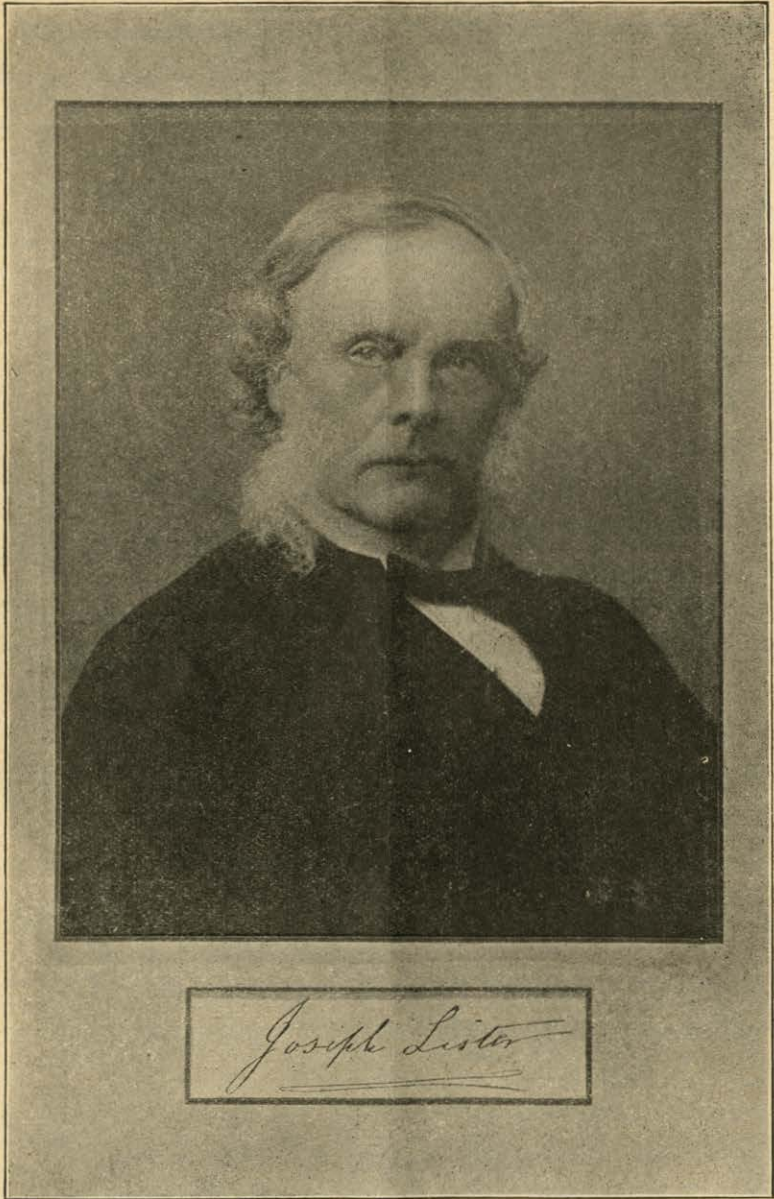




From "*The Professor At the Breakfast-Table.*"
(*Oliver Wendell Holmes*).

THERE are three wicks, you know, to the lamp of a man's life: brain, blood and breath. Press the brain a little, its light goes out, followed by both the others. Stop the heart a minute, and out go all three of the wicks. Choke the air out of the lungs, and presently the fluid ceases to supply the other centres of flame, and all is soon stagnation, cold, and darkness. The "tripod of life" a French physiologist called these three organs. It is all clear enough which leg of the tripod is going to break down here. I could tell you exactly what the difficulty is:— which would be as intelligible and amusing as a watchmaker's description of a diseased timekeeper to a plowman. It is enough to say, that I found just what I expected to, and that I think this attack is only the prelude of more serious consequences,— which expression means you very well know what.





LORD LISTER
1827-1912

Some French Views on Heart Disease

Cardiac Symptoms of Renal Disease and Renal Symptoms of Heart Disease.

In their book "Les Cardio-Rénaux," Josué and Parturier shed a flood of light on what, to me, was always a most difficult problem.

A patient complains of weakness and breathlessness on exertion and severe attacks of dyspnoea at night; he is found to have a rapid pulse, and enlarged heart with faint sounds but no murmurs, perhaps a normal systolic blood pressure and albuminuria. Is he suffering from heart failure or from chronic nephritis, or both? And how should he be treated?

We must tackle one problem at a time. In the first place, is the heart failing? From the dyspnoea the pulse rate, the enlargement of the heart and faintness of its sounds, it is quite obvious that it is. Then what of the blood pressure? A systolic reading in such a case is quite valueless unless we have a diastolic also; a normal systolic in the presence of a raised diastolic pressure and tachycardia is a certain sign of heart failure. In one of my cases the systolic pressure was only 148 m m.—quite normal in a man of 53; but the diastolic was 130 m m. and the pulse rate 116 and regular; he had decided albuminuria but no haematuria and no oedema. Six weeks later he died, and was found to have normal kidneys but a much hypertrophied and dilated heart.

I think this may be called a common case and a difficult case; much more common and much more difficult than ordinary mitral stenosis or aortic disease. My patient had, I should say, a systolic murmur conducted towards the axilla, but no valvular lesion was found post mortem.

Are the kidneys diseased? Josué and Parturier are most emphatic on one point, namely, that we cannot answer this question when the urinary output is diminished in amount by cardiac insufficiency.

Before proceeding further, it will be well to contrast the urine of heart-failure with that of chronic interstitial nephritis:—

	Heart-Failure	Chr. Nephritis.
Amount..	Less than 50 oz.	More than 50 oz.
Colour ...	Dark	Pale
Sp. Gr....	High	Low.
Albumen..	Abundant	Scanty or Absent.
Casts....	Few hyaline	Granular and Epithelial may be found if Centrifuged.
Blood....	Absent	May be seen in Centriuged specimen.
Urea....	Above 2%	Below 1%

The difference is so definite that in practice it is almost good enough to go by the colour alone in simple cases; but in difficult cases we must measure the amount secreted in the 24 hours.

Josué and Parturier divide cardio-renal cases into "False Cardio-Renals" and "True Cardio-Renals;" We cannot distinguish between these conditions in the presence of Oliguria.

Renal symptoms, such as vomiting, headache, Cheyne-Stokes respiration, and raised blood-urea concentration, may occur in a case of pure heart-failure, if the urinary output is *much* diminished, but not with moderate oliguria unless the kidneys are diseased. Healthy kidneys are capable of concentrating urea to 3 or 4 per cent. in the urine—various French authors give the figure as 4.5 to 5.5 per cent. With the chronic congestion of heart-failure we should hardly expect the kidneys to reach these very high figures, so let us say for the sake of argument, that the kidneys can turn out urine containing 3 per cent. of urea. Now, if on a given diet 25 grams of urea have to be excreted in the 24 hours, and the amount of urine is 1,500 c c. (50 oz.), then the concentration of urea in the 24 hours specimen will be 1.66 per cent. If, by reason of cardiac failure, the amount of urine falls to 1,000 c c., the 25 grams of urea can still be excreted by the kidneys simply concentrating it to 2.5 per cent. in the urine. But suppose the output falls still further, say, to 750 c c. (25 oz.), then the concentration of urea would have to be 3.3 per cent. if the whole of the 25 grams are to be excreted; but as the kidneys are only capable of turning out a 3 per cent. solution only 22.5 grams of urea can be excreted and the remaining 2.5grams will accumulate in the blood each day. Thus we see how simple cardiac insufficiency may give rise to "uraemia" without any kidney lesion.

This is called the "Uraemia of Oliguria" and the cases are called "False Cardio-Renals." The highest blood-urea which fell to normal under purely cardiac treatment was 125 mg. per 100 cc. (Josué).

We have now to deal with the cases in which both the heart and kidneys are diseased—"the true Cardio-Renals." These are distinguished from the "False Cardio-Renals" by the fact that the blood-urea in the latter can be brought down to normal by means of cardio- tonic treatment, whereas in the true Cardio-Renal cases, it remains above 40 mg. Now every case of chronic interstitial nephritis is a *potential* Cardio-Renal, the essential feature of chronic interstitial nephritis is that the kidneys are only able to concentrate urea to 1 per cent. in the urine instead of 3 per cent. or 4 per cent. a normal kidneys can, consequently, they have to eliminate more water in order to get rid of the same quantity of urea; that is why *polyuria* is a feature of this type of chronic nephritis; it has been described as the safety-valve of nephritis.

This can be made more clear by taking an example: McLean has shown by means of his urea-concentration test, that if urea is given by mouth to a healthy person, the urea in the urine may reach

2 per cent. to 4 per cent. in the second hour; but the granular kidney is only able to make a 1 per cent. or weaker solution of urea in the urine. Now, if 25 grams of urea have to be excreted each day and the kidneys can only concentrate it to 1 per cent. it will be necessary for them to turn out 2,500 cc. of urine (instead of the normal 1,500 cc.) daily. But if by reason of heart-failure this amount of urine should fall to 2,400 cc., then only 24 grams of urea will be excreted and the remaining 1 gram will accumulate in the blood each day. This fall in the output of urine is called "Relative Oliguria." We see also why it is that a slight diminution of urine is much more serious if the kidneys are diseased than if they are healthy. Since in the former case, the urea is not excreted at all but accumulates in the blood; but if the kidneys are healthy and can concentrate urea to 2 per cent. or 3 per cent. in the urine, a slightly lessened output from heart-failure will not cause any increase in the blood-urea, but only an increased concentration of urea in the urine, as has already been shown.

Polyuria is dependent upon the rate of blood flow through the kidneys and in interstitial nephritis, a greater pressure is required to keep up this rate—hence the raised arterial pressure of this disease. Increased blood-pressure means more work for the heart, which will hypertrophy up to a certain point, and the patients' condition will remain pretty good. The nephritis may be said to be compensated by *cardiae hypertrophy*. But this state of things cannot go on indefinitely, and sooner or later the heart will become unequal to its ever-increasing task; the case has now become a true "Cardio-Renal."

The first sign of what Sir Clifford Allbutt has so aptly called "Cardiac defeat" in high blood-pressure cases, is *diminution of the amount of urine excreted*; the diminution may be slight and the amount passed may still be well above normal, but in spite of this urea will accumulate in the blood and uraemic symptoms may occur. These may lead us to diagnose an acute or subacute exacerbation of the nephritis, but they are nothing of the sort; they are symptoms of heart-failure and are due to "relative oliguria." In this condition, improvement depends upon the heart muscle, although the signs in the heart itself may be insignificant. "Our treatment should be permeated with the idea that *salvation can only be brought about by the heart*. And this view is most important in Cardio-Renal asystole because the cardiac manifestations are so obscure. We cannot too strongly insist that failure of the heart need not necessarily display itself by its classical signs, but may only show itself by isolated symptoms, of which oliguria is by far the most important."

The following is an example of relative oliguria: "In one of our cases a fall in urinary output from 3,000 cc. to 2,200 cc. was accompanied by an increase of blood-urea from 54 to 74 mg. per 100 cc."

That the amount of urine excreted is of such vast importance in obscure "Uraemic" cases is not sufficiently recognized, and this is why so many cases of uraemia are found to have normal kidneys, or

at all events, kidneys in which there is not sufficient pathological evidence to account for the symptoms.

Two of Dr. Batty Shaws' cases which died of "Uraemia" were found to have kidneys which were almost normal microscopically; but in both of them the urinary output fell very markedly during the last few days, so that their death may well have been due to cardiac defect giving rise to oliguria, which in its turn caused the uraemia.

I must apologise for so many references to the blood-urea concentration, since its estimation, although not difficult, is hardly likely to be undertaken by a busy practitioner.

It is, however, interesting to note that a system of prognosis in renal cases similar to Professor Maclean's was devised by Widal as long ago as 1911. Further information on this subject with full details of the various tests can be got from Maclean & Russell's very lucid article or from Maclean's recent book.

To sum up: If the kidneys are healthy, slight diminution of the urinary output due to cardiac failure will be compensated by increased concentration of the urea in the urine; but if the oliguria be pronounced, urea will accumulate in the blood, and uraemic manifestations may occur. When the kidneys are diseased they are not able to compensate for default of the heart, however slight, so that even a small diminution of the amount of urine secreted will increase the concentration of urea in the blood, and may quickly be followed by "Uraemia."

(Article by Dr. Frewen Moor in the London—"Practitioner").

"*Hugh Maclean's Urea Concentration Test* is carried out as follows: The patient is asked to empty the bladder, and immediately afterwards he receives by mouth 15 grm. urea dissolved in about 100 cc. of water. The bladder is emptied *one hour* and *two hours* after the urea has been given and the specimens of urine examined for urea content. If either specimen gives a percentage above 2, the kidneys are held to be fairly efficient; the higher the concentration the more effective is the renal function. The reason why two specimens are taken is, that in certain patients the urea given by mouth may produce a diuresis which tends to dilute the urine passed during the first hour. In this case, the second hours specimen should be examined. Indeed, in routine work it is generally best to discard the first specimen altogether, and to rely on the result obtained from the second specimen. Not more than about 120 cc. should be passed in the second hour.

Occasionally, if there is much fluid in the patients' system, it may be necessary to take a specimen after *three* hours, or even to repeat the test, but this is seldom necessary. In patients with marked diuresis this must be allowed for in estimating the renal function."

(Modern Methods in the Diagnosis and Treatment of Renal Disease.)—(Hugh Maclean—London, Eng.)

A. B.

Chinese Medicine

By Chi-Chen Wang in Hygeia, March 1926.

The Origin of Chinese Medicine.

CHINESE medicine is founded on experience rather than physiology. According to tradition, the great mythological emperor, Shen Nung (2800 B. C.), or the Divine Farmer, had a transparent trunk and transparent internal organs. These enabled him to taste all kinds of herbs and to watch the effects of the herbs on the various parts of his body. A book on herbs, which is still read by the old Chinese, is attributed to him.

Since the time of Shen Nung new uses for drugs have been discovered and in the sixteenth century the Pen Taso Kang Mu was published by imperial decree. This colossal work of fifty-two medical books lists thousands of substances, comprising the vegetable, animal and mineral kingdoms, and describes the curative properties of each substance. The book has been revised and enlarged, until now it is one of the monumental works of Chinese literature.

There are numerous books on prescriptions, which, besides listing successful remedies, treat the effects that can be secured through combining various herbs. The most famous of these books is the Pu Chi Fang, or universal prescriptions, which consists of 160 books and contains 21,000 different prescriptions.

Every prospective Chinese doctor studies these two books until he knows the more important herbs and prescriptions by heart. After he has learned the secrets of the medical books, he serves an internship by immediately beginning to practice, for until recently no license was required for the practice of medicine in China.

So by blundering and practicing, the Chinese doctor learns his profession. It is surprising how well he does under the circumstances. It is no doubt due to the fact that through centuries of accumulated experience, the Chinese doctors have discovered a reliable system of diagnosis and standard prescriptions. Each Chinese doctor has his pet theories, but on the whole, he follows the accumulated experience of his predecessors and varies only in the minor details.

Diagnosis by Feeling the Pulse.

When called out to see a patient, a Chinese doctor first feels the forehead of the patient to determine the degree of the fever or the absence of it; he does not use a thermometer. Then he feels the pulse

of both hands of the patient to determine where the ailment lies and what is its nature. The books on pulsations seem to have incorporated into their volumes the characteristic movements of the heart that accompany different diseases. Determining the pulse of the patient takes from ten to thirty minutes, according to the nature and complexity of the ailment.

Pen, ink and paper are then brought and the doctor writes his prescription; the prescription often contains more than a dozen herbs. The amount of each herb is specified and the way the remedy should be taken is also given. The prescription is taken to a Chinese drug store, where thousands of medical substances are kept in drawers that line the walls of the building. Each herb is wrapped in a separate package and labeled. The herbs are carried home, emptied into an earthen pot with two cups of water and boiled over a slow fire until the water is boiled down to about one cup.

The prescription is used for two or three days; at the end of that time the doctor is sent for and makes alterations in the dosage according to the condition of the patient.

The system of diagnosis by observing the pulse has some scientific background. There are four cardinal principles of pulsation which Chinese doctors consider axiomatic: a light pulse indicates external disturbances or causes; a deep pulse indicates internal causes or disturbances; a quick pulse indicates fever or heat, and a slow pulse indicates colds or chills.

The Chinese doctor, however, is not satisfied with these general distinctions. Each wrist is supposed to represent a different part of the body and each wrist is again divided into three parts, roughly corresponding to the first three fingers when they are placed on the wrist to feel the pulse. These three points are known respectively as the *tsun*, *kuan* and *chih*.

L. C. Arlington, writing on "The Mystic Art of Feeling Pulse," indicates the nature of the diagnosis: "If the left *tsun* is light and rapid, there is disturbance in the region of the heart, such as caused by external heat. If the right *tsun* is superficial and quick, it indicates that the disease is caused by external heat in the lungs and chest. If the *kuan* on the left wrist is deep and quick there is internal heat in the liver and gall; but if the *kuan* on the right side is deep and quick there is internal heat in the spleen and stomach. If the left *chih* is superficial and slow it indicates external cold in the kidneys and bladder. If the right *chih* is superficial and slow it indicates external chill in the kidneys and colon."

Even these fine distinctions are not enough for the Chinese doctors; they even presume to be able to predict death by feeling the pulse.

L. C. Arlington writes regarding this: "If the left *kuan* is sharp as a knife, it indicates serious complications in the liver and death may be expected within eight days. If all the six pulses or the right *kuan* in particular resembles the noise of a bird pecking, the noise of running

waters, or is like the sound of water dripping from a roof, or like the noise of the upsetting of a cup containing water, it indicates serious congestion in the bowels and death may be expected within seven days."

Chinese Pharmaceutics.

Chinese doctors divide all herbs roughly into the cool and the hot varieties. Certain diseases are classified as hot and others as cool or cold; fevers are generally combated with cooling herbs. However, Chinese doctors do not like sudden changes. They fear that the cooling medicine, if used in excess or too suddenly, would inhibit the transpiration of the fever. They start in with some mild herbs, neutral in nature, and gradually increase the amount of cool herbs. This gradual use of cool herbs is followed in case of the more serious diseases. In simpler fevers, cooling medicines are used without the preparatory process. Licorice is believed to be a mild medicine and to be neutral in character. It is used in almost every prescription.

Chinese doctors may not be scientific, but through centuries of experience they have discovered a number of remedies for various ills which Western doctors now use. Kaolin, a whitish clay found in many parts of China, has been used for centuries in Chinese medical practice and has been one of the staple medical ingredients. It is a favorite with Chinese doctors in prescribing for manifold fevers and intestinal ailments prevalent in the summer months. One of these summer epidemics is cholera, which breaks out regularly in China during the summer, owing to the lack of sanitary water and sewage systems. Long before Western doctors discovered kaolin as a curative for cholera, Chinese doctors had been using it.

Huashih (literally meaning slippery stone)—the Chinese name for kaolin—is kept by Chinese drug stores in its natural state, in lumps of varying sizes; kaolin is kept by Western pharmacies in a purified powder form. Everything from herbs to minerals comes in its natural state in China. It is believed by the Chinese doctors that the slow boiling of the different herbs brings out their curative properties.

Most of the ingredients Chinese doctors use have been founded on experience, but a number of the things used are based on imagination and superstition. An ancient comb, for instance, is solemnly described in the medical books as a remedy for hair that has been swallowed. According to directions, the ancient comb is to be burned and the ashes used with herbs that the doctor may prescribe. The comb, as an instrument for straightening out unruly hair, is supposed to be a remedy for hair in the stomach.

Nearly everything under the sun is described in the Chinese medical books. The budding horns of a wild buck, the bile of snakes, the exuvia of the cicada, species of mountain scorpions, the dirt in the middle of the road, the first frost gathered from the leaves of plants, old combs, ancient coins—in fact there is hardly anything that one

can mention that has not been used by Chinese doctors for some kind of illness. Fantastic things are, of course, only rarely used; the greater number of odd substances are used for chronic ailments. After standard remedies have failed to effect a cure, the patient will try anything that the ingenious doctor can devise. It is in this way that fantastic remedies came to find a place in the Chinese medical books.

Progress of Modern Medicine.

But all these things are bound to change and to give place to the more scientific practice of the West. The fond grandmother who wanted to call a Chinese doctor, to attend the child with measles was, as are many other grandmothers, fighting a losing battle. As the frontiers of modern education and science push forward, ignorance, superstitions, tradition and prejudice are receding. With the cities as centers of scientific enlightenment, the frontiers set up by them will soon merge until there will be little room for old-fashioned and unscientific medical practices.

The term "Western doctor" does not apply only to European and American doctors; it includes Chinese doctors who have studied in modern medical schools. Modern methods of sanitation and preventive medicine are being taught to the masses; this is paving the way for a general acceptance of Western doctors.

In reviewing the medical progress in China since the founding of the republic in 1911, Dr. Wu Lien-Teh, noted for his work in suppressing the pneumonic plague in Manchuria, writes: "In spite of the disturbed state of the country since the establishment of the republic in 1911, the progress of medical and sanitary science has been marked and steady. This has shown itself in two ways: (1) the readiness with which both the central government and the provincial authorities have established and supported hospitals and institutions of a sanitary nature; and (2) the increased interest shown by the general public in Western medicine, home cleanliness and matters bearing a hygienic value."

Chinese to Make Contributions.

It is doubtful, however, if old-fashioned Chinese doctors will vanish in this generation. Experienced Chinese doctors are expert in the treatment of nonsurgical diseases; even Chinese Western doctors will admit this. For a generation or two Chinese doctors will probably practice side by side with Western doctors, and when they finally pass on, some of their practices and methods will probably be incorporated into the new Chinese medical practice.

"I believe that a scientific study of Chinese medical practice will result in the discovery of a scientific basis for the Chinese remedies that have proved efficacious and important contributions to modern medical science," said a young American-trained Chinese doctor.

The Speech Complications Involved in Certain Types of Inadequate Palate, Especially Congenital Short Palate.

BY ELMER L. KENYON, M. D.,
CHICAGO.

DEFINITION OF INADEQUATE PALATE.

From the speech standpoint an adequate palate is one that is capable of completely closing the oropharyngeal nasopharyngeal isthmus for speech purposes. This closure may be accomplished, (1) entirely by the palatal structure coupled with the controlling action of the palatal musculature; or (2) by the palatal structures (of themselves alone usually inadequate) plus the assistance of muscles extrinsic to the palate, especially the superior constrictors. An inadequate palate is one that fails to completely close the pharyngeal isthmus for speech purposes, either with or without the aid of the extrinsic palatal muscles. If the palate of itself alone is organically incapable of completely closing off the nasopharynx, it is to be hoped that the associated extrinsic muscles may attempt their assistance in overcoming the deficiency. This aid does spontaneously develop in a certain, but limited, percentage of the cases of organic palatal self-insufficiency.

Inadequate palates are due to: (1) congenial cleft; (2) congenial insufficiency without cleft ("congenial short palate"); (3) injured palate (by disease, traumatism or operation; (4) paresis; (5) functional insufficiency.

The primary purpose of this presentation is to study speech complications, and not palatal defects. When the secretary requested me to take this meeting, I happened to have certain patients under observation who I thought would be of interest to other physicians. They are chiefly patients with congenitally short palates, and I shall largely base my presentation on these patients.

It is universally understood that uncompensated palatal defect results in a voice possessing open nasality; but it is not generally understood that such defects also produce other types of speech disturbance, sometimes even more important than the nasality itself. In one of the cases herewith presented four distinct types of speech disorder are present; and in two others, three types.

THE CONGENITAL SHORT PALATE.

Little has been written, and little is known, concerning the origin of the congenital short palate. By ordinary examination such a palate appears normal, both as to structure and to movement. Only on close comparative study is it found inadequate to close the pharyngeal isthmus on phonation. The voice is necessarily to a greater or less degree nasal.

In the case of a congenitally short palate the length of the soft palate (b—d, Fig. 1) is inadequate, under the conditions of palatal action, to accomplish the closure of distance e—b. In some patients (Case No. 1) the distance b—d is by measurement definitely less than distance b—e. In other instances of congenital short palate these two distances may be nearly alike (Case 2) and yet the palate e be unable to reach the pharyngeal wall. This is explained by the evident fact that the soft palate requires considerable more length than that indicated by the distance b—e in order to allow for its necessarily irregular curved form when in actual action to close the palate.

If the soft palate be organically and congenitally inadequate, the inadequacy, it has been maintained, is due to deficiency, not in the soft but in the hard palate. Tending to substantiate this assumption, one finds by palpation in certain congenitally deficient palates a central indentation, or defect, pointing forwards, in the posterior border of the hard palate. (See Fig. 2.) This is said to be a miniature of the larger defects of like character found in cleft palates. Such an indentation is present in Case No. 1. On the other hand, this defect sign in the hard palate is not always definitely present in these cases. Such is the fact in our Case No. 2. Moreover, the indentation is present in certain cases of entirely adequate palates.

For the present I am compelled, for want of a better reason, to explain some of these cases by assuming that Nature at times and for unknown reasons skimps in supplying sufficient length for the soft palate. (Fig. Insert 2.).

SPEECH COMPLICATIONS.

From the speech standpoint, the congenitally short and similarly impaired palates (like, for example, Case No. 3) are more dangerous than cleft palates. This is because the cleft palate is understood and is known to require not only operation, but also especial speech attention, while the other types, not being understood, are as to the speech allowed to drift indefinitely. This leads to the serious situations illustrated by our first three cases. Each of these patients suffers from three distinct types of speech disorder: (1) open nasality, (2) disordered articulation, (3) abnormally high pitched and monotony of voice. In addition, patient No. 1 stammers.

All of these speech defects are dependent on the fact that the palatal inadequacy dates from birth, or (Case 3) from early childhood. In Cases Nos. 1 and 2, the articulative defects are so great as to render the speech in large part not understandable. In Case No. 3, whose palatal inadequacy began at three years, after speech had begun to develop, the articulative defects have never been so severe as in Cases 1 and 2, and have now largely disappeared. The nasality, however, is most severe in Case No. 3, and least evident in Case No. 1. In the latter patient the "palatal accessory muscles," the superior constrictors, have entered into the effort to close the palatal breach and have become of such aid to the shortened palate (more inadequate than in either of the other two patients), that, when talking at his best, the nasality entirely disappears.

In each of these first three cases the voice is produced monotonously at a uniform pitch much higher than the natural voice of the individual. The thyroid cartilage (determined by finger palpation), instead of playing normally downwards and upwards as the particular sound demands with each normal effort at voice production, is held steadily upwards against the hyoid bone.

As to the origin of the high pitched monotony of voice in such cases, I am prepared at this time to say but little. I began to observe the tendency to abnormally high pitch of voice in open nasality cases some six or more years ago. The relationship between the nasality and high pitch is not limited to patients with organic nasality alone, but occurs also in some cases of functional nasality. Monotony with high pitch occurs also without nasality, as in the falsetto voice of puberty. I believe that in the open nasal voice the high pitch is a secondary phenomenon and is related psychologically, and perhaps also organically, to the nasality. My attention was called to these cases through systematic study of the action of the extrinsic laryngeal musculature by finger palpation of the thyroid cartilage in talking. Further comment on the origin of this phenomenon of high pitch in open nasality patients must be left to the time when it is better understood. Nor can I here discuss its corrective treatment, excepting to remark that in intelligent patients correction is always possible and that intelligent use objectively of the movements of the larynx is very helpful in the procedure.

In children with marked open nasality the defects in articulation, which often are many and serious, are dependent on the early and continuous disturbance of the psychophysiologic processes of speech development, resulting from the inadequacy of the peripheral apparatus to respond fully to such psychologic processes. The effort of the child to reproduce the word as spoken by others is from the start largely thwarted by the nasality of quality due to the palatal defect. Thus psychologic confusions and discouragements arise. These tend to cause the particular child to waver in, and ultimately even to cease, the normal continuous psychophysiologic effort of improving his

reproduction of the heard word. Consequently many such persons in later life continue to respond for speech purposes to the memories established in the motor word center in early childhood, and retained there with little self correction.

These serious lapses in the psychophysiologic processes of learning to talk are quite regular occurrences in congenital palatal inadequacy, including that of cleft palate. Since the later eradication of the articulative defects is out of all proportion more difficult than their prevention, every case of inadequate palate including especially cleft palate, should have as a matter of routine, the guidance of a skilled expert in speech training from the moment the speech has begun.

Why Doctors Die Young.

It is two o'clock in the morning. Dr. Blank has just returned from a case which he has been working on since seven. Just as he gets into a sound sleep, the telephone rings. He wakes with a start, rubs his eyes and mechanically leans over and takes the phone.

"Is this Dr. Blank?"

"Yes."

"Doctor, could you tell me a word of eight letters, the third letter of which is 'l' and the fifth 'd', the word meaning a disease prevalent among the house mice of Zanzibar?"

B. B. in *Life*.

Safety First.

"What precautions do you take against microbes?"

"First, I boil the water—"

"Yes, and then?"

"Then I sterilize it—"

"That's right, and then?"

"I drink nothing but beer."—*Pickup*.

Another Immortal.

Announcement of a Texas Colleague.

DR. J. W. MCDONALD.

The Specialist Chronic Diseases. Giney Cologey and Obstetrics,
Eye, Ear Diseases Cancers, Tumors Pelegra, Ect.

No Charges for Consultations.

Office Hours 8 a. m. to 4 p. m.

Buffalo, Texas.

Problems in Medical Education

AT the recent Annual Congress held in Chicago on Medical Education, Medical Licensure and Hospitals, President A. S. Mackenzie of Dalhousie discussed the above subject, which is thus summarized by the A. M. A. Journal:—

“Frequently it has happened that an enthusiastic and able body of legal, medical or dental men have conceived, gestated and accouched an infant school for the training of men for their profession, and have brought the child to the stage at which they can no longer nourish it, and have then laid it on the doorstep of the university of the community. The pressing appeal to the university to adopt the child which must otherwise perish is usually too strong to be refused. In this way Dalhousie University, founded in 1818 for the purpose of giving a liberal education in arts and science, came by its professional faculties. The explanation of the acquiescence of Dalhousie to such pleas will be obvious when it is stated that Halifax is 800 miles from McGill University in Montreal, which is the nearest large Canadian university.

This explanation has been given in order to lead up to the question confronting Dalhousie in 1911, when it took over the Halifax Medical College, a proprietary school that had been affiliated with the university for many years. The question was what service should a medical school be reasonably expected to give to the local community in which it was located, and to its constituency at large, in addition to the students whom it prepares for the practice of their profession. The conclusions reached by its authorities, keeping in mind the limited resources at their command, might be thus summarized:

1. To act as a focus of investigation of medical problems, and to give a lead in the information of public opinion on matters relating to health.
2. To offer to the practicing medical men something in the way of annual “refresher” clinics.
3. To take an active share in the provision of advice and assistance to those citizens of Halifax who were financially unable to pay for proper medical attention.
4. To disseminate knowledge of preventive medicine to the community.
5. To provide opportunities for demonstrating to students the bearing of social and home conditions on health.

6. To inculcate, in the coming generation of medical practitioners, their responsibility to the people of the community in which they practice for the prevention of ill health, and their duty to give freely of their energies in this direction.

7. To provide means through the medical school by which the activities of all agencies engaged in the work of caring for the health of the people might be correlated.

8. To assist the various hospitals in their relations to one another, and to bring the medical school into the necessary close touch and co-operation with all of them.

9. To utilize wherever possible the various medical and allied philanthropic agencies and aid them in avoiding conflicts and duplication of effort.

Perhaps it is too early to speak with assurance of the success of the experiment, but yet there seems no reason why it should fail except for a lack of the spirit of willingness for co-operation among agencies engaged in good work".

The Family Doctor.

A provincial weekly newspaper publishes an article under the above heading, and one paragraph is suggestive to all practitioners: "Whether in city or country, we cannot well spare the old family doctor. He is a necessity in any community, and usually the best-loved man in it. He values his profession not so much because it is one of the learned societies as because it gives him an opportunity to be of service to his fellow men. He knows his patients; many of them he has known since babyhood. He understands their peculiarities, their faults, their virtues, the traits of their constitutions. He is patient, tireless, resourceful. Even his brusque manner—if he has one—is only a transparent, protective covering for a warm and sympathetic heart. He is more than a medical man; he is a wise counselor and friend. No one comes so close to the lives and affections of the whole community; no one, unless it be the minister, labors so unselfishly and continually for the good of his neighbors. How fortunate the village, the neighborhood, the district in the city that has one or two such citizens. How incomplete the community that lacks one."

Never Too Old to Learn!

Los Angeles Examiner.

Helen Keller, born deaf, dumb and blind, called on President Coolidge to-day and carried on a brief conversation with him by reading his lips with her finger tips. She has acquired the faculty of speech since birth.

An Experience with Novasural.

Samuel Marcus,
New Germany, N. S.

THERE have been appearing recently in medical literature very favourable reports on the efficacy of Novasural as a diuretic in dropsy of cardiac and renal origin, and it appears that many clinicians of note have found this drug of undoubted value. Dr. McPhedran, in his address "Heart Disease in General Practice" delivered at the annual meeting of the Medical Society of Nova Scotia at Bridgewater on July 1st, makes favourable mention of it, and the February 1926 issue of The Canadian Medical Association Journal devotes an editorial to it. It is these favourable reports from reliable sources that impelled me to use this drug, as a last resort, in a case of advanced cardio-vascular renal disease, and my experience with it in this single case is interesting, because in the literature on the subject that has so far come to my notice, there is no report of a similar occurrence.

On July 25, 1925, I began to treat a woman of sixty-five with advanced cardio-vascular renal disease. For a while her response to digitalis and the ordinary diuretics was favourable, but later these proved ineffective, oedema began to increase, and dyspnoea became very marked. Paracatheterism and multiple incisions on the legs afforded but temporary relief. Finally, late in October, with the usual remedial measures proving ineffective, I decided to give Novasural a trial, and my experience with it is as follows.

On October 27 I administered 1 cc. of Novasural intramuscularly. This was at noon. At three the next morning I was called to the patient's home. On arriving there, I learned that she had voided at least twenty times since the injection of the drug, that on four or five occasions micturition was very painful, and that on these four or five occasions, she passed blood clots with her urine. (I confirmed the presence of blood by subsequent microscopical examination of the urine passed at that time). I inquired as to any previous similar occurrence, and received an answer in the negative. The patient quieted down after a hypodermic of morphia. During the next three or four days, the diuresis continued, though in a lesser degree, micturition was not painful and no blood appeared in the urine. There was marked reduction in the oedema, and her general condition improved somewhat.

When the diuresis subsided, I decided to give her a second dose of Novasural. This I did, intramuscularly as before, ten days after the first injection. (Nov. 6). This time marked frequency was

again produced, but no painful micturition or haematuria. There was further reduction in the oedema.

Encouraged with the result of the second administration, I gave her a third intramuscular injection of 1 cc. seven days later (Nov. 13). This time there was a repetition of the symptoms following the first administration (marked frequency, painful micturition, haematuria) and although the haematuria and painful micturition did not last over twelve hours, they distressed the patient so much that I decided to discontinue the use of the drug. In a few days the oedema began to increase once more, dyspnoea became markedly worse, and the case terminated fatally in December.

From this single experience one cannot draw any definite conclusions, but it appears that Novasurol, although undoubtedly a powerful diuretic, is not without its unpleasant effects in cases such as reported above. Of course, there is the possibility of the haematuria in this case being caused by some lesion in the urinary tract, but the non-occurrence of this symptom previous to the administration of Novasurol would almost rule it out, and its occurrence very soon after its administration would make one very suspicious of Novasurol as a causative factor.

A Test Case.

"What is it?" asked the doctor who had been hurriedly summoned at midnight.

"Nothing this time, doc.," answered Newlywed, looking at his watch. "My wife just wanted to find out how soon you could get here in case the baby was suddenly taken ill."—*American Legion Weekly*.

"Take one pill three times a day," said the doctor.
"It can't be done," said the patient.

"Where am I?" exclaimed the invalid, waking from the long delirium of fever and feeling the comfort that loving hands had supplied. "Am I in heaven?"

"No, dear," cooed his wife, "I am still with you."—*Silent Partner*.

Evangelist: ". . . and there shall be weeping and wailing and gnashing of teeth."

Old lady (in audience): "But, sir, I have no teeth."

Evangelist: "Don't worry madam, teeth will be provided."
—*The Dental Student*.

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

Confined to, and Covering every Practising Physician in Nova Scotia.
Published on the 20th of each month. Advertising Forms close on the
5th of month of issue. Subscription Price:—\$3.00 per year.

EDITORIAL BOARD.

Editor-in-Chief - - - GEORGE H. MURPHY, M. D., C. M.
Associate Editors - - - S. J. MACLENNAN, B. A., M. D.
H. B. ATLEE, M. D., C. M.
A. BIRT, M. D.
Secretary to Editorial Board - SMITH L. WALKER, B. A., M. D.

VOL. V.

APRIL 1926

No. 4

The Written Examination

IT is an extraordinary paradox that we, who belong to a profession where *practice* bulks so large, are for the most part adjudicated as to our fitness to enter it by a method which deals almost entirely with *theory*. Is there any other profession in the world that demands such a training of the senses and such finished practical workmanship? Is there any calling known to man where a knowledge of why and what to do must be so closely wedded with a knowledge of how to do? Does it matter if the young minister stammer over his sermon and trip over his prayers? Does it matter greatly if the young lawyer fail to discover the exact case in Blackstone, or apply the right case in a clumsy fashion? It does matter if the young doctor cannot handle the persistent occipito-posterior or diagnose the ruptured gastric ulcer. It does matter if his knowledge has been gained rather in the lecture room and the text book than in the clinic and at the bedside.

In spite of this, however, we continue to examine our medical students largely by the written examination. We hale him up before us once every year and set him the sort of questions that he can usually answer far better if he has studied his books well than if he has studied his cases well. Indeed, it must be common knowledge amongst us all that the type of man who does best in the written examination is often a great failure, or distinctly not a great success in practice. *Au contraire* it is often remarkable that the man who failed signally to distinguish himself according to the university standard has made a great success according to the world standard. I therefore ask myself two questions. First, are these written examinations that form the college standard the

best criteria of a medical student's ability to practice medicine? Second if they are not why do we cling to them?

It is a deplorable fact, well known to all the clinical teachers at Dalhousie Medical School, that students show a distinct tendency to slacken off in their attendance at clinics, ward visits and hospital practice in general during the last month of the term. The reason for this is that they are spending the time at home reading out of books so that they can better pass examinations which call, except in Surgery and Medicine in the final year, for a theoretical rather than a practical knowledge of their work. To my personal knowledge the last two medalists at Dalhousie, and fine students they were in both practice and theory, refused to attend cases at the maternity hospital during the last weeks of the term because these cases came on in the middle of the night and the loss of sleep would unfit them for book study the next day. Surely it is a travesty on our method of examination when a student can best pass that examination by neglecting his clinical cases for the sake of his books.

It is a good thing to know theory—and a necessary thing—but as I see it the primary consideration of all medical schools should be to turn out practical rather than theoretical men. This can only be done by arranging a course and by setting the type of examination that will force the student to approach the study of clinical subjects from the bedside rather than from the text book. To that end it seems to me that we should at least in the clinical years make all of our examinations of a clinical or practical nature and discard entirely the written examination. Nor alone in these subjects would I make the examination practical. As a clinical teacher I get students who can describe glibly a pathological condition but who cannot recognize a specimen showing the precise pathology. It is the same with anatomy and physiology. Surely this is wrong. But the more I have to do with students the more I realize that until we examine them by other means than the written examination we will not change this deplorable state of affairs.

There is another unfortunate side to the question. The student who has learned at college that success in the pursuit of a knowledge of medicine depends largely on a knowledge of the contents of text-books tends to carry the same delusion into practice. He makes these text-books his sheet anchor. Instead of deducing from the symptoms presented by a patient the underlying pathology he goes, if he is in doubt, to a book and fits the symptoms to a condition there described. Far be it from me to decry the help of text-books, but they should never be a medical man's sheet anchor. The great physician and the great surgeon are those who, with a sound basic knowledge of anatomy, physiology and pathology depend on their own senses, their own powers of deduction and use the written page only as an adjuvant.

One confesses frankly that in advocating the introduction here in Nova Scotia of practical examinations to replace the written exam-

inations that one is advocating something not practised elsewhere. Apart from the clinical examinations in medicine and surgery in the final year no other medical school on this continent has other than written tests. But is that any reason why we should not be the first to break the pernicious cycle? Wasn't it here in Nova Scotia that representative government was first achieved in Canada? And if the practical examination would have the effect, which I feel sure it would, of driving the student into the ward for his knowledge and keeping him there, of developing his senses and his reason rather than his memory, we would be doing a great thing for our profession in this province and setting an example that other medical schools would sooner or later follow.

H. B. A.

The Sheppard-Towner Act in the United States, which was discussed by Dr. M. R. Elliot of Wolfville in the May 1924 Bulletin and again in the January 1925 Bulletin, is again the football of conflicting opinions. This is despite the fact that millions of dollars of federal and state monies have been spent to enable its supporters to establish its merits. The Act has been unreservedly condemned by the American Medical Association. It may even come to be a factor in the next presidential campaign.

At the last Annual Session of the American Medical Association, seven cases of dislocation of the cervical spine, a forward dislocation of the Atlas on the Axis, were reported. These were all due to the ignorant and rough manipulations of Chiropractors.

The Chiropractor in New Jersey has a hard time. In November and December ten of these Irregulars were convicted or pleaded guilty and paid the fines with costs. It appears strange that similar action cannot be taken by the Provincial Medical Board in Nova Scotia. The Dental Society has been able to restrain unlicensed dentists from operating, although under competent supervision, but the Medical Society pays no attention to the need of protection of the people from the chiropractic charlatau.

Unusual Muscular Control:—Many physicians in the province will recall a man who made his living by demonstrating nearly all the possible dislocations of the body. Now comes a still more remarkable instance of what a person can do with his muscles.

The Prague Correspondent of the A. M. A. Journal is authority for the following:—

The relative prevalence of trachoma in the different districts

has not changed in the course of years. The territory along the Elbe with rich agricultural villages seems to be especially favorable to the spread of the infection. On the other hand, the mountainous districts are remarkably free. Lack of hygienic conditions among the agricultural population is apparently the chief factor favoring the spread of the disease.

Ectopic Heart.

Recently the Prague medical profession has seen an otherwise normal boy who was born with complete ectopia of the heart. Only three similar cases are described in scientific literature. The sternum is not developed, so that the bony structure of the thorax is open anteriorly although completely covered with skin. The lobes of the lungs touch each other, so that no space remains for the heart. The heart is completely naked and protrudes through an opening in the skin below the neck in the median line. The aorta and pulmonary artery are fixed in the opening, and the heart undulates on the two vessels. Naturally, the heart suffered from the exposure and it was provided with a glass cover, and is kept warm and moist with a physiologic solution. The anomalous position of the heart is a great obstacle to the blood circulation.

Nova Scotia Society for Mental Hygiene. The *Windsor Tribune* has the following news item:—

“Nova Scotia Society for Mental Hygiene.

Officers.

Dr. S. H. Prince—President King's College, Halifax.

Dr. N. J. Symons—Vice-Pres., 58 Robie St., Halifax.

Mrs. Stead—Secretary-Treasurer, 18 Quinpool Rd., Halifax.

Mrs. P. M. Fielding, received to-day from Dr. Prince, a notice which reads—“At a meeting of the N. S. Society for Mental Hygiene at Halifax for March 12th, you were unanimously nominated as a member of that body. What next?”

Two Chiropractors of Red Wing, Minnesota, were recently awarded 30 days in jail and a fine of fifty dollars for practicing without a license. The State Board of Ohio has caused an arrest to be made on a charge of manslaughter of a man who treated varicose ulcers with an ointment containing lead and the patient died of lead poisoning. Of course, if he had been treating the patient for cancer, and death had been from arsenical poisoning, and the patient had been in one of the provinces of Canada, the Jury would have brought in No Bill.

Gonorrhoea and the Chiropractor.

Seeing recently some new Chiropractor card in the provincial press, reminds one of some evidence given in a libel suit in Edmonton in 1921. The Palmer School of Chiropractic entered action for libel against the City of Edmonton and the College of Physicians and Surgeons, because of the advertisement in the City Telephone Directory, comparing the hours of study required in the courses of Medicine Osteopathy and Chiropractic. Some of the evidence is so ridiculous that no attention should be paid were it not a grave danger for the patient. For instance as follows:—

Q. Do you claim to find sublaxations in all cases of gonorrhoea?

A. All cases that I have seen have a sublaxation.

Q. Within what period of time after contracting the disease would this sublaxation set up?

A. The sublaxation precedes the contraction.

Q. Has it anything to do with the cause?

A. It is the cause.

Q. The sublaxation is the cause?

A. Yes.

The U. S. Government Needs Physicians.

The U. S. Civil Service Commission announces that vacancies exist in the Indian Service, Public Health Service, Veterans' Bureau, Panama Canal Service, Coast and Geodetic Survey, and other branches of the government, and that applications for positions will be received until June 30. The entrance salary ranges from \$1,860 to \$5,200 a year; there are higher salaried positions to be filled, and promotion may be made in accordance with civil service rules. There is a special need for physicians qualified in the specialties and in general medicine and surgery. Applicants will not be required to report for examination, but will be rated on their education and training and experience. Information can be obtained from the U. S. Civil Service Commission, Washington, D. C. (*A. M. A. Journal*).

Chinese Medical Sayings and Proverbs.—1. A doctor cannot cure himself (physician cure thyself). 2. The unlucky doctor treats the beginning of an illness; the fortunate doctor, the end. 3. A Huang Lu physician (a quack). 4. A quack has fish for breakfast and meat for dinner. 5. Quack doctors kill people. 6. To put one's life into the hands of a quack is to ask an ignoramus to correct an elegant essay. 7. The prescription is good but the medicine bad. 8. Quacks puncture and plaster, but only use spurious drugs. 9. Altering the prescription without changing the medicine. 10. Without perseverance, one cannot even become a priest-doctor.—*China M. J.* 39:1100 (Dec.) 1925.

The British Medical Association continues to find fault with the present system of public health services in England. Eleven official physicians for one family is quite possible. Each act of parliament dealing with health services only increase the chaos and wastefulness of health administration.

(Doctor Shepherd's Portrait).

On Saturday afternoon, February 13th, in the Assembly Hall of the Medical Building, a portrait of Dr. Shepherd was presented to the Medical Faculty and the University.

The function was made the occasion of a tea to which were invited the Governors of the University, members of the Board of Management of the Montreal General Hospital, members of the Medical Faculty, former pupils, assistants and admirers of the honoured guest.

Dr. H. S. Birkett, Chairman of the Presentation Committee and formerly Senior Demonstrator of Anatomy under Dr. Sheperd, said: "We have come together to honour one who has freely given his talents and his service to the considerable advancement of this University and to the Medical Faculty in particular. I have been privileged to know Dr. Shepherd as an eminent surgeon and teacher, and as a wise counsellor and friend for more than forty years, ten of which I, with Dr. Finley and others, spent in the Department of Anatomy; a training which has proved invaluable in after practice to all who were so fortunate as to receive it."

Dr. Fred. G. Finley, in releasing the Union Jack which veiled the portrait, described the latter as "a tribute of affection and regard universally felt for an old teacher, professor and friend. Few had brought greater distinction to McGill and have acquired greater eminence than had Dr. Shepherd as Anatomist, Surgeon, Dermatologist and Teacher. His powers had been recognized by such conservative bodies as the Royal College of Surgeons, of England and of Edinburgh, and the Universities of Edinburgh and Harvard, who had conferred upon him the highest Academic honours."

Accepting the portrait on behalf of the University, Dr. C. F. Martin, Dean of the Medical Faculty, reminded the audience that the new Medical Building had been erected during Dr. Shepherd's term of office as Dean, and graven in stone on the front part of the building is the portrait of Dr. Shepherd as well as that of Lord Strathcona, the donor of the edifice. In concluding his remarks, Dr. Martin said: "The portrait presented to-day will bear everlasting testimony of what a great and grand gentleman Dr. Shepherd always was."

Dr. Shepherd received an ovation upon rising to tender his acknowledgement of the honour conferred upon him. In strong voice and with his usual vigour he belied his seventy-five years as he proceeded to review his connection with the Medical School and the General

Hospital. He sketched the development of these two institutions during the period of more than half a century in which he had been intimately connected with them. Fifty-six years ago he had entered as a student. At the age of 23 he had accepted his first post at McGill, that of Demonstrator of Anatomy, then the only demonstrator in that faculty. He regretted that students of the present day graduated at such an advanced age, compared to the student of his time, since he considers that the most active formation period of a man's career is between the ages of 25 and 35, after which some of his initiative had been lost. His idea of training is not to turn out men fully equipped, but "trained to observe and investigate."

The portrait was painted by Miss G. DesClayes at the request of Dr. Shepherd's pupils, assistants and admirers—over two hundred of whom responded to the opportunity to join in the presentation. (*McGill News*).

Mercury as a Spirocheticide.

It has long been the unique distinction of the arsphenamines (606 and its successors) that in non-toxic doses they were capable of acting as spirocheticides, whereas mercury has always been given in subcurative doses because of its comparative toxicity. Now the claim is made that the organic mercury compound, Mercurosal, is spirocheticidal in non-toxic doses.

Based on animal tests in cases of syphilis artificially induced, the spirocheticidal dose of Mercurosal for a luetic patient has been fixed at 3.5 milligrams per kilo of body-weight, the injections (intravenous) being repeated at intervals of three days until ten are given. A 70-kilo patient would therefore receive 245 milligrams (0.25 gram) at a dose; but it is advised that smaller doses be given at first to test the patient's sensitiveness toward mercury.

The manufacturers, Parke, Davis & Co., put out an intravenous dose of 0.1 gram, and in addition a 50-cc rubber-diaphragmed bottle containing in each cubic centimeter 0.025 gram of Mercurosal, or 0.25 gram in 10 cc. It is claimed that, with caution, the dose can be built up by degrees to this figure, or, if doses of 0.2 gram or less are preferred, the injections can be given at two-day intervals. Mercurosal is said to be harmless to the vein; and this being so, the intravenous method of administration is, of course, the ideal one. See Parke, Davis & Co's advertisement on Mercurosal in this issue.

Halifax Branch, Medical Society of Nova Scotia

A REGULAR meeting of the Halifax Branch was held on the evening of Feb. 25th in the Medical Sciences Building. There were thirty-nine in attendance. After the disposal of some routine business, the meeting was addressed by Drs. A. T. Bazin and F. H. MacKay of Montreal.

Dr. Bazin first explained the working of the Extra-mural Post-graduate course made possible by the generosity of the Sun Life Assurance Society.

Dr. MacKay took as his subject "Some Spinal Cord Lesions." The importance of timely diagnosis was stressed. Tumor of the cord is often missed and a diagnosis made of some degenerative lesion. Lumbar puncture generally discloses the nature of the case when there is blocking off of the posterior sub-arachnoid space by a tumor. The fluid shows greatly increased globulin content, low cell count, and the fluid is of a yellowish tint.

Accurate pressure measurements are obtained by means of a mercury manometer described by the speaker. The drop method of estimation is considered worse than useless. Estimation of the fluid level by combined spiral puncture and cisternal puncture was described. Cisternal puncture should only be made when absolutely necessary.

If no variation in fluid level follows jugular compression, a block in the sub-arachnoid space is present.

After going into the subject very deeply, the lecturer showed a number of slides illustrating Disseminated Sclerosis.

Dr. A. T. Bazin then addressed the meeting, taking as his subject "Infections of the Biliary Tract." He pointed out first that we have no complete knowledge of the physiology of the liver and gall bladder. Infection takes place through a number of channels; but up the duct from the duodenum the speaker considers rare. The chief modes of infection are from the liver to gall bladder; possibly from the lymph stream; through the portal circulation; and the systemic circulation which the speaker thinks the most usual.

Acute cholecystitis is usually an accident—super-imposed on a chronic condition. Fat, flatulent females over forty are the common victims. The history is long—10 to 15 years. Signs are few: sometimes none. The gall bladder may be large, but hidden behind the liver. Tenderness of the liver itself is not Murphy's sign.

The lecturer went deeply into the various symptoms and signs, and the things to be looked for at operation.

The X ray work with tetraiods-phenolphthalein was referred to, and a number of plates shown.

Two to four days before bile appears in the urine, it may be detected in the blood.

Hyperglycemia is present in 75% of cases with disfunction of the pancreas.

The speaker gave the following rules of procedure:—

1. When chronic infection is limited to the gall bladder excise the gall bladder.
2. With engorgement of the liver or thickening of the ducts, excise the gall bladder and drain the common duct.
3. When there is obstruction of the common duct by cicatricial tissue do not remove the gall bladder.

Discussion of the papers was taken part in by Drs. K. A. MacKenzie, Nicholls, H. K. MacDonald, Murphy and MacDougall.

A regular meeting of the Halifax Branch was held in the Medical Sciences Building, College St., on the evening of March 10th. Thirty-one members were present. The programme for the evening was provided by those two beloved veterans Drs. Chisholm and Stewart.

Dr. Murdoch Chisholm read a paper entitled "Reminiscences." He stated that it was a misfortune for a man to become too self-centered, or too "profession-centred," and advised his hearers to keep an open mind and a watchful eye.

He described a case of irreducible hernia in which taxis had been tried unsuccessfully and which had finally been overcome by having the patient lie with the hernial side uppermost and thighs flexed. Taxis in this position was successful.

The terrors of diphtheria epidemics before the general use of anti-toxin were referred to.

A case was described of neuroma of the finger which had been treated by excision of the growth, and in which another had developed in the elbow region thirty years later.

Schoolday trials and tribulations were recounted; and the reason for entering upon the study of medicine, instead of theology as originally intended, explained. This step was taken on the advice of Drs. Gordon and Parker. Student days at McGill were described, and tribute paid to the teachers of that time.

The speaker considers a period of country practice an excellent preparation for a post-graduate course. The days spent at St. Thomas Hospital, London were referred to.

Dr. Chisholm thinks our primary branches are as well conducted as any: the value of places abroad being the greater quantity of clinical material available.

The speaker exhibited a number of instruments of his own devising viz:—a uterine repository; empyema tube; reinforced filiform bougie; and a filiform bougie with a sheath.

Dr. John Stewart exhibited a large number of bones from the collection lately presented to the Surgical Department of Dalhousie University by Mr. Francis M. Caird of Edinburgh.

Dr. Stewart first showed a plaster cast of the head of one Robert Penman, giving the history of that young man of "remarkable fortitude."

The bones exhibited were from all parts of the body including skulls showing syphilitic and traumatic, rachitic pelvis, bilateral tuberculosis of the hip, fractured ribs, specific os innominatum, tuberculosis of the ischium, fracture of femur with malformation, ankylosis of knee, tubercular spine, section of spine with two ribs firmly ankylosed to it, and many others.

Dr. Stewart considers osteomyelitis a much graver condition than tuberculosis. No harm is done by early incision or trephining.

Discussion of the paper and demonstration was taken part in by Drs. Hogan, Murphy and Rankine.

Aphorisms of Hippocrates.

- (1) Life is short and Art long; the occasion fleeting; experience fallacious and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, attendants and externals co-operate.
- (2). In acute diseases it is not quite safe to prognosticate either death or recovery.
- (3). Acute diseases come to a crises in fourteen days.
- (4). Persons who are naturally fat are apt to die earlier than those who are slender.
- (5). Autumn is a bad season for persons with consumption.
- (6). Blood or pus in the urine indicates ulceration either of the kidneys or the bladder.
- (7) Those cases of epilepsy which come on before puberty may undergo a change; but those which come on after twenty-five years of age for the most part terminate in death.
- (8) Spontaneous lassitude indicate disease.
- (9). It is better that a fever succeed to a convulsion, than a convulsion to a fever.

Halifax Branch.

A REGULAR meeting of the Halifax Branch was held in Room 11, Medical Sciences Building on the evening of March 24th. Attendance 29.

Dr. Clement MacLeod was elected to membership.

After some routine business had been disposed of, the meeting was addressed by Dr. J. H. Allingham of Saint John, N. B., who dealt in a masterly manner with the subject of "The Surgery of Pulmonary Tuberculosis." He traced the development of the operation of extra pleural thoracoplasty, and pointed out that the proceeding was not curative: but simply puts the lung at rest. In this class of case, the closest co-operation between internist and surgeon is necessary.

Three operations are practiced, viz:—1. artificial pneumothorax. 2. extra-pleural thoracoplasty, 3. radical phrenicotomy. Pneumothorax is indicated in those cases which do not improve under ordinary treatment.

Where the lung fails to expand thoracotomy is indicated.

The mediastinum must be carefully observed for its reaction under collapse.

Indications for thoracotomy:—

1. Where the lesion is one sided.
2. Productive type—i.e. with a tendency to fibrosis.
3. Those cases in which pneumothorax has failed.
4. Those who for some reason cannot keep up pneumothorax treatment.
5. Those with much fibrosis, and with displacement of the heart.
6. Chronic otelectosis of the lung.

Contra-indications:—uncompensated heart disease, diabetes, etc.

The operation should not be performed upon patients under fifteen years of age.

Complicating tuberculous conditions in other parts of the body are not regarded as contra indications.

Patients should be in hospital at least a week before operation. Blood pressure, kidney function and vital capacity should be carefully estimated. A low blood pressure is a bad indication.

The vital capacity in the majority of cases is 1700 cc. the patient may with advantage be digitalized before operation.

Place the patient in the position which best favours the excretion of sputum.

The results of the operation are remarkable—the appearance of the patient changes rapidly for the better; temperature is reduced; facilli disappear from the sputum which becomes greatly lessened or absent. Bleeding and cough also disappear.

The operation should be done in two stages.

The posterior end of the rib should be cut as close to the spine as possible. The 11th rib must be cut to reduce the action of the diaphragm.

Section of the first rib is essential to secure collapse of the apex of the lung.

Some operators remove the lower ribs first; but Dr. Allingham prefers to begin with the upper. However, this is governed by the conditions existing.

The two stages should be performed within three weeks. Anesthetic: Novocaine 1% and nitrous oxide and oxygen.

Removal of too much rib may be worse than not enough. Fixation is probably of more importance than collapse.

The operative mortality is not high. Deaths within three months of operation are considered to be operative deaths.

Dr. Allingham has performed 35 operations on 15 cases with one death—a mortality of 6.6 per cent.

Phrenicotomy was then discussed. This is the section, or in some cases the removal of a portion of the phrenic nerve. Lesions at the base of the lung are the chief indication for this form of treatment. The operation is performed under local anaesthesia, and the speaker described the technique in detail. The infiltration often renders recognition of the nerve difficult, and one must be very careful to distinguish between phrenic and vagus. The latter has been cut by mistake.

Care must also be taken to avoid the sympathetic roots, and the thoracic duct.

Phrenicotomy is an adjunct to thoracotomy, and is also a big aid in itself.

A series of lantern slides was shown illustrating Dr. Allingham's cases; and he also exhibited several instruments that he has found particularly useful in performing thoracotomy.

The address was discussed by Drs. H. K. MacDonald, K. A. MacKenzie and Scieniewicz.

Before adjournment, a motion of sympathy was passed with the family of the late Dr. A. C. Hawkins who was a past president of the Halifax Medical Society.

W. L. M.

PERSONALS

Dr. J. S. Brean is again School Commissioner for the Mulgrave Schools.

At Springhill on February 8th, 1926, to Dr. H. L. and Mrs. Simpson, a daughter, Beatrice.

Mrs. Webster, wife of Dr. C. A. Webster, Yarmouth, with her two children, returned home the last of March, after spending the winter in Boston.

Dr. C. Sherlock McGill, (McGill University 1923) after having spent two years attached to the medical staff of the Rockefeller Institute in Pekin, has returned to his home in Shelburne, N. S.

It is suggested by the Eastern Chronicle that Dr. John Bell of New Glasgow, would be appointed to one of the vacant seats in the Legislative Council. It would be a popular appointment in Pictou County.

Dr. A. S. Kendall of Sydney, recently addressed the Y's Mens' Club at the Y. M. C. A. Sydney, at their regular luncheon. He spoke on the progress of medicine, emphasizing growth of hospitals and preventive medicine, also pointing out progress in methods of treatment.

Glace Bay appreciates its Health Officers. The Gazette has the following to say of Dr. M. T. Sullivan who had this duty for three years:—

"The reason for Dr. Sullivan's success as public health officer is to be found in the fact that he took a genuine interest in the duties of the office, and was at all times keenly alive to matters affecting the public health. He can take satisfaction in the reflection that at the close of his term, general health conditions in the community could hardly be better, and this, notwithstanding quite a number of drawbacks from the public health officer's standpoint."

It then goes on to speak a good word for his successor, Dr. Calder:—

"The supervision of the public health will, however, continue to be in competent hands. Dr. Calder, the new health officer, is, it is needless to inform the people of Glace Bay, thoroughly qualified for the post. As he is also a public spirited citizen, he may be depended upon to give the health of the community the attention which so important a duty calls for.

Dr. James Doull, who was mentioned in the Bulletin for February, as going to do special research work in Rio Janiero for John Hopkins, sailed from New York the last of March. He was accompanied by his wife and little daughter. Mrs. Doull was formerly Miss Ethel McQuarrie of Glace Bay. The doctor will study Epidemiology.

In the December Bulletin, reference was made to a number of Truro doctors who were prominent in football circles from 20 to 40 years ago. Reserve, C. B., claims in Dr. Dan McNeil a member of the 1906 famous Reserve team. "Big Dan" was not only a football player of might, but is said to have been willing at any time to settle disputes with his hands alone if desired.

On March 26th, 1926, in Toronto, one of the grand old men of Eastern Canada Methodism celebrated his eightieth birthday,— Rev. A. D. Morton, M. A. D. D. Thousands of people in the Maritime Provinces and Newfoundland would have been pleased to extend him their congratulations. Some two years ago he spent several weeks in Halifax, the guest of his son Dr. C. S. Morton. At that time he was making almost a continental tour and travelled alone.

A post card with a picture of the "Splendid Hotel Savoy" Naples, also conveys the following message:—

Day travel only, to see everything possible. After visits of varying length to London, Paris, Aix des Reims, Turin, Genoa, Rome, etc., we are now enjoying the delightful climate and beautiful scenes in and around Naples. Have just returned from a wonderful sea excursion on the Bay of Naples and Mediterranean, visiting the Islands of Capri, Loreneta, Blue Grotto, etc., Next week expect to visit Vesuvius, Pompei and other historic regions, and later embark on Cunard S. S. Mauretania for a visit to Monaco, Villefranchi, Nice, Mentone, Monte Carlo, Cannes and then along the French and Italian Riviera to Florence, Venice, and Vienna and then back to Paris again, that wonderful city which seems to have a magnetic influence upon us as upon those susceptible to the lures of the world, the flesh and the devil.

Kindest regards to all.

(Signed) W. B. MOORE."

March 15-1926.

OBITUARY

ARTHUR CHARLES HAWKINS, M.D., C.M., McGill University
1885 Halifax, N. S.

The Evening Echo of Halifax on March 19th, 1926, had the following reference to the late Dr. A. C. Hawkins:—

“Dr. A. C. Hawkins, one time Mayor of Halifax and one of the best known physicians in the North End, passed away this morning at his residence 383 Brunswick Street. Dr. Hawkins was ill since last September but it was only recently that his condition was known to be serious and the news of his death will come as a shock to many friends.

Born in Halifax 64 years ago, he had practiced here for over 40 years and his practice was large and extensive. He was kindly, generous man and always ready to aid those in trouble or difficulties. He was a graduate of McGill Medical College. For 13 years he served as alderman in the City Council representing wards 5 and 6, and was in 1918 Mayor of Halifax. He married Miss Caroline Spike, of Halifax, who survives him also surviving are six children, three grand children and one brother and one sister. The children are Dr. R. C. E, Arthur and Cecil, Miss Carol, May, wife of A. M. Butler, Dorothy, wife of C. Russell Johnson. The brother is Giles Hawkins, manager of the Bank of Montreal, Fredericton, and the sister Mrs. Anna Brehaut of Manchester, N. H.

The late Dr. Hawkins was a past master of Virgin Lodge A. F. and A. M., having been Master in 1890. He was also a member of the Knights of Pythias and was an Ex-President of the Halifax Medical Society.”

The death occurred in Halifax March 29th, 1926, of the widow of Colin Pitblado M. D. Mrs. Pitblado was a daughter of the late John Thomson of Halifax.

Dr. B. R. Ilsey, died January 23rd, in hospital in Vancouver. He was born and brought up in Kings County, N. S.

The death occurred at Sydney Mines on March 12th, 1926, of James Francis, aged 79 years. He has been connected with mining in important positions and in civic affairs in Sydney Mines all his life. Dr. Bernard Francis of Sydney Mines is a son of the deceased.

Report of Post Graduate Meetings

Under Canadian Medical Association Auspices for the Maritime Provinces and Newfoundland.

PLACE	DATE	SPEAKER
Sydney.....	Sept. 10, 1925....	DR. F. J. TEES, Montreal.
Sydney.....	Sept. 10, 1925....	DR. M. RABINOVITCH “
Kentville.....	Dec. 15, 1925....	DR. J. A. NUTTER “
Sydney.....	Dec. 16, 1925....	DR. J. A. NUTTER “
Halifax.....	Dec. 17, 1925....	DR. J. A. NUTTER “
Halifax.....	Feb. 25, 1926....	DR. A. T. BAZIN “ DR. F. H. MACKAY “
Summer Tour.....	June.....	3 speakers to be secured.
Dalhousie Summer School Halifax	August.....	4 speakers to be arranged.

PRINCE EDWARD ISLAND.

Summer School Charlottetown.... July 5-10, 1926... 3 speakers to be secured.

NEW BRUNSWICK.

Saint John.....	Dec. 14, 1925....	DR. J. A. NUTTER, Montreal.
Fredericton.....	Jan. 12, 1926....	DR. H. L. ABRAMSON, Saint John.
Fredericton.....	Feb. 22, 1926....	DR. A. T. BAZIN, Montreal. DR. F. H. MACKAY “
Saint John.....	Feb. 23, 1926....	DR. A. T. BAZIN, Montreal DR. F. H. MACKAY “
Moncton.....	Feb. 24, 1926....	DR. A. T. BAZIN, Montreal. DR. F. H. MACKAY “
Provincial Tour.....	April, 1926....	2 speakers to be secured.

NEWFOUNDLAND.

St. John's.....	July 11-17, 1926	SIR HENRY GRAY, Montreal. DR. K. A. MACKENZIE, Halifax
-----------------	------------------	---

THE CANADIAN MEDICAL ASSOCIATION

President—J. F. Kidd, Ottawa.

President-Elect—David Low, Regina. Annual Meeting, Regina, 1925.

Vice-Presidents ex-officio—Presidents of Affiliated Associations.

Honorary Treasurer—A. T. Bazin, 836 University Street, Montreal.

General Secretary—T. C. Routley, 184 College Street, Toronto.

THE COUNCIL

A. Primrose, Toronto, <i>Chairman</i> .	A. F. Menzies, Morden.
J. F. Kidd, Ottawa.	H. K. McDonald, Halifax.
David Low, Regina.	J. S. McEachern, Calgary.
A. T. Bazin, Montreal.	F. W. Marlow, Toronto.
A. D. Blackader, Montreal.	C. F. Martin, Montreal.
T. C. Routley, Toronto.	D. P. Miller, Prince Albert.
H. B. Anderson, Toronto.	A. S. Munro, Vancouver.
J. F. Argue, Ottawa.	L. R. Morse, Lawrencetown, N. S.
L. J. Austin, Kingston.	T. A. Morrison, Regina.
J. Bell, New Glasgow, N. S.	S. E. Moore, Regina.
R. J. Blanchard, Winnipeg.	G. H. Murphy, Halifax.
G. S. Cameron, Peterborough.	T. A. Patrick, Yorkton, Sask.
A. M. Campbell, Winnipeg.	J. I. Pratt, Port Arthur.
J. G. D. Campbell, Halifax.	W. D. Rankin, Woodstock, N. B.
G. F. Dewar, Charlottetown.	W. N. Rehfuss, Bridgewater, N. S.
W. J. Egan, Sydney.	W. G. Reilly, Montreal.
W. J. Elliott, Brandon.	W. H. Secord, Winnipeg.
F. J. Farley, Trenton.	H. B. Small, Ottawa.
W. A. Gardner, Winnipeg.	F. N. G. Starr, Toronto.
W. Hackney, Calgary.	D. A. Stewart, Ninette, Man.
T. G. Hamilton, Winnipeg.	W. Turnbull, Winnipeg.
V. E. Henderson, Toronto.	J. M. Ulrich, Regina.
A. W. Knox, Weyburn, Sask.	C. H. Vrooman, Vancouver.
T. M. Leask, Moose Jaw.	S. L. Walker, Halifax.
J. H. MacDermot, Vancouver.	T. W. Walker, Saskatoon.
N. J. MacLean, Winnipeg.	N. W. Warner, Winnipeg.
A. A. Macdonald, Souris, P. E. I.	A. MacG. Young, Saskatoon.
M. MacLaren, St. John, N. B.	Geo. S. Young, Toronto.

EXECUTIVE COMMITTEE

W. G. Reilly, Montreal, <i>Chairman</i> .	T. G. Hamilton, Winnipeg.
J. F. Kidd, Ottawa.	C. F. Martin, Montreal.
David Low, Regina.	S. E. Moore, Regina.
A. Primrose, Toronto.	J. S. McEachern, Calgary.
A. T. Bazin, Montreal.	M. MacLaren, St. John, N. B.
T. C. Routley, Toronto.	F. N. G. Starr, Toronto.
G. S. Cameron, Peterborough.	S. L. Walker, Halifax.

SPECIAL COMMITTEES

Lister Memorial - - - - -	R. J. Blanchard, Winnipeg.
Conference on Medical services - - - - -	A. Primrose, Toronto.

MEDICAL SOCIETY OF NOVA SCOTIA

ANNUAL MEETING, JULY, 1926, AT HALIFAX

OFFICERS FOR 1925-1926.

President.....	Dr. E. V. Hogan, Halifax.
1st Vice-President.....	Dr. J. J. Roy, Sydney.
2nd Vice-President.....	Dr. L. R. Morse, Lawrencetown.
Secretary-Treasurer.....	Dr. J. G. D. Campbell, Halifax.
Associate-Secretary.....	Dr. S. L. Walker, Halifax.

EXECUTIVE

Cape Breton.

Dr. E. M. McDonald, Sydney.
 Dr. D. R. McRae, Sydney Mines.
 Dr. Dan. McNeil, Glace Bay.

Eastern Counties.

Dr. J. J. Cameron, Antigonish.

Colchester-Hants.

Dr. C. H. Morris, Windsor.
 Dr. E. D. McLean, Truro.

Cumberland County.

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

Lunenburg-Queens.

Dr. R. G. McLellan, Lunenburg.

Valley Medical.

Dr. M. R. Elliott, Wolfville.
 Dr. W. F. Read, Digby.
 Dr. F. S. Messenger, Middleton.

Halifax Branch.

Dr. V. L. Miller.
 Dr. J. L. Churchill.
 Dr. A. R. Cunningham.
 Dr. P. Weatherbee.
 Dr. F. G. Mack.

Pictou County.

Dr. H. H. McKay, New Glasgow.
 Dr. G. A. Dunn, Pictou.

COMMITTEES

Cogswell Library.

Dr. A. G. Nicholls.
 Dr. J. R. Corston.
 Dr. John Stewart.
 Dr. Philip Weatherbee.
 Dr. C. S. Morton.

Public Health.

Dr. A. C. Jost, Halifax.
 Dr. E. Kennedy, New Glasgow.
 Dr. M. E. Armstrong, Bridgetown.
 Dr. J. K. McLeod, Sydney.
 Dr. W. N. Reh fuss, Bridgewater.

Arrangements.

Halifax Medical Society.

Editorial Board—C. M. A. Journal.

Dr. W. H. Hattie.
 Dr. G. H. Murphy.
 Dr. J. G. McDougall.
 Dr. K. A. McKenzie.
 Dr. E. V. Hogan.

Workmen's Compensation Board.

Dr. G. H. Murphy.
 Dr. E. V. Hogan.
 Dr. M. G. Burreis.

Members of C. M. A. Council.

Dr. E. V. Hogan (Ex-Officio)	Halifax.
Dr. J. G. D. Campbell (Ex-Officio)	Halifax.
Dr. S. L. Walker (Ex-Officio)	Halifax.
Dr. W. J. Egan,	Sydney.
Dr. L. R. Morse,	Lawrencetown.
Dr. H. K. McDonald,	Halifax.
Dr. G. H. Murphy,	Halifax.
Dr. Ross Millar,	Amherst.

Nominated to Education Committee C. M. A.

Dr. K. A. McKenzie, Halifax, N. S.

Nominated to Legislative Committee C. M. A.

Dr. J. G. McDougall, Halifax.

Dr. W. H. Hattie, Halifax.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

CAPE BRETON

President.....	Dr. Allister Calder, Glace Bay.
1st Vice-President.....	Dr. D. A. McLeod, Sydney.
2nd Vice-President.....	Dr. D. W. Archibald, Sydney Mines.
Secretary-Treasurer.....	Dr. J. G. B. Lynch, Sydney.

EXECUTIVE

The Officers with Doctors McDonald, Patton and Curry. Nominated to Provincial Executive:—Dr. E. M. McDonald, Sydney, Dr. D. R. McRae, Sydney Mines, Dr. Dan. McNeil, Glace Bay.

COLCHESTER-HANTS

Officers 1924-25

President.....	Dr. R. O. Shatford, Londonderry.
Vice-President.....	Dr. E. E. Bissett, Windsor.
Secretary-Treasurer.....	Dr. H. V. Kent, Truro.

Executive Committee

Dr. J. B. Reid, Truro. Dr. F. R. Shankel, Windsor.

Nominated to Provincial Executive

Dr. C. H. Morris, Windsor, and Dr. E. D. McLean, Truro.

CUMBERLAND COUNTY

Officers

President.....	Dr. Wm. Rockwell, River Hebert.
1st Vice-President.....	Dr. J. R. Gilroy, Oxford.
2nd Vice-President.....	Dr. M. McKenzie, Parrsboro.
3rd Vice-President.....	Dr. W. V. Goodwin, Pugwash.
Secretary-Treasurer.....	Dr. W. T. Purdy, Amherst, N. S.
Members of Executive Medical Society of Nova Scotia:	
	Dr. W. T. Purdy, Amherst.
	Dr. J. A. Munro, Amherst, N. S.

EASTERN COUNTIES

Hon. President.....	Dr. Geo. E. Buckley, Guysboro.
President.....	Dr. W. F. McKinnon, Antigonish.
Vice-Presidents.....	Dr. J. J. MacRitchie, Goldboro.
	Dr. John McDonald Sr., St. Peters.
	Dr. M. E. McGarry, Margaree.
	Dr. M. T. McLeod, Orangedale.
Secretary-Treasurer.....	Dr. P. S. Campbell, Port Hood.

Executive Committee

Dr. J. S. Brean, Dr. J. A. Proudfoot, Dr. A. J. McNeil, Dr. Alex. Kennedy,
Dr. Owen Cameron, Dr. R. C. McCullough, Dr. B. A. LeBlanc, Dr. P. A. McGarry.
Nominated to Provincial Executive:—Dr. J. J. Cameron, Antigonish.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

LUNENBURG-QUEENS

Officers for 1923-24

President	Dr. J. S. Chisholm, Mahone.
Vice-President	Dr. F. T. McLeod, Riverport.
Secretary-Treasurer	Dr. L. T. W. Penny, New Germany.

Executive

The above Officers with:

Dr. A. E. G. Forbes, Lunenburg. Dr. F. A. Davis, Bridgewater.
 Annual Meeting is held on the second Tuesday in June of each year, and other Meetings on the second Tuesday of August and January, the time and place of the wo latter Meetings to be decided by the Executive.

PICTOU COUNTY

Officers for 1924-25

President	Dr. Clarence Miller, New Glasgow
Vece-President	Dr. M. R. Young, Pictou.
Secretary-Treasurer	Dr. John Bell, New Glasgow.
Members of Executive and nominated to the Provincial Executive:—	
Dr. H. H. McKay, New Glasgow and Dr. G. A. Dunn, Pictou.	
Benvie, S. C. McKenzie, G. A. Dunn, C. W. Stramburg, F. B. Day.	
Meetings:—First Tuesday in January April, July and October. Annual Meeting in July.	

VALLEY MEDICAL SOCIETY

President	Dr. E. DuVernet, Digby.
Vice-Presidents	Dr. G. K. Smith, Grand Pre.
“ “	Dr. H. L. Roberts, Digby.
“ “	Dr. W. C. Archibald, Annapolis.
Secretary-Treasurer	Dr. C. E. A. DeWitt, Wolfville.

Representatives on Executive of Medical Society of Nova Scotia:—

Dr. M. R. Elliott, Wolfville. Dr. W. F. Read, Digby.
 Dr. F. S. Messenger, Middleton.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

President	Dr. C. A. Webster.
Vice-Presidents	Dr. H. J. Pothier, for Digby.
“ “	Dr. C. J. Fox, for Yarmouth.
“ “	Dr. L. P. Churchill, for Shelburne.
Secretary-Treasurer	Dr. T. A. Lebbetter, for Yarmouth.

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

Dr. A. R. Campbell, of Yarmouth.

HALIFAX MEDICAL SOCIETY

1925 Officers 1926

President.....	DR. F. R. LITTLE
1st Vice-President.....	DR. P. WEATHERBE
2ND Vice-President.....	DR. S. R. JOHNSTON
3RD Vice-President.....	DR. V. L. MILLER
Secretary-Treasurer.....	DR. W.L. MUIR

Executive

The above Officers with
 DR. H. W. SCHWARTZ
 DR. G. W. GRANT

PROGRAMME FOR 1925-1926

- NOV. 4th. Opening Meeting - - - - - Carleton Hotel
 PRESIDENT'S ADDRESS
- NOV. 18th. Nova Scotia Hospital.
 CLINICAL EVENING
- DEC. 2nd. Victoria General Hospital.
 CLINICAL SURGICAL
- DEC. 16th. "Paralytic Deformities, especially in Childhood."
 DR. J. APPLETON NUTTER
 Orthopaedic Surgeon to the Montreal General Hospital.
- JAN. 13th. "Purulent Disease of the Accessory Nasal Sinuses."
 DR. H. W. SCHWARTZ
- JAN. 27th. Victoria General Hospital.
 CLINICAL MEDICAL
- FEB. 10th. Dental Symposium—"Focal Infection, Deformities, etc., etc."
 DR. W. W. WOODBURY AND J. S. BAGNALL
- FEB. 24th. "X-Ray Diagnosis of Bone Conditions."
 DR. S. R. JOHNSTON
- MAR. 10th. Subjects to be Announced.
 DR. JOHN STEWART
 DR. MURDOCH CHISHOLM
- MAR. 24th. "The Surgery of Putmonary Tuberculosis."
 DR. J. H. ALLINGHAM
 Saint John, N. B.
- APR. 14th. "Recent Advances in the Physiology of Gastric Secretion."
 DR. BORIS BABKIN
 Professor of Physiology, Dalhousie University.
- APR. 28th. Annual Meeting.
 ELECTION OF OFFICERS, ETC., ETC.

Dr. Elliot P. Joslin, Boston's world famous expert in the insulin treatment for diabetes, was lecturing to a large group of patients and student physicians at the Deaconess Hospital.

Slender of build, but erect and wiry, radiating health and energy Dr. Joslin delivered his message in his usual rapid-fire style. Afterwards, relaxing a little, he devoted five minutes to a question and answer period.

Many and bitter were the wails from various sufferers, most of them over-weight, who are taking treatments which cut their daily rations down to measured calories, many of the diets falling hundreds of calories below the normal average of 1500.

Reassuring the complainants, Dr. Joslin attempted to explain how light a menu even he, a man in perfect health found satisfactory.

"How many calories a day, madam," he asked one ponderous woman, "Do you imagine I eat myself?"

The lady looked at the lecturer pittingly.

"About 80, I should think, doctor," she blurted out, "You seem so terribly skinny."

NEO-SILVOL

A Colloidal Compound of Silver Iodide

NEO-SILVOL appeals to discriminating physicians and is becoming increasingly popular with the profession for the reason that it is an effective germicide, does not cause irritation, and does not produce unsightly stains on the clothing or skin and mucous membrane.

Clinically, Neo-Silvol is very valuable in inflammatory infections of the eye, ear, nose and throat, in 10- to 25-per-cent solutions. In gonorrhoeal ophthalmia 25- to 50-per-cent solutions may be required.

Neo-Silvol is supplied in 1-ounce and 4-ounce bottles and in 6-grain capsules, 50 to the bottle. The contents of one capsule dissolved in a fluid drachm of water makes a 10-per-cent solution. An ointment of Neo-Silvol, 5%, in small collapsible tubes with elongated nozzle, and Vaginal Suppositories of Neo-Silvol, 5%, with a glycerogelatin base in soft tin capsules in boxes of twelve, may also be had.

PARKE, DAVIS & COMPANY

NEO-SILVOL HAS BEEN ACCEPTED FOR INCLUSION IN THE N. N. R. BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE A. M. A.