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82nd Annual Meeting of the Medical Society of Nova Scotia

PRESIDENTIAL ADDRESS, 1935

D. McNeil, M.D.

A YEAR ago, at the annual meeting in Yarmouth, your Society saw fit to elect me to the office of President for the ensuing year. I left that meeting feeling highly honored to have been chosen President of the Medical Society, but at the same time realizing the responsibility that goes with such an office. Feeling that the members of our society in large numbers would come to this year's meeting, to learn, to renew old acquaintances, and to enjoy real Cape Breton hospitality, I resolved to do everything possible to make our annual meeting, both as regards the scientific part and the matter of entertainment, one of the most successful. Unfortunately, many things—things over which we have no control—soon made it impossible for me to carry out my good resolutions. In a few months I began to feel that all was not well with me, with the result that for the past six months I have been a hospital patient, and most of that time practically at death's door. Thanks to Medical Science and to the Divine Healer, who rules over all, there seems to be a ray of hope, and the future looks much brighter than it did a few months ago. But if unable to attend to the details of arranging this meeting, your able, industrious and obliging Secretary, together with the members of the Cape Breton Medical Society have left nothing undone to make this meeting a success. Your Secretary has arranged the scientific part of the programme, and may I here, on behalf of our Society, welcome to Cape Breton, our distinguished guests: Doctors Bazin, Meakins and Frazer of Montreal and Dr. Menzies of N. B.; Dr. Dewar of P. E. I. May your stay with us be a pleasant one, and may we hope that you will return at some future date. The members of the Cape Breton Society have arranged the social side of the programme, and I hope and trust that each and every visiting member, with his family, will enjoy themselves to the full with the entertainment that has been provided. Need I express my deep personal sense of gratitude to our Secretary and to the members of the Cape Breton Medical Society.

It is customary for your President to review briefly the events of the past year. Without a doubt, the outstanding event was the celebration by the peoples of the British Empire, of the twenty-fifth anniversary of our beloved King's accession to the throne. This was a joyous occasion for us all, and a proud one for our profession and our society in that some of our members were the recipient of Jubilee medals for devoted service to suffering humanity and high-minded citizenship. I refer to the honors conferred on Dr. M. G. Tompkins of Dominion and the late Dr. Nat Macdonald of Sydney Mines and others.

On the occasion of the Jubilee, it was indeed a happy thought on the part of His Excellency, the Governor General of Canada, that Canada's

contribution should take the form of a general subscription to provide for the care and treatment of those afflicted with cancer, as well to encourage and assist research work for the conquering of this disease. The application of a scientific knowledge to the problem of cancer is, and ever must remain, the responsibility of the Medical Profession. Should it not be the earnest prayer of each and every one of us that the causes of cancer may be discovered in the research laboratories of our great Empire and effective remedies provided.

In looking over the ranks of our profession, it is indeed pleasing to state that during the past year the toll of Death has not been great; in fact, very few deaths have occurred among the members. Permit me to state, that we in Cape Breton suffered a great loss in the sudden and unexpected death of Dr. Nat MacDonald of Sydney Mines just a few weeks ago. And while, as I said, the number of deaths in our ranks has been small, still it is a striking fact that so many medical men pass to the Great Beyond in what should be the mid-day of their careers; men, between forty-five and sixty years of age; men carried away and too often suddenly at the time when they should be the most useful in their respective communities. There must be and there is a reason. The Scriptural injunction, "Physician, heal thyself," is too often forgotten. We are too conscientious regarding the aches and pains of our patients, and pay too little attention to ourselves. May I suggest that this matter be discussed at this meeting; that an amendment be placed in the constitution of our society, that each member undergo a thorough examination each year.

The BULLETIN, the monthly Journal of our society, has maintained its high standard during the year, and it is very much appreciated by the members, and by medical men beyond the boundaries of our Province. To the Editorial Staff, and to all who have contributed, we are deeply grateful. Might I suggest that in regard to the BULLETIN, more members avail themselves of the opportunity of reporting interesting cases, and the contributing of short papers on some scientific subject. Along with that, I would suggest that each one of our County Societies arrange for at least one purely scientific meeting yearly, and the respective Secretaries report fully the proceedings of the meeting for publication in our BULLETIN.

With regard to public health, this has received its fair share of attention. The Health Department of our Government has always been most courteous in attending to the matter of venereal diseases; in the outbreaks of serious epidemics, it has always been ready to co-operate with the medical men in preventing the spread of these diseases; in the matter of tuberculosis, despite the limited funds at their disposal, the Health Department is prepared to do everything in their power to eradicate and to prevent the spread of the disease. At the present moment, there is a move on foot to have a survey made, especially here in the industrial sections of Cape Breton, of our tuberculosis situation, and from it we hope and feel sure that increased hospitalization will result, either through the annex system, or by a central sanitorium similar to the institution at Kentville.

During the past year, the storm of industrial depression that swept over every country since 1929 has eased somewhat. Yet, it has reduced many persons from a position of financial independence to one of indigency; has brought those who were once in very good circumstances down to a scale of living below the comfort level. Along with this, we have had the slashing of incomes of the well-to-do, so that their contributions to charitable purposes

have been greatly reduced, and in some cases abandoned all together. Thus, with unemployment rampant, with charitable organizations lacking funds, Town, County and Federal authorities have been obliged to assume increased obligations in order to provide even food, and in some cases lodging for the destitute and needy. Certain communities have found the burden great, and frequently scanty provisions have been made for our poorer medical sick. The extra burden has fallen chiefly on the physicians and surgeons of the community to supply medical and surgical services to the indigent sick without remuneration. The members of the medical profession have responded nobly, with the result that there are many men within the medical ranks who are almost reduced to the level of indigency themselves. But yet, the health of any community is the responsibility of that community; the medical service of the indigent sick is a part of that responsibility, and it should be paid for from community's funds, and not borne by the physician. Consequently, more effective methods of supplying medical and surgical service to the indigent sick and suffering, and of providing suitable remuneration for those who give this service, is an immediate and urgent necessity. The present situation is of grave importace to the members of the medical profession. Various plans are in the air over this matter. There is a great deal of talk about state medicine and Health Insurance, and in some Provinces of the Dominion, plans have been adopted, notably in British Columbia and Alberta. Ontario, at the present moment, is considering the whole question. But it is sufficient to state here that any plan or system that in any way interferes or places any limitation on the practice of medicine by the physician through the substitution of a "Mass Production" practice, and subject to regulations, commercial, political or legislative, would be destructive to the practice of scientific medicine. Again, any plan adopted should include complete service for the patient; that is to say, Hospitalization, if necessary; X-ray and nursing attendance; should allow the free choice of physician or surgeon, who will be paid on the basis of service rendered, and especially in the case of the unemployed and indigent out of funds provided by the state.

In this connection, it might be well to make mention of the fact that our municipalities are planning to discuss the question of hospitalization of their indigent sick at their forthcoming convention in August, with a view of changing or amending the Act, whereby they are charged with the expenses for treatment, and at the same time taking out of the hands of the physician the power, if you will, of what shall be done with the indigent sick, and requiring the approval of the Overseers of the Poor. At the recent Nova Scotia and Prince Edward Island Hospital Convention, this matter was the subject of considerable discussion, and it was decided to send a strong delegation to the meeting of the municipalities to endeavor to convince that body of the danger of a change in the Act. I feel that a delegate from this society should attend this meeting also and support the Hospital Association in this matter. As has been already said, the responsibility for caring for the indigent sick belongs to the community.

In conclusion, I would again thank you for the honour that has been mine. That the Nova Scotia Medical Society may continue to prosper, is my earnest wish.

Tuberculosis Laryngitis*

A. E. DOULL, M.D.

TUBERCULOUS laryngitis is an infection of the laryngeal mucosa, the tubercle bacilli being the infecting organisms; and these are brought to the larynx by means of the lung secretions.

It has been estimated that between 25 and 30% of patients suffering with pulmonary tuberculosis are afflicted with involvement of the larynx. It is rarely found in children; most frequently in those under, rather than over forty, and the distribution is about equal in the sexes.

In speaking of tuberculous larynges, we will consider them as secondary to primary lesions in the lungs, and therefore they cannot be classified as separate diseases. There have been cases reported as primary, and it is quite within the range of possibility, that there might be an extension from a tuberculous ulcer of the tonsil, and Lake has reported involvement of the larynx from secretions from primary tuberculous infected ears, the Eustachian tube being the connecting link, the secretions passing from the middle ear. It is also possible that the larynx might become infected through the lymphatics, because of a cervical adenitis of tuberculous origin: but these cases are so few, that we will, for practical purposes consider all cases as secondary to the lung lesion; and perhaps this complication is the most frequent one in pulmonary tuberculosis. It may be difficult, at times, for the internist to detect the focus in the lung because of its small size, and then again, where there had been a focus, it may have healed.

The frequency varies with the stage of the pulmonary disease. The more advanced the lesion, the more likelihood of laryngeal involvement. In the early stage, about 12% of the patients have this complication, the moderately advanced cases, about 26%, and 45% or more in the terminal process.

The accepted theory as to its development is, that the infection is brought to the larynx through the secretions of the lungs, and when you consider how this thick discharge may lodge tenaciously in the larynx and bathe the parts with mucus, laden with tubercle bacilli as well as pyogenic bacteria, you will not wonder at the large percentage of patients who have this complaint.

This secretion tends to stagnate, and the pus germs produce injury to the superficial layers of the mucosa, and may even form small abscesses which rupture, and through these injured areas, the tubercle bacilli find their way and so enter the deeper structures, perhaps helped to reach these parts by the coughing, which would tend to force them in. Then they form the characteristic pathology of tuberculosis.

No part of the larynx seems able to escape, but the appearance differs, depending on the location. We find conditions which vary from early infiltration to an extensive ulcerated and destructive process. In the epiglottis in the early stages, there is a thickening on, or near the free edge, and there is a distinct redness at this spot. Sooner or later the whole of this body may become involved, and at times, we find here, a very destructive, ulcerated

*Read before the Halifax Medical Society, March 6th, 1935.

process. The arytenoids first show signs of oedema which may be bilateral or unilateral. When one arytenoid shows this oedematous swelling in the presence of pulmonary tuberculosis, we may feel quite certain that we are faced with extension of the disease. This swelling may pass along the whole or the aryepiglottic fold, that is the upper rim of the larynx, and so interfere with the closure of the larynx, thus allowing food to enter.

One of the most pathognomonic lesions of tuberculous laryngitis, is the smooth, reddened area involving the vocal process as well as the region immediately above it. The posterior part of the larynx, the interarytenoid space, is frequently infected, as here we find the germ-laden secretions tend to lodge and adhere most tenaciously. When the cords are affected, it is usually over their entire extent, and should they become ulcerated, they present a characteristic appearance, as though "mouse nibbled." Because of the contact of the two cords on phonation, there is great danger of the opposite cord becoming infected where only one cord was first involved.

There is not much difficulty in the way or diagnosis in the advanced cases, as any laryngeal trouble with pulmonary tuberculosis is practically certain to be also tuberculous. But early lesions may very easily be overlooked. Cancer and syphilis may be present at the same time, and hence a thorough examination with all available methods must be made in order to eliminate the possibility of these diseases. At times it is exceedingly difficult to come to a definite decision, as when there can be no tubercle bacilli found in the sputum, and where the chest can not be definitely proven tuberculous. Then we may have to resort to a biopsy, and continue a careful observaion of the patient. Be warned that a removal of a portion of the diseased part for biopsy may be very harmful, by causing a raw surface, which may easily become infected, and also the squeezing effort of the punch forceps has a tendency to force the infection into the lymphatics and so may cause a dissemination of the disease. Gentle cauterization of the exposed surface should always be carried out afterwards so as to minimize the dangers just referred to. We must eliminate the possibility of acute laryngitis or the presence of an impacted foreign body, as both these may cause an oedematous appearance, but careful history taking should not cause us much trouble here, especially as these conditions have an acute onset.

The symptoms of laryngeal tuberculosis are mainly two. First, the alteration of the voice which results from interference with the normal movements of the larynx, and pain, which is due to a peripheral neuritis or exposure of the nerve-endings when ulceration occurs.

The changes in the voice may vary from a slight huskiness to complete aphonia. Therefore, any change in the voice in pulmonary tuberculosis should immediately call for an examination of the larynx. In fact, it would be well to have the larynx examined occasionally in all lung cases. There may be changes in the voice from time to time, depending upon the presence or obscence of secretions; and in those cases where there is much swelling of the parts, we find the peculiar croaking or harshness due to thickening. Especially do the secretions tend to lodge in the posterior part of the larynx and this mechanically interfere with the approximation of the cords. When aphonia is present in the tuberculous larynx, it is always persistent, whereas recurrent aphonia is usually associated with nervous affections.

Pain. The distress and suffering caused by pain in these cases, is familiar to you all, but it usually depends upon the location rather than on the extent

of the lesion, and is most marked when taking food or swallowing It presents itself earliest when the epiglottis and the upper rim of the larynx are involved, even before ulceration makes its appearance. But if there is no pain, it does not follow that there is no tuberculosis, as there may be extensive trouble which the act of swallowing does not affect, as when the cords or ventricular bands are infected. The pain has a tendency to radiate to the back of the head and especially does it make itself felt in the ear, this latter causing much added distress. And it may be so severe as to interfere with the taking of food, and even fluids may be refused.

In the treatment of these cases it is absolutely necessary that the patients receive the best general care and treatment along with whatever steps may be considered for the local condition. As was stated before, the laryngeal complication is merely part of the pulmonary lesion and the are of the larynx is only one step toward helping the patient to recover.

The internist and specialist should work very closely in these cases. The internist can tell us just what laryngeal treatment at a given period might be harmful, and so any exhaustive measure would not be used, as some of our methods might at some time or another tend to cause a reaction, such as starting a rise in the temperature. The better the general condition, the better results are hoped for from local treatment, but when the lung disease has progressed so as to become hopeless, then laryngeal treatment is of no avail as to cure.

A certain number of cases will be cured by proper treatment of the pulmonary lesion alone, that is treatment as carried out in Sanatoria, outdoor atmosphere, moderate rest, regular exercise, good food, etc. It has been noted that in these cases, as the lung progress toward recovery, so does the larynx. The larynx can be observed from time to time, and as it gradually heals, it may be taken as an index that the lung is also progressing favourably.

Twenty-five years ago, or less, tuberculous laryngitis was considered by many, to be the evidence of approaching death and the expectation of life was placed roughly at from six months to a year or a little more. Nothing in the way of local treatment seemed to be of any avail, although then as now, some did recover.

About this time Sir St. Clair Thompson of London first introduced rest of the voice and since then it is insisted upon and patients are ordered to make the rest absolute. This means that they must only communicate by means of paper and pencil at all times. The larynx consists of a series of joints, and as rest in acute joints elsewhere is essential, so here the same holds good. A slight relaxation of this stern rule may be allowed at meal times, but at no other. Whispering and especially the so called "stage whisper" is found to be as injurious as using the voice in its full power. It is claimed that this rest of the voice has done as much for the larynx, as rest in bed has done for the lung. The intrinsic lesions will likely be more benefitted than the extrinsic, but insist on absolute rest in all these cases.

Treatment comes under two headings, namely surgical and medical. Surgery is applied when there is complete involvement of the epiglottis in its ulcerative form and when the pain is so severe, that some radical measure must be adopted in order that relief may be obtained. Under proper cccain anaesthesia, the whole structure of the epiglottis has been removed, either by the punch method or electric snare. The patients have been greatly relieved and apparently there has been no noticeable interference as regards the intake of food. This procedure is not often necessary.

The electric cautery has come to be the best means of treating practically all forms of laryngeal tuberculosis and has superceded nearly all other methods. Various tips are so constructed to do the work in the different localities. What is desired is not to kill the bacilli, but to form a ring of scar tissue about the infected area and from this, to expect healing. It should only be undertaken by those who are skilled in the use of the laryngeal mirror or those who can use the direct methods of Dr. Jackson.

The technique in the epiglottis and arytenoids is to puncture the swelling at an number of points about $\frac{1}{8}$ of an inch apart, using the point at white heat and allowing it to remain just long enough to whiten the surrounding tissue. This takes no more than a second. Care must be taken not to enter the parts too deeply and so injure the cartilage or joint localities. The epiglottis and the upper rim of the larynx lend themselves very well to this technique, while the lesions which are intra-laryngeal require different tips, which are flat or looped, the parts affected being lightly touched, so as not to cause destruction and so interfere with normal laryngeal movements. These measures are carried out under cocain anaesthesia and seem to cause the patients little or no distress, in fact relief from pain is often obtained immediately and food taken in a comfortable manner. In a few days the sloughing spots shed their scabs and granulating surfaces appear and with this, new vessels and also nourishment are brought to the parts, and healing begins. No repetition of the burning is done until the first points are healed, although it is permissible to touch some other place that may require the treatment. Treatment will have to be carried out for several weeks.

Such eminent men as Dr. George Wood of Philadelphia and Dr. Parfitt of the Calydor Sanatorium at Gravenhurst, state that 90% of the cases of tuberculous laryngitis may recover if diagnosis is made sufficiently early and electric cauterization carried out in a proper manner in patients who are in Sanatoria, under proper supervision, and where frequent examinations of the larynx are made. Even, if cures are not obtained, there is great relief from pain, and nourishment can be taken in sufficient quantities.

We have not performed these operations here, but plans are on the way to attempt to carry them out in this hospital and Dr. A F. Miller of the Nova Scotia Sanatorium at Kentville is hopeful of having this method adopted before long. It may be in use there now.

The medical man insists on absolute rest of the voice. They place hope in but a few drugs, the foremost of which is Chaulmoogra oil. This seems to be giving excellent results in the hands of some first-class men, but only the Burmese oil is used, as it contains the largest quantity of Chaulmoogric acid, which agent is relied upon for the results. It may be used in full strength or diluted with mineral oils to 10 or 20% strengths. But it must be properly and carefully applied. It is unirritating in the larynx, but if allowed to pass in to the oesophagus and on to the stomach, it is apt to set up a severe gastritis. It may be applied on a swab, or dropped into the larynx—or allowed to flow over the epiglottis and so down to the larynx. This treatment is carried out three times a week.

Freshly prepared solutions of formalin, starting at 3%, gradually increasing the strength of 50% are advocated by some. Its virtue seems to rest on the fact that it has a tendency to penetrate tissue. It is used three times a week. Lactic acid in strengths varying from 25% to 50% are used at times. This is quite irritating, and the mucosa had better be anaesthetized before

carrying this out. It leaves a whitish surface and this must be entirely gone before another application is made.

Pain must be relieved. Cocain solutions have proved effective, but leave the parts dry and cause added discomfort and usually the strength has to be increased. Usually start with a fairly weak solution, about 2%. and it should be sprayed carefully on the affected part about ten minutes before meals. Alcohol and smoking as well as irritating foods must be avoided, because they certainly have a tendency to increase irritation. Insufflations of such powders as orthoform analgesin and anaesthesin when properly applied through a powder blower, may have a good effect which may last twenty-four hours. Oily sprays of menthol, camphor, etc., do not relieve pain, but give a soothing sensation to the larynx and tend to soften the secretions and so allow them to be cleared away the more easily. Cracked ice at times, gives relief.

The pain may be so severe that it may be necessary to feed the patient by placing him in what is known as the Wolfenden position, which is as follows: The patient lies prone on the bed with the head and neck and shoulders extending over the edge. Liquid food, thin enough to pass through a glass rod, is placed in some sort of a vessel on the floor. The head and shoulders are lower than the edge of the bed and sucking the food up will allow of swallowing without much pain. This is known as the "horse position". Muscular action is all that is necessary here, while in the upright position, food will have a tendency to pass into the larynx and gravity has to be overcome.

Ear pain may add much distress to the patient because of its stabbing nature and may require special treatment of the nasal ganglion. This is carried out by coacinization in the posterior part of the nose. Nerve-blocking is repeatedly called for, the superior laryngeal nerve being the one sought for. It is injected with a solution of alcohol about 65% strength, and when successfully carried out, has been known to give relief for as long as several weeks.

Recapitulation. Make frequent examinations of the larynx.

Be on the alert when voice changes make their appearance and again examine the larynx.

Early recognition of tuberculous laryngitis will result in a large number of cases being cured, but all cases cannot be cured any more than can all cases of pulmonary tuberculosis.

Electric cauterization seems to offer the greatest chance for cure, but the patients should be in Sanatoria and under proper supervision.

Absolute rest of the voice.

Palliative treatment in all hopeless cases, even the use of the electric points to relieve pain, which, of course, cannot cure the disease.

Some Unusual Post-mortem Cases

RALPH P. SMITH M.D.,D.P.H.

OCCASIONALLY, the pathologist is called upon to elucidate, if possible, the relationship between the cause of death and an alleged injury. Such cases often present interesting and unusual features, both to the pathologist as well as the practitioner.

Case I, Man, aged 51 years, admitted to hospital and died after being bed-ridden for almost ten months, was stated to have given himself a wrench four and a half months previously, and to have fallen against a lever a month before admission. He ceased work for a few days subsequently, because of a pain in his back. After working a week or so he went into hospital where his main symptom was a severe pain low down in the back with a gradually developing paraplegia with paralysis of both legs and loss of sphincter control. Dr. Johnston's report of the X-ray was as follows: No displacement of 10-12th thoracic or 1st lumbar vertebrae, but a shadow is seen in that region. In his opinion the symptoms were not the result of pressure from the displaced bone. A consultant thought that the symptoms indicated a condition resembling transverse myelitis, or possibly the presence of a tumour involving the spinal cord, in an examination six months after, but in order to clinch the diagnosis a post-mortem was ordered and performed.

Post-mortem finding:

General appearances: The body was that of an elderly man, who was extremely emaciated, with the abdomen sunken and greenish from early decomposition. Rigor mortis had practically passed off and death apparently had occurred in the preceding twenty-four hours. There were three ulcerated areas present on the surface; a large bed sore 4" in diameter over the sacrum, a smaller one over the right ankle, and a small recent abscess on the middle of the back at the level of the 11th thoracic vertebra. The tissues below this in the lumbar region were oedematous.

Internal Examinations:

Pleural cavities: *Right*: Was obliterated by fibrous adhesions from an old pleurisy. On removing the viscera a hard oval swelling attached to the 7th and 8th ribs and corresponding dorsal vertebrae, measuring 1" x 2" x 1½" was seen.

Left: Except for a small adhesion at the left apex there was nothing pathological seen. On removing the lung a small hard swelling attached to the 7th thoracic vertebra and measuring 1" x 1" was found and also a larger bony outgrowth adherent to the bodies at the level of the 10th-12th thoracic vertebrae, measuring 2½" x 1½" x 1".

Bronchi: Nothing abnormal found.

Trachea: Normal.

Oesophagus: Nil of note.

Thyroid Gland: Small and atrophic. No evidence of carcinoma.

Thymus: Small and atrophic but showed no evidence of disease.

Bronchial glands: Showed no evidence of tuberculosis, being small and anthracotic.

Lungs: *Right*: Except for anthracosis and a terminal hypostatic congestion and oedema in the lower lobe it was normal.

Left: There was a small apical healed fibroid tuberculous area. This lung showed no special change other than anthracosis.

Pericardial Sac: Nil of note.

Aorta: Was normal. There was no evidence of syphilis found.

Heart: Was somewhat smaller than usual, showed a degree of brown atrophy. The myocardium showed in addition some cloudy swelling. The valves and chambers and pulmonary artery were healthy. There was a terminal dilatation of the right side with some relative incompetence of the tricuspid valve.

Peritoneal Sac: No excess of free fluid seen or other change.

Stomach: Was empty but quite healthy.

Intestines: Showed no pathological change although the descending colon and rectum were loaded with faeces.

Pancreas: Nil of note.

Gall-bladder: Healthy but somewhat distended.

Liver: Was somewhat enlarged and riddled with neoplastic deposits varying in size from a pin's head to an orange. Most of the areas had a greenish soft character. The latter and the most of the deposits, of which some on the surface were umbilicated, were situated mainly in the right lobe. The rest of the substance showed a fine cirrhosis and fatty change, associated with cloudy swelling.

Spleen: Was not grossly enlarged but showed marked toxic change, being soft and friable.

Adrenals: Showed no pathological change.

Prostate: Nil of Note.

Kidneys: Were both the seat of an ascending suppurative pyelonephritis, their pelves being filled with pus, and abscesses were seen to be extending into the cortex and medulla. No true nephritic condition but some fatty degeneration was present.

The Urinary Bladder: Was the seat of a chronic cystitis.

Vertebral Column: Revealed the bony outgrowths described under pleural caities.

The laminae were removed from the 2nd thoracic to the 2nd lumbar and the spinal cord removed for further examination.

On viewing the vertebral canal from the posterior aspect there was a small soft reddish area, situated at the level of the 11th and 12th thoracic vertebrae and communicating with the larger bony mass on left side laterally but no evidence of any fracture-dislocation. The dura was adherent from the 10th to 12th thoracic vertebra and eroded at level of 11th and 12th. Situated extradurally in this region was a small oval greenish semi-fibroid mass measuring 1″ x ½″.

The external abscess over the 11th vertebra did not penetrate deeply. On opening the bony outgrowths they were found to be somewhat softened and necrotic and in places somewhat semi-pultaceous and of a reddish green colour.

Spinal Cord: Showed a small depressed area corresponding to the 7th and 8th thoracic vertebrae, and also beginning just above the lumbar enlargement was a marked softening for 1½".

The Brain: Was not examined as the patient remained mentally alert to the end.

Histological Examination: Sections were made from the liver, bony outgrowths of vertebra, extra-dural tumour, and the cord, and one of the lumbar nerve roots.

The Liver: Reveals the presence of a fine cirrhosis and a multiple primary liver cell tumour or hepatoma which is bile-stained. The extra-dural tumour has the same characters as the tumour in the liver and is evidently an extension from the bodies of the 10-12th thoracic vertebra.

The Bony growths in Vertebrae reveal tumours of the same nature as the liver associated with some fibrous and osteoid irritative overgrowth.

The Spinal Cord and Lumbar Nerve Root reveal colliquative necrosis from pressure and this is most marked in the lumbar enlargement and to a lesser degree at level of 7th thoracic vertebra.

The Cause of death was Primary Liver-cell Carcinoma with metatases to the vertebral column and the formation of a secondary extra-dural growth which had caused pressure on the spinal cord with a consequent paraplegia and terminal cystitis with ascending suppurative pyelonephritis.

Conclusions: Having fully reviewed the history of this case, and examined the X-ray pictures, and in view of the post-mortem findings I had no hesitation in saying that an injury played no part in the causation of this man's death. I have met with two similar cases where the primary tumour was situated in the stomach, namely a scirrhous carcinoma, with metastases in the vertebral column, and in both there was a history of accident to the back.

Case II.

History: Man, aged 70 years, fell seven or eight feet on to a submerged log while working on a bridge, and struck his right side. Shortly afterwards he complained of pain in the right loin. About four weeks later he developed pleurisy which was followed by effusion from which four quarts in all was aspirated. Clinically, there was evidence of enlargement of the liver and involvement of the right lung (dullness on percussion and diminished breath sounds). A few pus cells were found in the urine. The patient progressively lost weight and strength and his chief complaint was always severe pain in the back in the region of the 12th rib on the right side. He died five and a quarter months later.

The following organs were sent to me for examination:

Right lung with portion of diaphragm adherent. Right diaphragm. Right kidney. Portion of liver. Two retro-peritoneal lymph glands.

Morbid appearances.

The right lung: Is greatly collapsed and small and adhering to it is a piece of diaphragm. The surface reveals a moderately recent fibrinous pleurisy with thickening of the pleura and a great thickening of the diaphragm, with its pleural surface partially covered with a nodular whitish tumour growth. On section, the lobes of the lung have a slate-grey colour and are compressed with the bronchi looking more numerous than normal.

On section the diaphragm has a whitish firm character but cuts easily and is apparently of neoplastic nature.

The Bronchi: Show definite chronic bronchitis.

Liver: Shows a marked nutmeg condition from chronic venous congestion and fatty infiltration.

Right kidney: Is pale yellowish and shows a few retention cysts and granularity of its surface from arterio-sclerotic change. A few small whitish areas are seen but these do not have the pronounced character of tumour.

Retro-peritoneal lymph glands: The two glands sent are completely calcified. Evidently from an old healed caseous tuberculosis.

Histological Examination.

Sections through diaphragm. Reveal a typical endothelioma of the pleura. There are masses of large polyhedral and spindle shaped cells with hyperchromatic vesicular nuclei, many showing mitosis, and even a modified giant cell character, occurring in small alveoli, in single and double rows between a cellular connective tissue to which some are adherent.

A section made through adherent portion of diaphragm and lung reveals the endotheliomatous growth, but it is only infiltrating the first few surface alveoli.

Right lung: Shows a fibrinous pleurisy superimposed on a chronic pleurisy on its surface and collapse of the alveoli. There is a degree of congestion and some small healed fibrotic tuberculous areas in relation to the peribronchial tissue present.

Bronchi: Show a simple chronic bronchitis.

Liver: Reveals marked fatty infiltration, a moderate degree of chronic venous congestion with accumulation of haemosiderin pigment in the liver cells at the centres of the lobules. No secondary deposits were found.

Right kidney: Showed some arterio-sclerotic atrophy and cloudy swelling, but no secondary deposits.

Retro-peritoneal lymph glands. Were not sectioned as they were completely calcified from an old healed tuberculosis.

Conclusions. The cause of death has apparently been an Endothelioma of the Pleura associated with a sero-fibrinous pleurisy with collapse of the right lung (no statement as to the state of the rest of organs or tissues of the body was given). A pleurisy almost invariably accompanies an Enthothelioma of the Pleura and is regarded as a result of the irritation of the tumour growth. The clinical course of such cases is that of a chronic pleurisy with thickening and adhesions.

A few workers (Rossier, etc.) believe the chronic pleurisy precedes the tumour growth. However, in view of the short duration between the time of being struck on the right side, i.e., about four weeks, and the definite onset of symptoms, eg. pleurisy, and also the nature of the tumour, I did not regard the alleged injury as a factor in the cause of death. The Literature does not point to injury as a causative agent in the production of Endothelioma of the Pleura.

Case III. Man, aged 65 years.

History: First seen by his Doctor two days before his death, who found great pallor, restlessness and weakness, with greenish spots over the body; urine scanty and dark in colour; comatose during the last twenty-four hours. At first the Doctor thought death was due to Pernicious Anaemia, but subsequently, almost two years later, felt that chronic lead poisoning was the cause, as he was a foreman painter to trade. The widow stated that her husband had been ailing for thirteen or fourteen years following an attack of lead colic and had suffered from a previous one twenty-five years before. She noticed yellowish green spots on the face and body two years before his death. In order to settle the question I was requested to do an autopsy on the exhumed body and examine any of the organs which remained, for lead.

Findings of Post-mortem examination performed two years and six weeks after death.

The body showed advanced putrefaction but sufficient material was secured to make a full examination for the presence of lead.

Pleural Sacs: Showed no free fluid or evidence of pleurisy.

Bronchi: Were thickened and had evidently been the seat of a chronic bronchitis.

Lungs: Showed an atrophous emphysema with a small healed tuberculous lesion at both apices. There was no evidence of pneumonia.

Pericardial Sac: Revealed no pericarditis.

Heart: The myocardium showed definite fatty degeneration and some fibrosis. There was some dilatation of the right auricle and ventricle with relative incompetence of the tricuspid valve. The other valves and chambers showed no special change. There was no hypertrophy of the left ventricle. The coronary arteries and aorta showed definite nodular atheroma.

Peritoneal Sac: No signs of peritonitis were seen but decomposition was marked.

Liver: Was small and much decomposed. It weighed 310 gms. and seemed to show an excess of haemosiderin.

Adrenals: Had disappeared.

Kidneys: Were almost gone and together only weighed 52 gms. They did not show the typical granular contracted kidney of chronic lead poisoning.

Spleen: Was of approximately normal size and very soft and decomposed.

Gall-bladdder: Had disintegrated.

Urinary bladder: Was empty but showed a little thickening of its wall with an enlarged middle lobe of the prostate projecting into it. It thus probably was the seat of a chronic cystitis.

Brain: On opening the skull the brain was completely pulped and no special pathological features could be identified.

Bones: The bone marrow of the femur showed no erythroblastic reaction but appeared fatty and somewhat gelatinous. The lower third of right femur, the left radius and ulnar bones (755 gms.) were taken for further examination for lead.

Stomach and Intestines: Had disintegrated.

Examination of the Liver, Kidneys, Brain, Bones for presence of lead. Proved absolutely negative for the presence of lead (after incineration) A positive control test was performed at the same time.

Conclusions: Owing to the advanced state of decomposition it is difficult to give a very definite opinion as to the cause of death, but there was present a chronic bronchitis, generalized arterio-sclerosis with some fibrosis of the myocardium and chronic cystitis with enlarged prostate. In addition, in view of the history, there was possibly a pernicious anaemia of aplastic type.

I was convinced that the deceased did not die of chronic lead poisoning.

Equal to the Occasion.

Every teacher should ponder the remark of a five-year-old. In an intelligence test she was asked, "Are you a boy or girl?" She looked the teacher squarely in the eye and solemnly replied, "Boy."

Later she told her mother, "When a person asks you a silly question, it's all right to give a silly answer."

Forty to Sixty*

E. C. MENZIES, M.D.
Saint John, N. B.

THERE is no need to aplogise for bringing this subject before the profession, as I do not doubt that all of you who are before me to-day have at least one or two patients within the above age limits, who are showing symptoms of mental instability.

Three factors impinge on us all with peculiar force as we approach the age of fifty.

1. At forty this mysterious force that we call life, has about reached its climax. This life impulse, whatever may be its nature, is at first very powerful. With the union of the gametes to form the zygote, we witness the release of a tremendous drive, growth is very rapid in the intra-uterine period and comparatively rapid after it, but there is a steady diminution as the first two decades pass. Energy also diminishes, till at fifty we are pretty well to the top of the hill and there is no longer present the reserve of vitality and vigor that hitherto sustained us.

2. It is precisely at this period that our environment makes its greatest demands on us. At no time are the demands made by our business, our families and our communities so insistent and pressing.

We are not young, we are not old; and the world expects and exacts maximum effort from us.

3. Coincident with these factors appears a psychic stress of no mean magnitude. In fact, to me it is the greatest of all. When a woman finds that her periods are ceasing (see footnote page 351), or a man wakes up on his fiftieth birthday, neither one can disguise from themselves the fact that life is passing, that many dreams and ambitions they have hitherto cherished and refused to give up in spite of, it may be, repeated disappointments, must now be laid aside because they have reached the top of the hill with the rest of the way leading downwards and the shadows of night already visible.

Every individual must then in this period of life meet this three-fold stress; lowered vitality, together with maximum demands, and by no means neglible psychic factor. In other words, I am simply saying that in no other period of life do we need more reserves of philosophy or emotional stability than in the decade which we are considering. Most individuals do have sufficient of these reserves but in my experience, I have noted that people who fail to survive this period without a breakdown, generally have histories showing that they were deficient in this very important attribute of personality. Indeed, it was the observation and recognition of this defect which first led me some years ago to formulate my ideas regarding these so-called involutional psychoses in the manner in which I am now presenting them to you.

I would ask all who are listening to me to-day, to cast back in their minds to patients of this type, whom they have had under observation and see if almost all of them did not generally, for years before their breakdown, present

*Read before the annual meeting of the Medical Society of Nova Scotia at Sydney, N. S., July 3rd.

certain symptoms of this fundamental defect, which I am now about to set before you.

These people all paid too much attention to their own feelings. They were unable to withstand any emotional laceration, their own feelings were very important to them. Every family physician will readily, recognize the mother who "just *cannot bear* to see her child sick, who *cannot* bear to even think of losing it". I think every physician has heard—"Doctor, she *must* get better, you *must* make her well, I *cannot bear* to lose her". This type of mother does not say "What a pity she is sick and suffering; what a pity her young existence should end before life has opened up for her". The mother's whole thought is of her own threatened parental instincts. This is the type of mother who will become unreasonably jealous of her daughter's or son's fiancé, who "cannot bear" to think of losing her children by marriage. We see this defect again in the over-sensitive individual, the person whose feelings are always being hurt, the wife who dissolves in tears because a hurried husband neglects to kiss her good-bye in the morning; we see it in the one who is always receiving a fancied slight, and continually sees a reference to himself when none is intended. The inability to take even moderate criticism without anger or tears is another symptom. Still another aspect to the same fundamental defect is seen in the people who are over-conscientious, forever striving to be perfect. The exclamation "To think that *I* would do that," "I cannot bear to think that *I* am that sort of person," often means that the individual is more wounded in his self-esteem than that he is worrying over the possible consequences of his acts to others. These people are often witty and sarcastic, but there is a lack of humour, and a deadly seriousness about everything which concerns their own feelings. If they are in trouble, that particular trouble and the feelings which it stirs blot out all the rest of the world. They often exaggerate the importance of any fault of which they are guilty. Walk through the wards of any mental hospital and you will be told not once but many times, "I am the worst woman in the world". The magnification of their feelings goes even further than this; their faults are so great that the whole world is suffering therefrom; they read of a flood on the Mississippi or a famine in China, and they are convinced that these calamities happened because of their sins. Going through the wards of the hospital one can almost pick out this defect as distinguished from those of other groups by this magnified personality which they practically all exhibit. These people are completely absorbed in themselves and their own troubles. They often do not lose all contact with the world; they sometimes read, talk, take notice of what goes on about them, but everything is related to themselves, their self or ego has grown so large that they cannot see the world in its proper perspective; everything is blocked out except what they can relate to themselves. On the wards three or four will surround the doctor all talking at once, all occupied with themselves, all highly indignant that they cannot possess the ear of the doctor exclusively. To pick a typical example.

Mr. Z., 50 years of age, a highly educated, conscientious member of one of our learned professions, became very depressed and attempted suicide after the death of his wife. He was brought to us very much distressed, absolutely unable to talk or think about anything but his own condition, unable at first to take his thoughts off himself sufficiently to perform even the simplest tasks. As time went on he became able to occupy himself with

gardening. One day after he was, as we thought, well on the road to recovery, I heard him return the greeting of a sick nurse who was sitting in a wheeled chair on the grounds. He knew that this nurse was very sick, that she, an intelligent young woman just about to graduate, had been stricken down by a disease which would at best incapacitate her for years and might end in death, yet as he walked away and I made some comment on the dark future which was awaiting this girl, his reaction to it was to say "I did not sleep very well last night". This man has since recovered from his depression and now realizes that this enlargement of his self has been characteristic of him during all his adult life. He realizes that while he believed that he was unselfish and conscientious, yet this unselfishness and attention to duty arose not from a real and vital interest of his fellow men but from the fact that his anxious care of his own feelings was so great that he could not allow any shortcomings in what he had been trained from boyhood to regard as his duty. Had he allowed himself such derelictions, his feelings of self-esteem would have been wounded.

Friends and acquaintances instinctively recognize this absence of spontaneous and true interest in them and their affairs on the part of one so afflicted, and are often puzzled as to why, in view of the good qualities which the individual often has, they do not like him better than they do. In the case of Mr. Z., two or three people told me they could not understand why it was that, though they respected him as a very good man, they never had any instinctive and deep liking for him. To quote another exmple of this.

A few months ago a young woman came to me much concerned because she had been driven to recognize the fact that she did not like her mother. This realization distressed her very much, and she thought the fault must certainly be in herself since her mother was a good woman, one who had done everything for her daughter, denying herself in order that the girl might have piano lessons, go to a good school, etc. A little investigation disclosed, however, the further facts that the mother was very sensitive, very easily hurt, very jealous of any friends which the daughter might make, that she was continually complaining that her children did not love her; in other words, the mother's self-sacrifice did not rise from a true selfless interest in the child; rather it was an offering to her own over-valued parental instincts.

The significance of this defect lies in the fact that the people who possess it stand emotional stresses very poorly. They cannot bring themselves to face facts that give them great pain, consequently when faced with the triple stress already noted, is it any wonder that they refuse to accept it but try instead to find escape in some illogical fashion!

The precise mode of escape or in other words, the type of mental ailment by which the patient will evade the necessity of meeting his troubles is determined by other factors both enviromental and innate, and time forbids any mention of them here, but irrespective of the reasons they choose these different roads, I want to point out that we can get rid of the necessity of facing our troubles in any one of three great ways.

1. The patient may throw off his load in a simple fit of excitement or mania. I am not talking here of the mania of the true manic-depressive. The genesis of that is quite different from the excitements which occur only after forty. This way of escape by mania after forty is rather rare, a far more common way is by an attack of melancholia. Again, I do not refer to the depression of the true life-long manic depressive, both it and its genesis are

also different. It may seem strange to characterize melancholia as an escape from trouble but it is true in that the patient is simply lying down under his burdens, instead of facing and surmounting them. Both mania and depression are, however, very simple and inefficient modes of escape. The patient must within a comparatively short time, that is to say, a time measured by months rather than years either face his problems and carry his burdens or else seek a more efficient method of evading them. This efficient method is, of course, the flight from reality or the building up of an unreal world, which ultimately if not at first, is far more pleasing than the world of reality from which he has escaped. How often do we see an individual after being sunk in dejection for months, beginning to blame other people for his condition, little by little discover that the reason for his wretchedness is the persecutions of others, from this he gradually reaches the plane of the persecuted hero, i.e., he discovers that he is a great man being kept from his station in life by enemies, then as fantasy and rationalizations more and more enter in, he becomes the triumphant hero, a great man, the King of Siam it may be, and we say that we have made a mistake in our diagnosis that this case was not depression or mania but was really praecox.

Actually all that has happened is that the patient has recovered from his depression in the wrong way.

I have stated that the reasons why an individual should choose this efficient and hence fatal way of escaping from stress is outside the scope of this paper. It is also outside this paper's province to speculate on how he does it; sufficice it to say that I think we all have inherent within ourselves quite normal and necessary mental mechanisms which even in a state of mental health, allow us to escape by illogical thinking, a great deal of stress and anxiety. "Kidding ourselves" is a slang expression with a good deal of truth in it.

Treatment: Preventive measures are of even more value here than in other branches of medicine. I firmly believe that it is possible for the family physician and for that matter, the family minister to recognize years before any breakdown occurs, the presence of this great defect; this lack of emotional reserve that I have so sketchily endeavoured to indicate. I also believe that it is possible for him to give proper warning and counsel. We have taught the public to heed our advice in other fields and once we equip ourselves to observe dangerous personality traits with the same thoroughness that we do in other branches of our work, it should be possible to do the same thing in the field of mental hygiene.

Once symptoms set in the treatment is, of course, only palliative. Examine for and treat all organic conditions but do not, in your anxiety to find a physical basis increase their neuresthenia by too anxious and continuous examination.

A few patients may benefit by absolute rest and quiet in bed, but with the majority these measures may prove fatal in that they will supply the precise conditions under which an incurable flight from reality may take place. Keep up the physical condition. Always be on your guard against symptoms of the patient getting better in the wrong way. Keep him in contact with reality by a correct regime of sleep, recreation, exercise and occupation. Hypnosis and suggestion have their place. Psycho-analysis in skilled hands, and with certain patients, is another weapon. Occasionally, dramatic measures such

as the induction of a prolonged "twilight" condition (three days to two weeks), may cut short the vicious circle. These things are all of value and are available at any modern psychiatric clinic. But the fact remains that while we can do much for these patients after symptoms set in, it would be much easier, once the public were educated to accept our advice, to prevent the symptoms, and in this as in other fields of medicine we must depend on the mainstay of our profession—the family doctor.

A great deal of loose thinking exists in regard to the menopause as a cause of mental trouble in women. It does not follow because a woman showns signs of emotional instability during the decade in which her menopause takes place that this cessation is necessarily the cause of her mental upset. No thought is given to the fact that while the menopause is constant, mental trouble at this period is by no means constant. The menopause is only *one* symptom of the great underlying fact that I have tried to indicate, *viz.*, that life is passing. The woman at 45 has reached the apex of her physical powers, her hair begins to turn, she feels herself that she is not as young as she was. Many a man blinds himself to this fact for years after the world knows he is too old. To a woman, however, the menopause brings home the unwelcome truth that youth has passed in a way that brooks no concealment. So far as I am aware there is no proof that the physiological condition termed the menopause causes insanity *per se.* It, like greying hair, is only one of the many symptoms of the ebbing stream of life. It is a further pertinent fact that men at fifty show mental conditions which cannot clinically be distinguished from those so-called menopausal psychoses of women.

Beyond Him.

At a Rugger international between England and Scotland, an English supporter kept shouting, "Sit on 'em, sit on 'em!" At last one old Scot could stand him no longer. "Na, na, my guid man," he said, "you may sit on a rose, you can sit on a shamrock, but I'm hanged if you can sit on a thistle."

Caught in the Act.

Entering a London bar, an elderly man ordered a whiskey and soda, and was about to drink it when he looked up and noticed a painter at work upon the walls.

Immediately the customer went out without touching his drink. The painter climbed down his ladder and lifted the customer's glass.

"Hi!" said the barman, "you can't do that. That chap will be back in a minute, I expect."

"Oh, no, 'e won't," said the painter. "You see he's the president of our local temperance society.. and I'm the secretary".

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THE ANNUAL MEETING

THE great event of 1935 for the Nova Scotia Medical Society has passed and now comes up for the usual post-mortem.

I.

The first feature of the meeting, though a negative one, was the absence of our President, Dr. Dan McNeil of Glace Bay, for whom regret and sympathy were everywhere felt and expressed. As emissaries of the Society as well as on our own account, we gave ourselves the pleasure of calling on him at his home to pay our respects. We found him bearing his enforced confinement and discomfort with characteristic fortitude, and showing a very keen interest in the doings of the Society. We understand that he felt very keenly the fact that he could not in person welcome us to Cape Breton. His presidential address was read however, and is given premier place in this number. His place was taken in executive by Dr. Dunbar of Truro and in the general sessions, on the first day by Dr. D. A. MacLeod of Sydney, and on the second day by Dr. MacAskill of Glace Bay.

II.

The local committee of arrangements had apparently set themselves to see that there would be no dull time on our hands while we were there and it must be a source of profound gratification to them that they succeeded in creating such an atmosphere of the warmest hospitality and friendliness. These qualities are said to be the normal media of exchange in Cape Breton but they were none the less delightfully refreshing.

An unusual feature was their provision for speakers at the mid-day luncheons who would give us impressions of their local products. The first dealt with things animate and under the title "Some interesting people I have known" gave a series of very humorous descriptions of Cape Breton characters. It didn't matter that the lunch was cold; in the language of the street this was "hot stuff" and was thoroughly enjoyed. The second speaker took "Coal" as his title. It might well have been "The Romance of Coal". This speaker commanded our complete attention as he led us through the changes entering into the formation of coal, touched upon its chemistry and

on certain mining phenomena and confirmed Genesis from Geology. He climaxed his romance with an allusion to the colors of flowers as being derived from the sun, their imprisonment through countless ages in coal and their release again by chemistry as analine dyes.

The inevitable golf tournament was held. Lou Morton wasn't there—indeed we missed the whole Yarmouth contingent this year—so the big trophy came to Halifax. Full results will be published elsewhere.

The final care for us should have the word "care" questioned, for their bounty at Big Pond might well have been distressing. However the distance back to town was sufficient to settle the lobsters so that probably none had a bad night on their account. This feast was garnished by the presence of a piper dressed cap-a-pie in Highland costume. It was suggested that pipers do their best work with a little stimulant in them, and to this end after some scurrying around, a little was found for him. (The proverbial abstemiousness of medical men was as apparent in Cape Breton as elsewhere). One long drink which he took himself and a small one which he ceremoniously poured down the pipes was the order of administration. We "have not the Gaelic" and our souls are not attuned to the appreciation of such fine music, so we are unable to say whether the result was his best work or otherwise.

III

We are happy to express hereby our gratitude to our Cape Breton confreres for their efforts toward making our visit there a very pleasant one. The benefits that accrue from friendly intercourse on such occasions are immeasurable; but there are matters of greater moment.

The business of Medical Organization is preeminently the most important part of those meetings. Now, it is in the natural order of things that in the main, the Society's business should be deputed to officers and to committees, but upon none of these are the qualities of infallibility and absolutism conferred. It follows then that all reports and particularly all recommendations of such officers or committees should be subjected to the closest scrutiny and be made subjects for discussion. It would seem to be the weakness of our society that we like peace in our councils. This writer is not disposed to believe that such peace is consistent with corporate health; for health denotes vitality and that begets ambition which in turn engenders striving. It would be foolish to imagine that in a society as large as ours such a peaceful session indicates unanimity throughout our membership. We know that that cannot be, but it is a matter for regret that those who hold divergent views do not give us the benefit of their criticism upon the floor of our "house" rather than engage in sniping tactics from a distance.

The very important matter of fusion with the Canadian Medical Association was very excellently presented by Dr. Meakins the President and Dr. Routley the Secretary of the C. M. A. It appeared that the advantages which would accrue from the consummation of this union would be very great. There would seem to be everything to gain. The principle of the thing was therefore regarded as sound, but the method by which it might best be brought about suggested a problem of considerable difficulty. The consideration of its possibilities, and a charge to bring in recommendations at next year's meeting in Halifax, have been laid upon a strong committee, and notice of motion to change our by-laws to conform with any accepted recommendations, will make possible the implementing of their recommendations as soon as

they are adopted. This will place next year's business sessions among the most momentous in our history. In this connection we would like to compliment the nominating committee, who, in selecting our officers for the year, seem to have done so with an eye to the importance of the occasion.

IV

The scientific programme was vastly more interesting than the printed programme foreshadowed. Probably all its addresses but one will find their way into this journal. Dr. Bazin's presentation depended in large proportion upon his lantern slides. It was an intensely interesting review of embryological development, normal and abnormal with innumerable points of practical importance in diagnosis and treatment.

All the papers were heard by large gatherings of our members with great interest. Some of them, however, were allowed to run too long. We do not believe that this should be permitted. The time-table is made for our guide and when any man's time is up let the changes be rung and get on with the job. If he has miscalculated his time and has not finished, his effort might be saved from loss by being published in the proceedings of the Society.

V

It was a very enjoyable meeting and when the time comes for a meeting in Cape Breton again the answer to the slogan of Sydney's 150th anniversary "Will ye no' come back again", will be answered in a hearty affirmative.

N. H. G.

PERSONNEL AND PERSONALITIES

I

The mantle of the Presidency has fallen upon Dr. Benvie of Stellarton. No question of a more popular selection could be raised at this time. Dr. Benvie is eminently qualified to fill the office with grace and with the distinction which the times demand. The BULLETIN bows in dutiful obeisance to its new head and respectfully proffers its heartiest congratulations!

II

The Editorial Board of the BULLETIN has seen great changes, with the retirement of Dr. Atlee and Dr. Holland. Dr. Atlee had given about seven years of service to the BULLETIN. Because of his literary ability he is pre-eminently qualified for this work and he was so reliable and so otherwise valuable that he will be very greatly missed. With the increase of other demands upon his time he has found it increasingly harder to meet the obligations of the Journal and asked that he be not re-nominated this year. The BULLETIN thanks Dr. Atlee for his unfailing interest and years of faithful service.

Dr. Holland was elected only last year, but with his multiplicity of activities it was found that he could not do justice to the BULLETIN'S demands. Our thanks go to him also for his interest and good offices.

Dr. J. A. Corston and Dr. Arthur Murphy have been elected to their places. Dr. Corston requires no introduction to our readers. He is known as a man who has always closely indentified himself with medical organization in this Province from "British Medical" days to the present time. He is well known to be possessed of an unusual soundness of judgment and an excellent

command of the language. Dr. Murphy is of another generation and not yet so well known. To many, however, he is known to be possessed of very considerable literary ability, the tendency to which he probably inherited from his illustrious father, and erstwhile Editor-in-Chief of the BULLETIN, Dr. George H. Murphy.

We welcome them as co-editors, and hope that this infusion of new blood will soon show in the virility of the Journal.

III

Among those who attended the meeting at Sydney was Dr. W. B. Moore, who was for many years a leading member of the Medical Society of Nova Scotia. His last practice was in Kentville, but he has spent the last six or eight years in travelling around the globe. He appears to be as active as ever, erect of carriage, quick of memory, nimble of wit and as interesting a dinner companion as one could find. One is driven to wonder whether during his extensive peregrinations he had discovered the elixir of life. Much regret was expressed that the programme was too full to find a place for him, but many of us had personal talks with him and that was much the better way of hearing him.

The BULLETIN wishes him many years of life and of the enjoyment of it which is now his.

N. H. G.

The Secretary has received a letter from Dr. J. M. Stewart, of Upper Stewiacke, who wishes to sell his practice. Further particulars may be obtained from Dr. Stewart.

The Annual Meeting at Atlantic City

DURING the week of June 10-14 the Canadian Medical Association, for the first time in its history, met in joint session with the American Medical Association. The choice of Atlantic City was a very happy one as it provided hotel and convention facilities in an admirable way. The attendance was a record; eight thousand Americans met with over three hundred Canadians; including wives and families the registration almost reached to fifteen thousand. Few places could have provided for such a large medical gathering. Canadians made their headquarters at the Chalfonte-Haddon Hotel, one of the finest in the City. The Canadian Council transacted business for the first two days at this hotel, while the House of Delegates of the American Association had their headquarters and business meetings at the Ambassador Hotel. On Monday the Canadian Council entertained the American delegates at luncheon where Dr. McEachran delivered his valedictory address and installed the new President, Dr. J. C. Meakins. At this meeting a unique Gavel was presented to the American Association. The handle of the Gavel was made of American walnut modelled after an Egyptian mace, the head of English oak, removed from a London bridge, and said to be 900 years old. It was welded together with Canadian silver suitably engraved. It signified the Egyptian origin of medicine, the currents of British medicine to Canada and the United States, and was a token of fellowship and good will which has existed for so long a time between the medical profession of these countries. It was very happily presented in well chosen words by Dr. George S. Young, Chairman of the Canadian Council to (Dr. Walter L. Bierring, the retiring preisdent of the American Medical Association) who accepted it and responded in a touching manner. On Tuesday a return luncheon was tendered. The Gavel was first used at the general meeting on Wednesday evening, where addresses were given by the Hon. Walter Edge, Dr. James S. McLester and Dr. Johnathan C. Meakins, the newly elected presidents of the American and Canadian associations. This meeting was also honored by a few words from Dr. A. R. Dafoe who conveyed the greetings of the Dionne Quintuplets to the American people.

The scientific activities, held conjointly, took place in the magnificent Auditorium, the largest in the world, built at a cost of fifteen million dollars by the Corporation of Atlantic City. This huge structure can seat seventy-five thousand people; or more than the entire resident population of Atlantic City. It contains the largest pipe organ in the world.

The most interesting feature of the meeting was the technical and scientific exhibits all displayed in one room. Here one found all modern appliances, books, drugs, vaccines, sera, foods, in charge of capable and obliging demonstrators. The scientific exhibit covered the whole field of medicine illustrated by charts, photographs, models, moulages, pathological specimens, historical articles, etc. Members of the profession of both countries carried on a con-

tinuous clinic on most subjects of interest, freely illustrating their talks with moving pictures. Here one saw vividly, special operations, demonstrations of resuscitation, and many other things. The only disappointment was that there was not sufficient time to take in but a fraction of what was provided.

The scientific meetings consisted of three general, and numerous sectional sessions in which the best known physicians of the North American Continent took a prominent part. Contributions were also made by three prominent London doctors, Mr. Leslie Paton, Mr. Norman Patterson and Sir Francis Shipway. Over three hundred papers were read, one third of which were Canadian. Papers were limited to fifteen minutes and discussion to five. Sessions started and finished on time and everything proceeded with clock-like regularity. Of special interest was the Osler Oration by Dr. Lewellys Barker.

The entertainment was all that could be desired. In addition to numerous dinners and luncheons, special amusement was provided at the Steel pier. The President's Reception and Ball was a noteworthy affair in which several Canadian officers took part. Numerous functions were arranged for the ladies. Outside attractions were unlimitd and offered something for every taste.

This meeting will be remembered as a great international event. We cannot too highly praise our American colleagues for their great kindness and courtesies. An invitation has been extended for a return visit to Canada in 1940 and it has been hinted that an international meeting may be hoped for in the near future.

K. A. MacK.

Quite a number of our members attended the conjoint meeting of the Canadian Medical Association and the American Medical Association at Atlantic City. The following were from Nova Scotia, Dr. A. B. Campbell, Bear River; Dr. G. R. Forbes, Kentville; Dr. and Mrs. C. E. A. deWitt, Wolfville; Dr. D. F. McInnis, Shubenacadie; Dr. G. A. Dunn and family, Pictou; Dr. and Mrs. P. E. Belliveau, Metaghan; Dr. and Mrs. C. L. MacMillan, Baddeck; Drs. A. R. Cunningham, H. B. Atlee, G. R. Burns, H. G. Grant, N. B. Dreyer, K. A. MacKenzie, Halifax; Dr. and Mrs. A. L. McLean, and Dr. and Mrs. W. M. Muir, Halifax. Former Nova Scotians attending were as follows: Dr. and Mrs. Gordon Bruce, New York; Dr. and Mrs. A. L. MacLean, Baltimore; Dr. J. O. MacLean, Scranton, Pa.; Dr. C. St. C. Guild, New York; Dr. Ross Millar, Ottawa; Dr. E. L. McQuade, Charlottesville, Va.; Dr. A. McG. Young, Saskatoon; Dr. Colin Sutherland, Montreal; Dr. George R. Johnson, Calgary; Dr. H. M. Dawson, New York; Dr. Ross Cameron, Hagerstown, Md.; Dr. A. C. Jost, Dover, Delaware and Dr. J. F. Brown, Hawaii.

CASE REPORTS

A Case of Osteo-Chondritis Desicans.

A MALE, age 39 years, has been seen frequently by me at Camp Hill Hospital. His general physical examination was negative except for the knee joint. During April, 1933 he was operated upon for a displaced internal semilunar cartilage which was causing frequent attacks of locking and effusion. At operation the internal cartilage was found displaced towards the intercondyloid notch with a longitudinal split.

Following the operation he made a good recovery and did not complain of the knee until about six months had elapsed. He then complained of his knee swelling and at times "catching."

X-Ray examinations were made at intervals and were negative.

About a year later an X-ray of his knee joint showed an area of the articulating cartilage on the outer aspect of the internal condyle to be separating and fragmented. We advised the man to wait until the piece of cartilage and bone became definitely loose and then an operation for its removal would be indicated. He was lost sight of for several months as he moved to another town.

He returned to Halifax during April, 1935 and still complained bitterly of his knee swelling and paining. It was negative to physical examination, except for tenderness over the inner aspect of the joint. Another X-ray showed the fragment of bone to be partially detached and fragmented. An operation was advised and carried out. The old scar was excised. On opening the joint an area of cartilage about $\frac{3}{4}'' \times \frac{1}{2}''$ over the outer aspect of the internal condyle was definitely loose. The surface did not show the normal lustre and it was surrounded by a fine line. It could be easily rocked by pressing with a curette. The area of cartilage and underlying bone fragment, were lifted out, leaving quite a deep cavity. The edges were smoothed and the joint closed in layers.

Comment

This condition is a comparatively rare one, although many cases have been reported in the literature. The knee joint is the most common to be involved, although isolated cases have been reported in the elbow, shoulder, hip and ankle joints. Symptoms may be remarkably few unless the cartilage becomes loose when it will cause the typical locking and effusion. The radiographic appearance is characteristic. Note that the same part of the internal condyle is always involved, the lateral part of the internal condyle shows a fragment of bone apparently loose and lying in a depression of identical size and shape. There are many theories as to the etiology. Fairbank in a recent number of the British Journal of Surgery, supports the view that the condition is a result of injury and caused by the tibial spine, striking against the internal condyle, when the joint is rotated out. This theory accounts for the fact that it is always the same portion of bone to be affected. Other theories are that it is a vascular lesion, and some hold that it is an attenuated tuberculous infection. The microscopic examination of the bone does not

support these views, as there is not any inflammatory or degenerative change. The prognosis is guarded as osteo-arthritis is prone to develop.

W. ALAN CURRY

A Master Mariner as Surgeon.

A Norwegian oil tanker about three hundred miles off Halifax wirelessed that she was making for port in order to land a dangerously ill officer. A very interesting letter from the Master of the tanker accompanied the patient to Camp Hill Hospital. The Chief Engineer, who had been in poor health during the past year on account of rheumatic pains radiating down the right leg, and diabetes, suddenly developed haematuria and frequency of micturition. Retention of urine followed in twenty-four hours, with agonizing abdominal pain. There was not a physician on the ship. The Master produced the first aid book supplied by the Norwegian Government. After careful perusal of the book, a catheter was passed and the Engineer had marked relief. The next day the retention returned and only a few drops of blood-stained urine could be squeezed out. The book was again consulted and as a last resource, suprepubic puncture was advised. The Engineer told me that the Master gave him morphia and a shipmate held him down on his bunk whilst the Master boldly inserted the trocar into the bladder region. Blood-stained urine escaped with marked relief of his symptoms.

On admission to Camp Hill Hospital on January 26th, 1935, twenty-four hours or so later, he was voiding frequently small quantities of blood-stained urine. His bladder was distended to the umbilicus and very tender to palpation. Rectal examination revealed an enlarged nodular, hard and fixed prostate. It had all the ear-marks of malignant disease. A catheter was passed with difficulty into the bladder and only drew off a small quantity of blood-stained urine. The tender swelling in the hypogastric region persisted. A suprapubic cystotomy was performed. The bladder contained an enormous quantity of foul smelling blood clot. After cleaning out the blood clot, a retractor was introduced. In the region of the right ureteral orifice an indurated, ulcerated area was seen and palpated. A section of the bladder wall was taken for microscopic diagnosis. Finally, a self-retaining catheter was left in the bladder and the wound closed.

X-ray examination of the pelvis and lumbar vertebrae did not disclose any evidence of metastases. The biopsy report was an adeno-carcinoma originating in the prostate with secondary involvement of the bladder. This made the prognosis hopeless. As palliative treatment, deep X-ray therapy was given. A few weeks later the officer was sent back to Norway.

COMMENT

We must admire the courage and skill of a Master Mariner at sea, who, after careful consideration of his reading from a book, boldly plunged a trocar into the bladder. A trained physician would only do it with a good deal of trepidation. The Master also showed shrewd clinical instinct when he said in his letter that the Engineer had been suffering from supposedly rheumatic pain down his right leg for the last year. To a trained mind this, of course, suggested malignancy with metastases. I made careful enquiries from the Engineer about the Master's training. He had never seen a trocar used and had only attended the customary course of first aid lectures prescribed by the law of his country.

W. ALAN CURRY

"A Case of Unusual Cystic Degeneration of the Breasts."

The following case is of some interest in that it presents unusual features of cystic degeneration of both breasts occurring in a woman suffering from other glandular disturbances.

The patient, a woman 43 years of age, referred by Dr. B. S. Bishop, gives a history of being perfectly well until about fifteen years ago, at which time she developed a swelling in her neck. This increased in size and accompanying it, she developed all the symptoms of thyroitoxicosis. The eyes became prominent, she became very nervous and irritable and lost a great deal of weight. Palpitation of the heart was marked and she became very short of breath on exertion. This existed for a period of five years when a thyroidectomy was done ten years ago. Following it she gained weight and heart symptoms disappeared, but she became very dull and listless. Her skin became dry and yellowish and she felt cold most of the time, in other words she developed all the symptoms of myxoedema. She was put on thryoid extract with marked improvement, but became careless about her treatment and dropped it. She has had no thyroid treatment for the past three years, with the result that her myxoedematous symptoms have reappeared.

Three years ago she began to have severe uterine hemorrhage. That of course, was worse during expected periods, but she bled considerably during the intervals. This persisted for three or four months when the patient became almost exsanguinated and she was taken to hospital. Blood transfusions were given. Pelvic examination showed only a slightly enlarged antiverted uterus with no demonstrable pelvic tumor. A diagnosis of chronic endometritis was made and radium treatment given. This consisted of 80 M. C. H. of radium inserted into the uterus for a period of 21 hours. The treatment was effective in producing an artificial menopause and since then there has been no bleeding, menstrual or otherwise, but she occasionally has a little chocolate colored discharge.

Soon after this she noted that her breasts were becoming painful, more especially the right one, and two years ago noted that both breasts contained "lumps". These progressively increased in size and pain became a more marked feature. During the past two months the right breast was very painful and the left one also to a lesser extent. It is also to be noted that during the past two years and more especially the last year she has suffered a good deal with burning urination and some frequency.

There is nothing of interest in her family or personal history, except that her husband is an arrested pulmonary tuberculous patient. She herself is subject to periodic attacks of asthma and bronchitis, but has no evidence of tuberculosis.

Examined on March 8, 1935. The following findings are recorded:

Local Condition: Both breasts are pendulous, the right one being obviously larger than the left. There is no retraction of either nipple and no discharge from the nipples. In the right breast there is a large, hard mass, the size of an orange, but somewhat flattened as a disc. This mass is stony hard, rough and irregular. It is not attached to the underlying pectoral muscle, but is slightly attached to the skin and the skin over it is slightly reddened. No axillery glands are felt.

The left breast is filled with a large granular mass about half the size of the mass in the right one. This is much softer and has the feel of a diffuse chronic mastitis.

General Physical: The only points of interest to be noted were her dull and listless appearance,the dry yellow skin and the coarse, dry hair with thin eyebrows. The pulse was slow (50) and the blood pressure low, 105/10. Her B. M. R. on admission was -27, and after two weeks' treatment of thyroid gr. VI (B. & W.) daily, the B. M. R. was -20.

Another point of interest was that about the urethra, the mucous membrane was thickened, oedematous and of a deep mahogany color. This extended upward on the anterior wall of the vagina. The part was markedly tender and prevented proper examination of the pelvis, but as far as one could make out, no masses were present. This peculiar inflammatory appearance existed also in two spots in both lateral vaginal walls. This might possibly be explained as a delayed radium reaction. (See Article by Newell & Crossen, Surg. Gyn. & Obs., Vol. LX, No. 4) .

On March 16, 1935, a simple mastectomy was done of the right breast under local anaesthetic. The operation report is as follows:

"Novocain 1% was infiltrated in an eliptical fashion above the breast and the breast removed completely as a simple mastectomy. The removed breast tissue consisted of one solid mass of tumor. It was well encapsulated and was not at all attachd to the pectoral fascia. When the tumor was cut through it presented a very peculiar appearance. Everywhere there exuded a thick creamy rather greenish fluid appearing like tuberculous pus. Small cavities existed throughout the whole breast, about half the size of a pea, but no large cystic cavity or abscess. The tissue itself was of various consistency. In places it was soft, brownish and gelatenoid. In other places it was extremely hard, whitish and cut like turnip top suggesting carcinoma. The wound was closed with S. W. G. temporary drain inserted.

The whole breast was sent to Dr. Ralph Smith for examination, who reports:

The Breast is much enlarged and on section shows a marked cystic condition with the cysts filled with a caseous pus.

The Histologisal appearances reveal a cystic hyperplasia with marked cystic formation. The cysts are filled with pus cells and cholesterol and in their vicinity some foreign body giant cells and simple chronic inflammatory change is seen. There is no evidence of malignancy or of tuberculosis.

Remarks. The appearances here are distinctly unusual. They are those of a true chronic simple suppurative intra-acinar mastitis, i.e., a suppurative change superimposed on a cystic hyperplasia or so-called chronic interstitial mastitis.

(Sgd.) Ralph P. Smith, M.D.,D.P.H.,
Provincial Pathologist.

Following the removal of the right breast, the left rapidly developed into a similar condition. In little more than a week it changed from a rather soft granular feel to a solid, very hard plaque, and appeared in practically every way similar to the other breast.

This breast was removed on March 27, 1935 under nitrous oxide-oxygen anaesthesia and sent to Dr. Smith for examination with the following report:

The left breast shows a similar condition to that found in the right breast, but there is no true suppurative change found. The appearances are those of a marked simple cystic hyperplasia (or so-called simple chronic interstitial mastitis). The cystic change is marked enough to designate it "Schimmelbusch's Disease." Many of the cysts are filled with a cheesy material of structureless character, evidently containing cholestreol. I can detect no evidence of malignancy. I am interested in hearing of the effect of the thyroid treatment.

(Sgd.) Ralph P. Smith, M.D.,D.P.H.,
Provincial Pathologist.

Since discharge from the hospital patient has been taking thyroid gr. VI daily awith very little improvement in general condition. She at present is having severe attacks of asthma and bronchitis and when this is better she will be readmitted for a check on the basal metabolic rate.

V. D. SCHAFFNER, Kentville, N. S.

Addisons Disease.

A clergyman aged 68 years complained in August, 1934 of lack of pep and faint spells.

His story is roughly as follows: Married, wife living and well, children alive and well. He had mumps with testicular involvement as a young man, and except for varicose veins was well until 1929 when he had influenza. Shortly after this he developed joint pains, a search was made for infection and some teeth removed. Two days later he collapsed, and was unable to resume work. After a six months rest he regained his strength and was able to carry on his work until the present illness.

Present illness began in August, 1934 with complaints as noted above. In September he fainted during church service, and was finding work increasingly difficult, being completely exhausted each evening. Weakness increased daily until by Oct. 12 he was unable to rise from his couch. He had lost many pounds in weight.

Examination: A thin grey haired man, pale and with no obvious pigmentation. Temperature normal.

Respiratory Syst: No symptoms referable. Slight impairment and roughened breathing at right apex, otherwise neg.

Cardiovascular: Palpitation on exertion. Pulse normal rate and rythm, somewhat weak. Vessels soft. Unable to estimate heart size. Heart sounds were distant and there were no murmurs. B. P. 126/78.

Alimentary: Fair appetite, no dyspepsia or pain but a gone feeling in the epigastrium. No constipation, diarrohoea or melaena. The tongue and the remaining teeth normal. Some bluish black spots, three or four in number, round and varying in size from a pin to a tack head were noted on the gums where the right upper molars were extracted. The spots were centrally placed on the biting surface of the gum. The abdomen was normal except for a right inguinal hernia, controlled by a truss and the skin under the pad of this truss which was a dark drown colour, contrasting with the pale skin around it.

Except for atrophy of the right testicle all else, including blood picture, Kahn and urine normal.

A diagnosis of Addisons Disease was made because of the asthenia and the pigmentation in the mouth and under the truss. Treatment was by an extract of adrenal cortex, Eschatin, made by Parke Davis. It proved a potent and valuable agent. The diet was mixed and liberal and included liberal salt.

For the	first two	days he was given	injections of	Eschatin	10 c.c.
"	next two	"	"	"	5 c.c.
"	" seven	"	"	"	3 c.c.
"	" fourteen	"	"	"	2 c.c.

and takes and will continue on 1 c.c. daily.

After the first injection improvement in strength was observed, and this was maintained and progressive. The pigmentation gradually cleared, he gained 25 pounds in weight and in two months went back to work feeling better than he has for years.

Discussion: The diagnosis was made in the absence of low blood pressure and gastro-intestinal symptoms because of the weakness and pigmentation. Blood pressure is not a reliable guide. It may not fall until late in the disease, when it will be extreme. The spotty type of pigmentation occurs only in the mouth or other cavity, on the skin being always even and diffuse, although the colour varies. It tends to occur on exposed parts of the body as an intense sun browning, but may occur only under areas of firm pressure, as in this case the truss.

The response to Eschatin was prompt and satisfactory.

I am indebted to Dr. J. V. Graham with whom I saw this case, for permission to publish this record.

J. W. REID

Progressive Lipodystrophy.

This is a case of a girl of eleven years who was brought to the Clinic complaining of nausea after meals, headache and progressive loss of weight.

The family history reveals nothing of interest, the girl being the eleventh child in a family of fifteen, all of whom are living and well.

The personal history was that of a normal healthy child until two years ago when she began to lose weight. Her parents noticed that her face was becoming thin and drawn, notwithstanding the fact that the child's appetite remained good, bowels were normal, and she worked and played in a normal manner. A few weeks ago the symptoms of nausea and headache appeared and the child was brought to the Clinic.

Examination showed the child to be suffering from a mild pyelo-nephritis. This responded to treatment. Several bad teeth and ragged dirty tonsils were considered a primary foci, and the child was referred to hospital for their removal.

Her symptoms of nausea and headache had now cleared up. Urinalysis still showed an occasional cell and slight albumen. The appetite and general conditions were good. The extreme wasting of the face and upper part of the body remained unchanged. Examination showed no evidence of Tuberculosis. The Kahn test was negative. Blood picture showed W. B. C. 7,800; R. B. C. 3,800,000; Hb. 80%. The nervous system revealed nothing abnormal. Mentality was good for a child in her station of life, an intelligence quotient of 73.

The only positive findings were as follows: When seen in bed with the covers drawn up one had the impression of a child who had been grossly undernourished, or who was recovering from a severe wasting illness. This impression was strengthened on examining the shoulders, upper arms and thorax, In this area, and the face, there is a remarkably complete disappearance of the subcutaneous fat. This gives to the face an almost cadaverous appearance. The skin is loose and wrinkled. There is, however, no apparent change in the musculature, nor is there any evidence of loss of sensation or loss of power in the affected parts. This is important in distinguishing from a muscular dystrophy or from a wasting of the tissues following polio.

On continuing the examination the skin over the abdomen was found to contain a fair amount of subcutaneous tissue but the vulva was almost devoid of fat. In marked contrast the buttocks and legs showed an abundance of fat and were quite normally developed. With the above findings and the progressive history of the case we thought a diagnosis of Progressive Lipodystrophy was justified.

The first case of this kind to be reported in the Literature was in 1906. Since that time there have been about 90 cases reported but very little has been added to our knowledge regarding the causes or treatment of this malady.

Coates has defined Lipodystrophy as a disease especially liable to affect children of five to eight years of age, in which characteristically there is a loss of subcutaneous fat of the face, neck, thorax, arms and abdomen without assignable cause or gross symptoms of ill health. In association with this there is in females an increase in subcutaneous fat below the iliac crests.

The outstanding features are the almost cadaverous looking face and the upper part of the trunk, while the lower part of the trunk and the legs appear either normally, or better than normally, nourished. Also there is no loss of muscular power or disturbance or sensation over the affected parts and the individual is active and strong and well in every respect.

Although the face appears pale no anaemia can be demonstrated, and our case while showing a mild secondary anaemia will probably return to normal blood picture, since the foci of infection have been eradicated.

The present symptom is the progressive wasting of the face and neck. This is a slowly progressive condition and the parents are usually unable to fix a definite date to the onset. The face shows a very striking contrast to the remainder of the body which presents a plump well nourished appearance; an old appearance, skin wrinkled and usually has a sallow tinge.

Etiology. Nothing is known as to cause. Tuberculosis and syphilis seem to play no part. It is not hereditary. Several theories have been advanced. Deficiency of the endocrine glands is always suggested in cases where there is defective development in children. but there is no evidence to warrant such an assumption. Another theory is that it follows acute infections being related to the encephalitic group; but with thousands of children developing acute infections why do so few go on to lipodystrophy.

I can find no record of any autopsies probably because the conditions seem in no way to shorten life. Biopsies have been done but show nothing except a complete absence of fat in the subcutaneous tissues.

Prognosis. Good as to life. The condition does not seem to affect the patient's health. In the event of a severe wasting illness the absence of a reserve of fat upon which the body may draw may have some effect on the ultimate result. These patients seem to suffer more from the cold, due no doubt to the increased ratio between skin surface and body weights. Prognosis as to cure is bad.

Treatment. There is no treatment unless something can be done by tne plastic surgeon to improve the appearance of the face. Endocrine therapy, diet, anti-syphilitic treatment have all proved useless.

In spite of its infrequency the disease must be kept in mind because the emaciation of the face and trunk may tend to lead the observer to suspect tuberculosis, and to treat the patient for this disease for some time before the true diagnosis is apparent.

F. A. MINSHULL

CANCER SECTION

THE USE OF THE PROCTOSCOPE IN THE EARLY DETECTION OF LESIONS OF THE RECTUM AND COLON

JOSEPH COLT BLOODGOOD, Baltimore, Md.

THE general practitioner and many specialists do not appreciate the value of the proctoscope even when they see their patients with definite symptoms suggesting trouble in the lower bowel and rectum. The majority of cases of fully developed cancer of the rectum, even to-day, have not been proctoscoped until quite definite symptoms had been present some time and suggestive symptoms a much longer time. The majority of the medical profession are not prepared to make a routine proctoscopic examination in their offices and often fail to make a routine examination with the finger. I have sufficient evidence to prove that a large number of patients come under observation of doctors, in their own offices or in the dispensary, with sufficient symptoms to justify a routine proctoscopic examination, but they do not get it. There are very few places in the world, where there are doctors and hospitals, that anyone could not get a proctoscopic examination.

I find the following letter addressed to Dr. H. Lyons Hunt, American Medical Editors' and Authors' Association, 4 East 61st Street, New York City.

This letter was dated November 15, 1934, I was confined to bed with a temporary illness and apparently took this opportunity to write Dr. Hunt about a subject I had had in mind for some little time. It was my object to suggest to Dr. Hunt that he distribute it among the members of the American Medical Editors' and Authors' Association. We were not able to carry it through to publication. So I am using it in my last paper to be published in July in the Nova Scotia MEDICAL BULLETIN.

"I am going to give you a statement in regard to the prevention of cancer and the earliest recognition of things that precede cancer or may be cancer. The use of the proctoscope in all examinations of the rectum irrespective of symptoms, is very important. There is sufficient evidence to-day that in those portions of the rectum which can be seen with the proctoscope and above the area which can be felt with the examining finger, we may see cancer before it is cancer, or the earliest stage of cancer, a period in which either irradiation or surgery offers most. I would urge that whenever a doctor makes a rectal examination, he should use the proctoscope. Should the bowel be filled with fecal matter, he can advise the patient to come back the next day or at a convenient time. Whenever the finger is placed in the rectum for an examination of the prostate, there should also be a proctoscopic examination. This early examination of any lesion of the rectum which can be seen at the proctoscopic examination or felt with the finger, has for its chief purpose the recog-

nition of cancer in its earliest stage, when there is a possibility it can be cured without loss of function and without colostomy."

On December 1st, Dr. Hunt read this letter to his Executive Committee, and I was appointed Chairman of a Committee to take charge of the matter. And here, in this BULLETIN, will be found a short summary of the study.

I will note, first, that it is perfectly possible to ultimately educate the public, men and women, and the profession to employ proctoscopic examination at the most favorable time. For example, a married woman, past the menopause, who had had a few hemorrhoids and some bleeding during her child-bearing periods, noticed one morning a few drops of blood from the rectum. She took an enema, and there were a few more drops of blood. She reported that afternoon to the office of a surgeon and an immediate proctoscopic examination was made. The bowel was clean and there was no difficulty in seeing the entire lower colon and rectum. In the region of the anus there was an area of blood-stained mucous membrane which suggested that a small hemmorrhoid had ruptured. Nothing could be felt on palpation. This solved the situation at once. It took less than twenty minutes, and everything has been normal since a period of six months.

This shows how quickly and how simply a proctoscopic examination can be made, and there is nothing more precise than such an examination in determining what the trouble is.

Another patient had noticed in the past few days ribbon stools and immediately told her son, a surgeon, about this. The proctoscope examination was made at once, and we saw, high up in the rectum, projecting from one side of the colon, a mass about the size of a thumb. It looked like colon material, but the possibility of a tumor of some kind growing from the wall of the gut and buried in this material, was considered. An enema was given and, finally, everything was washed away leaving nothing but a normal mucous membrane.

I have sufficient evidence to tell me that the number of such instances has increased when the doctor has talked to his patients along the lines of preventive medicine. This reduces their fear of such an examination and really urges them to have the curiosity to have any suspicious symptoms immediately cleared up.

Doctors must learn how to make their patients preventive-medicine minded and become so themselves, The majority of the best physicians have the same fears and anxieties as their patients when they observe the first sign-or symptoms, and even at present are very apt to put the matter off rather than see at once what the trouble really is. I am confident that ultimately the doctors and their patients will realize that if the proctoscopic examination is made at once, on the first sign or symptom, cancer may not be found. They must all realize that when cancer is found it may be cured by irradiation, and even when operation is indicated, it is no more serious than an operation for hemorrhoids.

Here is an example of an early cancer of the lower rectum. The patient, a woman over forty, observed a little bleeding from the rectum and went to her family physician at once who took her to a surgeon who found that the bleeding was from the vagina. He immediately made a vaginal examination and found an oblong ulcer bigger than the two phalanges of the large thumb. A biopsy was immediately made, and the section revealed a typical cancer of superficial origin. Complete operation was advised. When this patient

came under my care, I felt that there was no danger in trying irradiation first. The complete operation would have resulted in the destruction of the sphincter muscle and a colostomy. I referred this patient to my colleague, Dr. Burnam at the Kelly Hospital. The treatment was simplicity itself. The patient was put in the Syms position giving perfect visibility, and was then treated with radum emanations for a certain number of minutes every so often. The treatment was not much more than covering the visible and palpable ulcerated area with small cloths containing the emanations. It is now over a year and a half, the ulcer has entirely disappeared. We have therefore sufficient evidence to demonstrate to patients and their doctors that if they are examined at once, the chances are that a non-cancerous lesion will be found, and if a malignant lesion is demonstrated, it may be cured by irradiation only. But, if surgery must be done, the chances of a cure are best.

We have not yet succeeded in educating the public or ourselves about the value of an immediate answer to any warning. Our educational publicity or preventive medicine is just beginning, but is moving, and results are being obtained. Irradiation therapy with X-rays or radium is moving rapidly towards more frequent employment, but as yet has not moved as rapidly towards earlier employment. We are making some progress in getting people to report after they are definitely warned, but much less progress in getting people to report in time for routine examinations. My article on Cancer of the Cervix in Women, A Preventable Disease, has just been published, I think, in the May number of the BULLETIN. There is no question that women, (mothers), are still too infrequently cured of cancer of the cervix in spite of the accessibility of radium and of Doctors who understand its use, due to the fact that women wait for symptoms or signs of the possible cancer instead of reporting at least twice a year for a routine pelvic examination.

I feel confident that the ultimate protection from cancer originating in the lower bowel, colon and caecum will depend upon routine proctoscopic and X-ray examination made upon all people at certain periods. For example when a mother reports at the advised interval for her protective examination against cancer of the cervix, she will also receive a proctoscopic examination and X-ray picture of the colon. When the male at definite ages reports for the routine protective prostatic examination, there will also be a proctoscopic examination and an X-ray picture of the colon.

These examinations do not add to the expense, but like all forms of insurance are ultimately economic. Our chief cause of failure to-day to cure people of cancer is not so much our lack of skill in the diagnosis and treatment when they come under our care as in getting them under our care in that time in which our diagnosis and treatment will give the best results. The medical and the dental professions are not yet as well educated as they should be in their relation to their own patients. But great improvements are taking place. I have observed this in the past few years in all departments of medicine and dentistry and especially in relation to diseases of the colon and lower bowel.

Department of the Public Health

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Townsend, H. J., Louisburg.
Gouthro, A. C., Little Bras d'Or Bridge, East Side.

COLCHESTER COUNTY

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

CUMBERLAND COUNTY

Bliss, G. C. W., Amherst.
Drury, D., Maccan (County).
Gilroy, J. R., Oxford.
Hill, F. L., Parrsboro.
Eaton, R. B., River Hebert (Joggins).
Withrow, R. R., Springhill.

DIGBY COUNTY

McCleave, J. R., Digby.
Rice, F. E., Sandy Cove (Mcpy.).
Belliveau. P. E., Meteghan.

GUYSBORO COUNTY

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

HALIFAX COUNTY

Almon, W. B., Halifax.
Forrest, W. D., Halifax (County).
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 (Hantsport).

INVERNESS COUNTY

MacLeod, J. R., Port Hawkesbury
Chisholm, D. M., Port Hood.
Chisholm, M., Margaree Harbour (County).
Ratchford, H. A., Inverness.

KINGS COUNTY

Bishop, B. S., Kentville.
Bethune, R. O., Berwick (Co. and Town).
deWitt, C. E. A., Wolfville.

LUNENBURG COUNTY

Marcus, S., Bridgewater (McPy.).
Rehfuss, W. N., Bridgewater.
McKinnon, C. G., Mahone Bay
Zinck, R. C., Lunenburg.
Zwicker, D. W. N., Chester (Chester Mcpy).

PICTOU COUNTY

Blackett, A. E., New Glasgow.
Chisholm, H. D., Springville.
MacMillan, J. L. Westville.
Stramberg, C. W., Trenton.
Sutherland, R. N., Pictou.
Benvie, R. M., Stellarton.

QUEENS COUNTY

Ford, T. R., Liverpool (Town and County).
Hebb, F. J., Liverpool.

RICHMOND COUNTY

Deveau, G. R., Arichat (County).

SHELBURNE COUNTY

Brown, G. W., Clark's Harbour.
Churchill, L. P., Shelburne (County).
Fuller, L. O., Shelburne.
Banks, H. H., Barrington Passage (Barrington Mcpy).
Herbin, C. A., Lockeport.

VICTORIA COUNTY

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

YARMOUTH COUNTY

Blackadar, R. L., Port Maitland (County).
Burton, G. V., Yarmouth.
O'Brien, W. C., Wedgeport.
Siddall, A. M., Pubnico (Argyle Mcpy.).

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

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

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

Report on Tissues sectioned and examined at the Provincial Pathological Laboratory from June 1st., to July 1st., 1935.

The number of tissues sectioned is 201. In addition to this, 20 tissues from 5 autopsies were sectioned, making 221 tissues in all.

Tumours, malignant	26
Tumours, simple	17
Tumours, suspicious	1
Other conditions	157
Tissues from 5 autopsies	20
	—221

Communicable Diseases Reported by the Medical Health Officers for the month of June, 1935.

County	Chicken Pox	Diphtheria	Influenza	Measles	Mumps	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. Pulmonary	Tbc. other Forms	V. D. G.	V. D: S.	Whooping Cough	German Measles	Undulant Fever	Erysipelas	Septic Meningitis	Chancroid	TOTAL
Annapolis	..	..	..	..	21	..	..	..	..	1	..	..	8	..	..	..	..	..	30
Antigonish	..	..	..	..	..	..	10	..	..	..	..	..	..	..	..	..	..	..	10
Cape Breton	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
Colchester	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	1	..	2
Cumberland	3	..	..	..	..	..	1	..	..	..	1	..	..	7	..	..	..	..	12
Digby	..	..	..	57	..	2	10	4	..	..	..	..	..	..	..	..	..	..	73
Guysboro	..	..	..	..	..	..	..	..	2	..	..	1	..	1	..	..	..	..	4
Halifax City	1	12	..	..	..	..	38	..	..	..	..	..	8	10	..	2	..	..	71
Halifax	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	2
Hants	..	..	..	..	..	..	..	..	..	..	6	..	..	..	..	..	..	..	6
Inverness	..	..	..	..	..	..	..	..	2	..	2	..	..	..	..	..	..	..	4
Kings	..	..	7	..	..	..	..	..	2	..	..	..	..	3	..	..	..	..	12
Lunenburg	..	..	..	..	..	..	5	..	..	..	..	..	..	..	..	..	..	..	5
Pictou	..	..	..	..	..	1	3	..	..	..	2	..	..	..	1	..	..	..	7
Queens	..	..	..	..	..	..	4	..	..	..	..	..	..	..	..	..	..	..	4
Richmond	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	...
Shelburne	..	..	3	..	..	1	..	..	1	..	..	..	..	..	..	..	..	..	5
Victoria	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	25	25
Yarmouth	..	..	..	..	30	..	8	..	..	..	2	2	..	..	..	..	..	..	42
TOTAL	5	12	10	57	51	4	81	4	7	2	13	3	16	21	1	2	1	25	315

Positive cases Tbc. reported by D' M. H. O's. 52.

RETURNS VITAL STATISTICS FOR MAY, 1935.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis	12	13	9	12	11	0
Antigonish	14	9	2	14	11	1
Cape Breton	117	145	23	78	66	12
Colchester	26	19	12	15	9	3
Cumberland	50	36	16	23	21	1
Digby	19	18	8	6	6	1
Guysboro	27	14	4	18	12	4
Halifax	132	98	58	78	53	9
Hants	22	24	2	15	9	2
Inverness	33	22	11	11	13	3
Kings	15	26	11	17	14	0
Lunenburg	27	24	8	26	17	1
Pictou	36	42	7	40	36	5
Queens	13	17	3	4	7	1
Richmond	12	12	2	11	3	2
Shelburne	15	12	4	3	12	0
Victoria	4	3	3	8	7	0
Yarmouth	20	31	11	8	10	2
	594	565	194	387	317	47

OBITUARY

THE death occurred at Winnipeg on June 4th of Dr. James Gilbert Munroe prominent in medical work in that city since 1903. Dr. Munroe, sixty-two years of age, was born in River John, Pictou County, N. S. in 1873. After receiving his early education at Pictou Academy he went to Dalhousie University where he graduated in medicine in 1899. His first few years of practice were spent in Lockeport, N. S. After taking post-graduate work in New York, London, Edinburgh and Vienna Dr. Munroe moved to Winnipeg where he has practised ever since. He leaves to mourn him his widow, the former Miss Flora MacKinnon; one daughter, Miss Harriet Ellen Munroe, and one son, Dr. James D. Munroe of Enderby, B. C.

Dr. Fred C. Hemeon, sixty-five, passed away at his home in Dorchester, Mass., on June 4th. Dr. Hemeon was a native of Liverpool, N. S. After attending Acadia College at Wolfville he entered the Jefferson Medical College in Philadelphia where he graduated in 1897. He practised his profession in Dorchester for the past thirty-eight years. Besides his widow, the former Miss Frances D. Shetland, Dr. Hemeon leaves a son, James Russell Hemeon of Trenton, N. J., and a daughter, Mrs. Godfrey Spier of Hempstead, Long Island, N. Y.

Dr. H. Campbell Smith, a prominent specialist in Brookline, Mass., died suddenly June 11th, 1935. Dr. Smith was a native of Port Hood, N. S., and graduated from St. Francis Xavier in 1905. He was Assistant Professor of Laryngology at Harvard Medical School, Senior Surgeon of the Massachusetts Eye and Ear Infirmary and of the Massachusetts General Hospital, and a member of the Harvard Club. Dr. Smith is survived by his wife, nee Alice Rice, a daughter, Miss Polly, and a son Duncan C. Jr., a student at St. Francis Xavier University; also by three sisters, Mrs. G. Chisholm, Halifax; Mrs. James Connolly, Truro; and Sister St. Berthold, C.N.D., Port Hood.

Our whole Society will mourn the death of one of our most prominent and beloved physicians, Dr. John Locke Churchill, Superintendent of the Nova Scotia Hospital. Although it was known to a few that Dr. Churchill did not enjoy the best of health his death came to most of us as a distinct shock. He passed away in his sleep during the night of June 21st; death was due to a heart attack. Dr. Churchill was born at Lockeport, N. S. in 1872. He first graduated from Acadia University, and from there went to study medicine at McGill. After graduating from McGill he took post-graduate study in New York and first started practice at Bridgewater. Following a successful practice there Dr. Churchill came to Halifax where he immediately took a great interest in civic affairs, particularly in public health matters. He was Chairman of the Board of Health of the City of Halifax, from which

position he retired in 1923. In the latter period of his life Dr. Churchill took a keen interest in politics and was known for his fair judgments on political issues. He also served as a member of the Faculty of Medicine of Dalhousie University lecturing on contagious diseases. Next to his profession probably his greatest love was literature; he was well versed in the classics and particularly fond of poetry. Surviving him are his widow, formerly Miss Charlotte MacMillan of New Glasgow, and one daughter, Mrs. Frank H. Curry of Halifax. The funeral was held at Lockeport on June 26th.

It is our sad duty to record the death of Dr. John E. L. Pollard of Hantsport who passed away on June 20th. Until a few days before his death Dr. Pollard had been enjoying good health and his death came as a shock both to his family and relatives. Born seventy-two years ago in Lancashire, England, Dr. Pollard was educated at London and Edinburgh Universities, and first practised his profession in England. He came to Canada in 1923 and settled at Hantsport. Dr. Pollard took a keen interest in sport, particularly in cricket and was associated for a number of years with the Windsor XI of which his son was a member. He is survived by his wife, one daughter living at Hantsport, and one son a member of the Royal Canadian Mounted Police stationed at Halifax.

Another great loss to our ranks occurred in the death of William Patrick Mackasey of Halifax who passed away suddenly in Montreal on June 20th. He was stricken by a heart attack and died shortly afterwards in a St. James Street office in Montreal. Dr. Mackasey was born in Moncton in 1882, a son of Patrick and Julia Mackasey. He was educated there and afterwards taught school at Sheet Harbour and later at St. Mary's College, Halifax. He then went to the Dalhousie Medical School and graduated in 1914. Following graduation he spent a year as interne at the Victoria General Hospital. Going overseas in the spring of 1915, Dr. Mackasey served in the British Medical Corps in England for three months, then going to the Mediterranean and serving at Salonika. While there he developed malaria and was quite ill for several months; returning to England he spent some two months in hospital, and on recovering went to German East Africa in charge of a field ambulance detachment. During this campaign, which was severe on account of the heat and the prevalence of tropical diseases, he further undermined his health. His overseas services unquestionably were responsible for his early passing. Returning to Canada Dr. Mackasey began practice in Halifax, where he quickly worked up one of the largest practices in the city. In 1922 he was appointed Pensions Medical Examiner. He is survived by two daughters, Helen and Dorothy, and one son, Billie, Halifax; two sisters, Edna of Providence, R. I., and Claire, Mrs. Doherty, of Moncton; and three brothers, Harry of Montreal, Frank of Quebec City and Andrew of Toronto.

Personal Interest Notes

To Dr. and Mrs. H. A. Creighton, Lunenburg, June 20th, a daughter.

Dr. D. W. M. Zwicker of Chester who has spent sometime in hospital at Halifax has returned to his practice.

Dr. and Mrs. J. C. Wickwire of Liverpool who have recently been spending some time in Boston have returned home.

Dr. and Mrs. A. S. Burns and daughter of Kentville have recently returned from a trip to Saint John, N. B. Dr. Burns, who has not practised for the past year, has in that time made a special study of diseases of the nervous system and will again take up his practice in Kentville.

Dr. A. R. Chisholm, of Vancouver, who graduated from Dalhousie in 1925, is spending the summer at Kentville.

Dr. and Mrs. T. F. Meahan of New Aberdeen have recently visited Dr. Meahan's parents at Bathurst, N. B.

The appointment of Dr. W. W. Woodbury as Dean of the Dental School of Dalhousie was announced recently by the President, Mr. Carleton Stanley. Dr. Woodbury was a graduate of the Halifax Academy and later, Dalhousie University. He afterwards pursued his course in dentistry at the Philadelphia Dental College. He returned to Halifax when the Dental School was being formed and was one of its first demonstrators. He has been on the Faculty of the School of Dentistry since its beginning as Professor of Orthodontia. Dr. Woodbury became President of the Dental Board of Nova Scotia in 1932.

Dr. and Mrs. G. M. Bruce arrived recently from New York and are spending sometime at Shelburne with relatives. Dr. Bruce is a graduate of Dalhousie, 1925.

Dr. George E. Buckley, Guysboro, celebrated his eighty-eighth birthday, Tuesday, May 28th. He has been practising his profession in Guysboro for the past sixty-seven years and is still in harness, despite a severe accident eight years ago which left him a semi-invalid. Dr. Buckley is an honorary member of the Medical Society of Nova Scotia..

Dr. F. T. Macleod of New Waterford has returned from a trip to Vancouver and other parts of the Canadian West.

Dr. C. B. Crummey who has been practising at Ship Harbour for a number of years has now opened up an office at Trenton.

The wedding took place at Inverness on June 20th of Miss Agnes MacNeil, daughter of the late Captain and Mrs. Angus MacNeil, and Dr. John R. MacNeil, both of Glace Bay. After a wedding trip through the province Dr. and Mrs. MacNeil returned to Glace Bay.

Dr. R. W. M. MacKay, assistant superintendent of the Nova Scotia Hospital, and his wife, recently motored to London, Ontario, where they were visiting relatives.

The Hospital Association of Nova Scotia and Prince Edward Island held a most successful convention at University Hall, Wolfville, June 18th, 19th and 20th. After receiving a welcome by A. M. Wheaton, Mayor of Wolfville, the Association listened to a most interesting address by the Hon. F. R. Davis, Minister of Public Health for Nova Scotia. The programme was most comprehensive dealing with the questions of hospital economics, the care of the mentally ill, sterilization problems in hospitals, and also many phases of public health. On the evening of June 19th there was a general meeting open to the public at which addresses were given by Dr. Agnew of Toronto, Dr. Gosse of Halifax, Professor A. B. McDonald of Antigonish, Dr. H. G. Grant of Halifax, and Mr. L. D. Currie of Glace Bay. A moving picture dealing with tuberculosis was also shown at this evening's session. Perhaps one of the most important parts of the meeting was the resolution that was passed by the Association, opposing any action to repeal the law of 1925 by which Municipalities are obligated to pay for hospital fees incurred by Municipal patients unable to afford the hospital charges. The slate for the following year brought in by Rev. Mother Ignatius of Antigonish, was as follows:

Honorary Presidents: Rev. H. G. Wright, Inverness; W. K. Rogers, Charlottetown.

President: Dr. D. J. Hartigan, New Waterford.

Vice-presidents: A. J. MacDonald, Glace Bay; Rev. Sister Anna Seton, Halifax.

Secretary-Treasurer: Miss Anne Slattery, Windsor.

Exerctive: Rev. H. G. Wright, Inverness; Mrs. P. M. Fielding, Windsor; Miss L. Marshall, Bridgewater; R. T. Holman, Summerside; L. D. Currie, Glace Bay; Fred MacDonald, Sydney Mines; Mayor H. F. Muggah, Sydney; Miss M. Boa, New Glasgow; Dr. H. L. Scammell, Halifax; Miss V. Bengston, Wolfville; B. H. Wetmore, Yarmouth; Father R. C. McGillivray, Sydney; Rev. Mother Ignatius, Rev. J. R. McDonald, Antigonish; Rev. Sister Paula, Charlottetown; Miss A. Kilgour, Truro.

Legislative Committee: Fred McDonald, Sydney Mines; Convenor, L. D. Currie and A. J. MacDonald of Glace Bay.

Nursing Education: Miss Clara McKinnon, Glace Bay, Convenor, Publicity: Dr. H. L. Scammell, Halifax, Convenor.

Programme: Miss Anna Slattery, Windsor, convenor; Dr. H. L. Scammell, Sister Anna Seton, Halifax; Miss M. Boa, New Glasgow, Miss L. Marshall, Bridgewater.

The regular monthly meeting of the Cape Breton Medical Society was held in the General Hospital at Glace Bay with Dr. MacAskill of Glace Bay presiding Dr. B. C. Archibald of Glace Bay gave a paper entitled "Dystrophia Adiposa Gemitalis" and Dr. Arthur Green of Glace Bay also gave a paper on "Acute Nephritis". Cases of Parkinsons Disease were presented by Dr. MacAskill and several "Stomach Cases" illustrated with X-ray pictures by Dr. Patton. An interesting feature of the meeting was the appearance of the famous Siamese twins who were at that time playing an engagement at the Savoy Theatre.

Nurses Graduating Exercises at New Waterford.

Graduation exercises were held at the Strand Hall, New Waterford, on June 3rd at which six nurses received their diplomas; Alma MacDonald, Sydney; Jessie MacIntyre, Glace Bay; Muriel MacKay, Mary MacLeod, Mary Haley and Margaret Young of New Waterford. Mr. Arthur Burke, President of the Executive Board of the New Waterford General Hospital Corporation, presided; the chief speakers were Dr. A. W. Miller, Hon. Michael Dwyer, Dr. D. J. Hartigan, Rev. W. J. Jones and the Rev. M. N. Tompkins.

Dr. G. F. White, formerly of Annapolis Royal, is reported now to be ship's physician on an ocean liner between London, England and Sydney, Australia.

Medical Council of Canada Maritime Pass List—The pass list in the recent examinations held by the Medical Council of Canada has been announced by Dr. J. Fenton Argue of Ottawa. The examinations were held at several centres throughout Canada. Two hundred and sixty-nine successful candidates are now qualified to practise medicine in Canada. The Maritime list follows: H. A. Collins, Kentville; E. M. Found, New London, P. E. I.; J. K. Hewat, L. G. Holland, T. C. C. Sodero, Halifax; G. W. A. Keddy, Windsor; K. W. McKenzie, Campbellton, N. B.; E. Stiles, River Glade, N. B.; S. Warson, Saint John; F. L. Whitehead, Charlottetown, P. E. I.; F. H. Wigmore, Emerald, P. E. I.; W. F. Anderson, Pictou; S. A. Creighton, Woodstock; L. C. Haslam, Springfield, P. E. I.; R. A. Hughes, Charlottetown, P. E. I.; M. K. MacGougan, Summerside, P. E. I.; J. A. McLaughlin, Arthurette, N. B.; O. B. Petrie, Newcastle, N. B.; G. H. Raymond, Charlottetown, P. E. I.; D. E. Rodger, Amherst, N. S.; D. R. Webster, Pictou, N. S.; Mary E. Cunningham, Saint John, N. B.; P. J. Losier, Chatham, E. S. Peters, St. Jonns.

Annual Graduation Exercises Aberdeen Hospital.

Attended by more than three hundred interested citizens and friends of the graduates, the annual graduation exercises of the Aberdeen Hospital Training School for Nurses, New Glasgow, were held June 6th in the High School Auditorium. The nurses graduating were—Christene Haggart, New Glasgow; Evelyn Hoyt, Pictou; Mildred McDonald, Avondale; Lilian Quigley, Inverness and Helen Morash, Lunenburg. Mr. W. F. Fraser, President of the Board acted as Chairman. The address to the graduates was given by Dr. H. B. Whitman of Westville. The special speaker of the evening was the Hon. F. R. Davis, M.D., Minister of Public Health.

On July 4th Dr. A. C. Fales gave an illustrated lecture at the meeting of the Kings County Fish and Game Protective Association at Kentville. There were over three hundred people in attendance. Dr. Fales' illustrated lecture, a hunting trip in the Yukon, was not only unsurpassed for mountain scenery and pictures of wild life, but was filled with exciting moments for the experienced as well as the novice hunter.

Speaking before the Canadian Tuberculosis Association Dr. David A. Stewart, Superintendent of Manitoba Sanatoria, advocated the free treatment of tubercular patients throughout the Dominion. Dr. Stewart stressed this as the next step in the elimination of this disease from our Dominion.

Flight Lieutenant Dr. Keith Muir was in Halifax the end of June on furlough. after spending the past two years in Irak. He was the guest of his mother, Mrs. Muir, in Eureka for a few weeks, and sailed for England where he will resume his duties.

Dr. J. A. Sponagle of Middleton is at the Lahey Clinic, Boston, where he went for treatment.

The wedding took place in Halifax on June 19th of Miss Ellen (Nellie) L. Hook, R.N., daughter of the late Mr. and Mrs. Albert P. Hook, formerly of Dartmouth, and Dr. Angus J. MacDonald, of New Germany, formerly of Cape Breton. After the ceremony Dr. and Mrs. MacDonald left on a short motor trip through the province. Mrs. MacDonald graduated a registered nurse from the Victoria General Hospital, Halifax. Dr. MacDonald graduated from Dalhousie Medical College in 1933.

Son Knew Dad.

Dad and Dave were working about the yard when Dad stubbed his toes against an old tree stump. "——that — stump!" he cried. "I wish the —— thing was in hell."

"You shouldn't say that, Dad," drawled Dave; " 'cause it might be, and, then you'd be fallin' over it agen some day."

A FAMILY DOCTOR

There are some people in this old world of ours who believe in "letting something good be said" of those ministering saints that belong to the medical profession.

In the little town of Shelby, in the state of Michigan, a local family doctor was recently signally honored by its citizens, and last week the story was published in a California city paper three thousand miles distant from Michigan and used as a front page feature.

Upon reading the article a Nova Scotian's attention is immediately centered on the sea girt province by the Atlantic, and of the medical profession generally. At once you think of the old garrison city of Halifax and recall the name of the late lamented John Stewart, the dean of the profession who passed away recently so universally honored and beloved. Then in New Glasgow you think of the names of Dr. John W. McKay and of Dr. Hector H. McKay, and others in the town, County and Province who served well and faithfully their day and generation, leaving the work to younger members to carry on.

That "front page" feature is typical of many doctors in Nova Scotia, and tells its own story; and whether one lives there or away out in Michigan it will be read with genuine interest and appreciation.

It follows thus:

"Widespread newspaper publicity during the past few weeks has made Dr. William L. Griffin, of Shelby, Mich., famous. Dr. Griffin is 75 years old, has been practicing medicine in the vicinity of Shelby 46 years, and during that period brought 3,500 babies into the world. In addition, Dr. Griffin and his wife provided a home and schooling for 52 boys and girls.

All in all, Dr. Griffin has made a record of usefulness rarely equalled. In any event, that is the view his neighbours of the Shelby section took of Dr. Griffin when, not long ago, they arranged a celebration of appreciation. The affair was managed by several hundred of his grown-up "babies" and was a veritable happy time for the good doctor. There were speeches of appreciation, and flowers and something more substantial in the way of a token of esteem from Dr. Griffin's clientele.

This incident appears to answer the question as to what has become of the old-fashioned general practitioner who was on duty every hour in the day, every day in the year. It has been the fashion to assume he and his kind have disappeared from the earth. Most had supposed his place was taken by methodical persons who remain pretty much in their offices and consider it entirely unethical, not to say downright disgraceful, for anybody to get sick out of office hours.

However, Dr. Griffin is not the only surviving proof there once existed a great many doctors such as he. We have some of them in San Bernardino. We have on our own roster of citizens, men, and women, too, who are the salt of the earth—warm-hearted folk whose energies and purses are open to the needy and the deserving at all times. These people are not only physicians and nurses, and all the auxiliaries to the medical profession, but they are found in all walks of life.

We cannot do with all of them as the people of Shelby, Mich., did with the good Dr. Griffin. But we can express to them our appreciation when occasion serves. Let's tell them now and not wait to put the flowers upon their caskets when they are beyond learning how much we appreciate them.