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CONTENTS

SCIENTIFIC:

A Glimpse at the History of Therapeutics—Dr. Robert Dawson Rudolf, Toronto	- -	63
Appendicitis in the Small Rural Hospital—Dr. L. R. Morse, Lawrencetown, N. S.	- -	73
Sub-Acute Bacterial Endocarditis—Dr. O. R. Stone, Bridgetown, N. S.	- - -	77
Effects of Some Drugs on Gastric and Intestinal Motility—Dr. N. B. Dreyer, Halifax	- - -	82

EDITORIAL:

On the Writing of Case Histories—Dr. H. W. Schwartz	- - - - -	85
Our Profession—Dr. O. R. Stone	- - - - -	87
Notes from the Dalhousie Medical Library	- - - - -	88

CORRESPONDENCE—Letter from Dr. Mina MacKenzie	- - - - -	89
-----------------------------------------------	-----------	----

CASE REPORTS:

Nasopharyngeal Fibroma—Dr. J. P. McGrath	- - - - -	91
Wilm's Tumor of the Kidney—Drs. Chute and Schaffner	- - - - -	92
An Interesting Experience with Methylene Blue—Dr. R. M. Benvie	- - - - -	93

ABSTRACTS FROM CURRENT JOURNALS	- - - - -	95
WORKMEN'S COMPENSATION ACT	- - - - -	97
DEPARTMENT OF THE PUBLIC HEALTH	- - - - -	100
SOCIETY MEETINGS	- - - - -	103
PERSONAL INTEREST NOTES	- - - - -	107
OBITUARIES	- - - - -	110
Lines to a Skeleton	- - - - -	112

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"Say Schwartz and Be Sure"

A Glimpse at the History of Therapeutics

ROBERT DAWSON RUDOLF

Emeritus Professor of Therapeutics, University of Toronto.

THE word "therapeutics" comes from the Greek *therapeia* which means "to care for," and when we care for a sick man we do not treat the disease directly, except in a few instances, but help him while he struggles against his enemy, the disease. This help means far more than the giving of drugs, but includes every physical, psychic, nutritive and other factor which may assist him in his efforts towards health.

It often happens that the practitioner can best help the sufferer by stopping all drugs with which the patient may have unwittingly been thwarting nature in her efforts to restore him.

The therapist may be compared to a guide trying to lead his party, the sick man, to the goal called health. Sometimes the road is broad and clear, having been surveyed and mapped out by previous explorers, and the guide goes confidently ahead. But it may be that the country is difficult,—one into which science has scarcely penetrated and where there are no roads or even blazed trails. What is he to do? Give up his guideship and abandon his party to its fate? No, by no means no! But if he does, perhaps some native may glide out of the bush and taking the patient by the hand may lead him by pathways that are on no map, and may so save him. Such pathways are empirical. They have not been shown by scientists to lead correctly and yet they often do so. Many of our best drugs have been discovered empirically. They have gradually been studied and improved in many ways but it must always be remembered that they were there and were used by ignorant natives long before they reached the pharmacopoeias.

The history and evolution of treatment form a most interesting chapter of medicine. In this short attempt at looking backwards I will not weary my audience by naming the outstanding men who through the centuries have added this or that to the edifice of our knowledge of disease, or the different periods in the advance of our art. Many histories covering these items have been written and are most useful for reference, but a mere list such as I would only have time to give would be as uninteresting as were the names and dates of the kings and queens of England, which used to haunt us in our school days. Rather I am going to attempt to show in a general way how through the ages and under most various forms of therapy diseased persons tended to recover; in other words to emphasize the overwhelming importance of the *vis medicatrix naturae*.

All living creatures have a therapy; have some simple remedies which instinct has taught them to use. One cannot watch a dog which has eaten something which disagrees select a certain grass as an emetic without realising this. In the same way the most primitive peoples found out many things which have since proved to be of the greatest value in the conditions that

they took them for. Thus were discovered opium, cinchona, ipecacuanha, and indeed most of our vegetable drugs.

Instinct or the silent call of the tissues has taught animals what best to eat. Put a dog, a horse and a fowl into an enclosure in which are a number of different foods. Will they all eat the same substances and to the same extent. No, each will, under the direction of instinct, pick out the right amount of what suits him best.

Who taught the nations of the field and wood
To shun their poison and to choose their food?

If we add man, a human animal, to the party, will he alone err, and perhaps poison himself with what nature never intended him to take? He may do so sometimes, having, under his artificial surroundings, acquired certain bad habits, but generally speaking it is likely that man, in spite of his follies and excesses, has still an instinct which leads him to take what on the whole is best for him. His instinct is not entirely submerged by civilization and his tissues will call with a voice that he calls appetite for what they need for their obscure metabolic processes.

In recent years the value of the different vitamins has been discovered and the fact that their absence produces various diseases. Thus, a deficiency of vitamin D causes rickets. In a recent experiment at the Guelph Agricultural College a number of chickens confined in a large pen were supplied with dishes of various foods, including two of a mash, one of which contained cod liver oil and the other only mash. Cod liver oil is rich in vitamin D. Now this necessary vitamin can be supplied either thus in food or by the action of the ultra-violet rays of sunshine acting on the skin. It was found that on dull days the chickens all went for the cod liver oil mash, but on sunny days they preferred the other. Here the silent call of their tissues asked for the necessary vitamin.

Animal, having no imagination, have kept on in the same way as did their forebears; but man, being so gifted, began to theorise about the causation of disease and then about how to treat it. Now theories are necessary to progress, but they are tricky mounts and apt to run away with their riders and land them in all sorts of troubles; and history, although showing a gradual and uneven advance, is full of such catastrophies, and man has suffered much from many of the systems of treatment founded on theories that have later been shown to be fallacious.

Fortunately, theories are very often, so to speak, only skin deep, and a sort of instinct, call it what we may, seems usually to guide men aright. For example, the natives of South America had a theory that fever and ague was due to an evil spirit and that cinchona drove this away. The theory that the disease was of supernatural origin was wrong, but the practice of giving cinchona was right. Iron was used from the earliest times as a spirit scarer in anaemia and the results were excellent.

It will be found that nearly all theories have a germ of truth in them and it should be our aim to find that germ and to discard the thick husk of exaggeration, nonsense and even fraud which clog the systems of treatment founded on them.

Some of these theories and the systems of therapy founded on them will now be discussed.

1. *Astrology.* The occult influence of the heavenly bodies in the affairs of man dates from very ancient times and was of special importance in the

dark ages. Hippocrates himself said, "Astronomy is not of slight but of very essential importance in medical art." According to the Babylonian code of Hammurabi, 2200 B.C., a surgeon who operated when the stars were not propitious should have his hands cut off. It seems that all peoples have at some time shown their belief in astronomy as affecting disease and its treatment, and it is hard to believe that such a widespread opinion can have no foundation in fact.

With astronomy of such importance, almanacs and calendars were of the greatest moment and no medicine could be taken or operation performed without the sufferers' horoscope having first been cast and found to be favourable. We see traces of such belief today when people hesitate to start an enterprise upon a Friday, especially if that Friday happens to be the 13th of the month.

11. *Supernatural Origin of Disease.* The theory that disease was of supernatural origin was probably the earliest of all and the priests were hence the first practitioners.

Disease was believed to be due either to a demon entering the body or causing the trouble from a distance. By the way, most of the disease demons were female. With the object of driving or tempting the evil spirit out of the sufferer exorcism was practiced. Various methods were used, such as the beating of drums, the beating of the patient himself and a host of other scaring processes. Some examples I cull from my own experience in India. Has Baboo Hemneryhain, the respected clerk of the local law court, the jaundice or do his aging joints pain him when he rises in the cold December mornings, it will never occur to him to consult the English doctor sahib, or go to the Government hospital for treatment. "No; he is not ill enough for that," say his friends, and so the wise woman of the village is sent for and she with much muttering and mysticism will compound a potion or will make up some charm for the special trouble complained of. If the patient improves then she gets the credit (and may deserve it); if he does not do so she will explain that the spirit is angry and a priest will probably be called in. He does not believe in drugs as a rule although he occasionally uses them as spirit scarers. His powers lie chiefly in incantations and charms, and for a small pecuniary consideration he will exercise them, and either by tempting or driving the spirit of the disease out will try to cure the patient.

But perhaps, in spite of all this treatment, the old man gets worse. He is yellower; the rotund figure which in the East lends so much dignity to the owner, dwindles, and his ribs show through the sagging skin. His European superiors at court remark upon his altered appearance and persuade him at last to see the doctor sahib, who probably recognises the case as one of cancer and as such hopeless. It is *kismet* say his friends; the spirit will not leave him say the priests, and they may add that as long as they attended him he lived but when the doctor sahib took charge he dies. It will be understood that the European doctors have a high mortality rate in their native practice.

When cholera rages in an Indian village a dreadful hubbub is kept up by the inhabitants as they try to scare the goddess of cholera away. But in the neighbouring villages the people are alive to the danger and by lighting fires (which was done in London, by the way, in 1665) and if possible by making more noise than in the infected village they hope to dissuade the spirit from coming to them. Naturally if the villagers of one hamlet are doing their best

to frighten the spirit from out of their domain and those of the other are trying to prevent it from crossing the boundary, ill-feeling is apt to arise between the villagers, and such has often been the cause of serious feuds.

As epidemics were supposed to be due to spirits it was quite certain that eye-witness evidence would be forthcoming. When many years ago the plague was raging terribly in Bombay, both Hindoos and Mahometans believed it to be due to a hostile spirit, a goddess, and as one might have expected a witness soon appeared in the form of an old Mahometan woman whose eyes had been cleared by a visit to the sacred city of Mecca. This old lady swore that she saw the plague goddess in the form of a gaunt female, with bloody fangs and fleshless sinewy arms, sheeted in white, stalking through the streets of the city. Similarly, during an outbreak of small pox in Calcutta, in 1897, it was believed that the goddess Sitala (the deity presiding over small pox) was seen at dead of night, this time by a native policeman. In consequence the people flocked to the shrine of the goddess and offered prayers and gifts. The epidemic just then began to decline (owing doubtless to the excellent work of the Health Department), and the people of course thought that the goddess had been appeased. The policeman, by the way, said that he had boldly gone up to the spirit and had been about to lay hands upon her when he was prevented by an unseen agency—probably the goddess of fear. The irate spirit pronounced sentence of death upon him for the same hour next night and then vanished. Sure enough, he expired on the following night after telling his story. Of course we would say that he died of fright.

With such a fallacious groundwork to go on as regards the etiology of disease the common people of India have nevertheless gradually evolved many very wise hygienic rules. Thus they believe that when a man has small pox it angers the goddess if his friends go near him and also if they travel abroad. Now evidently the united observation of many people through centuries had noted that when persons went near such a patient they were apt to get the disease themselves; and when, having been near him they travelled elsewhere the infection might spread in their wake. They thus had established a system of quarantine.

The idea of the transference of disease has always been common, as when the legions of devils passed into the Gadarene swine. Marcellus (300 A.D. tells us that for gripes a live duck was applied to the abdomen and the pain passed away from the patient into the duck where it proved fatal. A few years ago a Dr. Rorie saw a case in which a nurse maid, suffering from *impetigo contagiosa* had deliberately infected a child with it with the object of herself getting rid of the disease. (B. M. J., June, 1904).

The scape-goat idea is of similar nature.

Charms and talismans of various sorts were largely used in many countries. "This magic treatment was believed to be especially efficacious if exorcism had been written or engraved upon paper, gold, precious stones, etc., in which case they were suspended around the neck of the patient. The rope of the hung criminal plays a conspicuous part in antique magic. Peoples, religions, philosophical systems, political revolutions, have risen and fallen but the belief in the curative action of the rope has survived." (Magnus). The washings from the tombs of saints were very effective. Hear what that light of the Church, Gregory of Tours, had to say of these;—"Oh, indescribable mixture, incomparable elixir, antidote beyond all praise! Celestial purgative (if I may be permitted to use the expression), which throws into the shade

every medical prescription, which surpasses in fragrance every earthly aroma, and is more powerful than all essences; which purges the body like the juice of asammony, clears the lungs like hyssop, and the head like sneezewort; which not only cures the ailing limbs but also, and this is much more valuable, washes off the stains from the conscience." (Magnus).

Many charms survive to the present day. Who has not seen the most educated carry a potato in the pocket to ward off rheumatism. An iron ring is also much worn. Special groupings of numbers and circles were much used as talismans.

Temple sleep and later Church sleep as a curative method were of very ancient origin. Here the patient would enter the sacred edifice and after certain purifying processes would stay there for varying periods, weeks, months and even years, always with the hope that the evil spirit would dislike the environment and would depart. Many historical cases of cure are on record. Thus, a certain man, deaf, dumb and blind, known by the name of Amagildus, tried the sleep in the Church of St. Julian, at Brioude. He had to stay there for a year before the curative power of the holy martyr delivered him from his ailments. Veranus, the slave of one of the clergy under Gregory, was so violently attacked by gout that he was absolutely unable to move for an entire year. Thereupon his master pledged himself to advance the afflicted slave to the priesthood if St. Martin would be willing to cure him. The poor wretch was carried to the Church and there placed at the feet of the saint. Finally on the sixth day he was visited by a man who seized his foot and drew it out straight. The slave rose in terror and perceived that he was cured. Here human effort entered into the treatment, and it often happened that patients were even cut for stone while in the sacred edifice always, as they believed, by the special saint himself.

It is interesting to note that the oldest hospital in London commenced in this way. The ancient Church which still stands was used by the Londoner for Church sleep, but they did not all get better and so a hospital, St. Bartholomews, was founded near it by Rahere in 1123 A.D. to look after them.

Church sleep lingered in England at Christ Church, Monmouth until 1804. At the present day even it is still carried on in the Churches of Southern Italy and the Grecian Islands. (D. McKenzie).

Now there is no doubt that many of these fantastic methods of treatment were successful. The superior twentieth century observer will say that this was either because valuable drugs had been hit upon under some wrong theory or because of the uplifting effect of hope and faith. Or lastly because of the action of the doctor's best friend, the *vis medicatrix naturae*. As regards hope and faith you may remember how that neurotic French author exclaimed, "What doctor possesses such curative resources as are latent in a spark of happiness or a single ray of hope." The old lady in Punch was an example of this when she exclaimed as she handed the thermometer back "Ah, doctor, that did me a deal of good."

To quote from Paracelsus, "Whether the object of your faith is real or false, you will, nevertheless, obtain the same effects. Faith produces miracles."

In psycho-therapy three elements are necessary, which were well put by Sir William Osler,—“First, a strong personality, in whom the individual has faith—Christ, Aesculapius (in the days of Greece), one of the saints or, what has served the turn of common humanity very well, a physician. Secondly, certain accessories—a shrine, a sanctuary, the services of a temple, or for

us a hospital or its equivalent, with a skilled nurse. Thirdly, suggestion, either the 'only believe,' 'feel it,' 'will it' attitude of mind, which is the essence of every cult and creed, or the active belief in the assurance of the physician that the precious boom of health is within reach."

III. The Humeral theory was a very ancient one, dating from Babylonian times. Hippocrates elaborated it and taught that there were four humours,—blood, phlegm, yellow bile and black bile, which were later the explanation of the sanguine, phlegmatic, choleric and melancholic temperaments. Disease was due to a disturbance of the equilibrium between these humours. This theory, like the later Brunonian one, lead in time and after the temperate influence of Hippocrates had gone, to excessive bleeding, purgation, salivation and the use of diuretics, all with the idea of getting rid of an excess of some humour.

It is interesting to note, (I quote from Rolleston's recent article in the British Medical Journal) that as late as 1842 Ayres described as humeral diseases syphilis, cancer, melanosis, scrofula and inflammation.

IV. The Iatro-chemical theory of the causation of disease was first propounded by that great but revolutionary physician, Paracelsus (1493-1541). He was the man who publicly burned the works of Hippocrates and Galen and substituted chemistry for the humours. He and his followers agreed that acids and alkalis were responsible for disease and thus was born the great subject of biochemistry. By the way, "the word chemistry was derived from Chema the ancient name of Egypt, the Black Land. Hence chemistry was called the Black Art." (I quote from Bernard Dawson's excellent little book on the History of Medicine.)

V. *Solidism*. This theory was a very old one. According to it disease was caused by organic changes in the different organs of the body. Themison was its chief exponent a century before Christ. Ailments were due to constriction or relaxation of the pores, between the atoms of which the body and its fluids or parts of them were thought to be composed. Many workers through the centuries have added to the sum of knowledge of organic changes in the organs. Even in *our* early days these physical alterations in the tissues were considered to be a sufficient explanation of disease. Lately, however, the chemical and humeral views are coming into their own again, in, of course, a very modified form.

VI. In the eighteenth century John Brown, cutting adrift from the teaching of Cullen, who had upheld the solidism theory very strongly, started the idea that all disease was either "Sthenic or Asthenic"; and with it the view that patients must either be lowered or raised, the former by venesection, purging starvation, sweating and other depletory methods. The asthenic ones were to be stimulated by alcohol and various stimulants.

The stimulating therapy probably did little harm, but that cannot be said of the depletion, which reached its climax at the end of the 18th and the beginning of the 19th centuries. It was said of Broussais, a French physician, that he shed more blood than did Napoleon. Then a reaction set in and in opposition to the starvation therapy Graves asked that the epitaph on his tomb stone should be "he fed fevers."

Lettsom, the founder of the Medical Society of London, evidently belonged to the Brunonian school, for an enemy wrote the following skit,—

When folks is sick they come me,
 I physics, bleeds and sweats 'em,
 Sometimes they live, sometimes they die,
 But what cares I.—I. Lettssom.

As a matter of fact his initial was J., but one must allow for poetic license. Also in those days I. and J. were the same letter.

In 1842 Oliver Wendel Holmes wrote, "I firmly believe that if the whole materia medica, as now used, could be sunk to the bottom of the sea it would be all the better for mankind, and all the worse for the fishes." We must remember, as Rolleston says, that Holmes was a mere anatomist.

VII. *Homeopathy*. Much earlier than Holmes, in the end of the eighteenth century, Hahnemann published his work, *The Organon of Medicine*, VII. Hahnemann was an ordinary practitioner in Germany. He became dissatisfied with the current treatment founded on the Brunonian theory. The old school, he wrote, "presupposes the existence of excess of blood (plethora, which is never present), sometimes of morbid matters and acridities, hence it taps off the life's blood and exerts itself either to clear away the imaginary morbid matter, or conducts it elsewhere by emetics, purgatives, sialagogues, diaphoretics, diuretics, drawing plasters, setons, issues, etc., in the vain belief that the disease will thereby be weakened and substantially eradicated; in face of which the patient's sufferings are thereby increased and by such rather painful appliances the forces and nutritive juices, indispensable to the curative processes, are abstracted from the organism. It assails the body with large doses of medicines, often repeated in rapid succession for a long time, whose long-enduring and often frightful effects it knows not, and which it, purposely it would often seem, makes unrecognisable by the co-mingling of several such unknown substances in one prescription, and by their long-continued employment it develops in the body new and often ineradicable diseases."

And a little later, "It is under the old physician who has been at last gradually convinced of the mischievous nature of the so-called art after many years of misdeeds, and who only continues to treat the severest diseases with strawberry syrup mixed with plantain water (i.e., nothing) that the smallest number are injured and die."

Having thus condemned the prevailing medical practice he propounded the theory of Like curing Like. The doctrine was not a new one, but a revival of that of Paracelsus who was a believer in the curative powers of the spiritual entities present in the body. Hahnemann thought the effects were due to drugs, which, strange to say, were more powerful the less the dose. The two elements in his therapy were (1) a drug would cure a disease which resembled the effects that the drug itself could produce. Thus belladonna occasionally causes a scarletina-like rash and therefore was to be used in scarletina; ipecacuanha causes nausea and vomiting and hence would relieve such symptoms, etc. (2) the power of a drug increased as the dose was lessened. Hahnemann was able to try his treatment in hospital and it soon became evident that his results were better than in the regular hospitals, and so the cult grew.

Hahnemann just missed being a great discoverer, for his work showed (although he never admitted it) that patients tended to recover without any drugs. In fact he rediscovered the powers of the *vis medicatrix naturae*. The healing power of nature was a Hippocratic doctrine. Not that Hippo-

crates taught, as he was afterwards reproached with teaching, that nature is sufficient for the cure of disease, for he held strongly to the efficacy of art. But he recognised, at least in acute diseases, a natural process which the humours went through,—being first “crude,” then passing through “coction” or digestion, and finally being expelled by resolution or “crisis” through one of the natural channels of the body. The duty of the physician was to foresee these changes and to assist or not to hinder them; so that the sick man might conquer the disease with the help of the physician.” (Encycloped. Brit. XV, 800).

But, alas, this tendency towards health seemed to have been completely forgotten and was only again brought to light by accident, so to speak, by the results of Hahnemann’s masterly inactivity. But Hahnemann did not see this for he wrote “Nature is a bad physician and not to be trusted; drugs are the real curative agents, provided by the beneficence of the Almighty.” (Encyclop. Brit. XII, 128).

VIII. *Endocrinology.* From the dawn of history we find evidence of the belief of man in the power of the tissues of the various organs of the body to produce effects when taken internally. Thus men would eat of the heart of the lion or of a captured enemy in the belief that it would make them brave, of the brain to make them clever, and so on. The conception that the organs produced substances which carried elsewhere in the blood caused certain effects was first promulgated by the famous physiologist, Claud Bernard, in 1855, and the idea was received with such scepticism at the time that it nearly ruined his reputation. But truth will out, and the therapeutic use of extracts from the internal organs, first started by Murray in 1891 in the treatment of throid insufficiency, soon spread until nearly every organ in the body was attacked and extracts made therefrom and given in all manner of supposed deficiency diseases. There seems no doubt but that the pendulum swung too far, but the fact that certain organs secrete internal secretions, hormones, that influence the activity of other organs stands out as a proved fact. The pendulum, as I say, has swung too far and even threatens to become a commercial menace, but the value of thyroid extract, suprarenal extract, insulin and pituitrin is beyond cavil and several others might safely be added to the list.

“Indiscriminate prescription of endocrine products, without reference to the possibility of their Physiological or pharmacological activity, merely impedes progress and brings discredit on an important subject.”

Sir Walter Langdon-Brown.

B. M. J., Oct. 17/36.

Pernicious anaemia is perhaps the latest addition to the number of so-called deficiency diseases and the outlook of sufferers from this formerly inevitable fatal complaint has been completely altered by the use of liver and other extracts which contain the missing hormone.

IX. *Infection.* When bacteriology was brought into being by the work of Pasteur and Koch over fifty years ago the importance of microorganisms as a cause of disease became evident and for long overshadowed that of the soil. Infection was everything and the body was its defenseless prey. But gradually

it was realized that the living organism had great natural powers of defence, either inherent or acquired, and as a consequence the establishment of immunity rather than a direct attack upon the invading organisms became the chief object of the practitioner. Drugs were here of less value than vaccines and sera, although certain of them such as quinine in malaria, and emetin in amoebic dysentery more or less attacked the invaders or their toxins.

Inoculation for small pox, and later vaccination, established by Jenner in 1796, are examples of the induction of immunity. As an illustration of the saying that there is nothing new under the sun, vaccination was used in India over three thousand years ago. It is on record that Dhanwantari, a Hindoo physician, who lived about 1500 B. C., described it and even the method of obtaining the lymph from the cow's udder.

Lately focal infection has been much in evidence and in some places has probably been given too much lime light. It is not new. "Benjamin Rush in 1803 wrote on the subject and gave a number of examples of the benefits from the extraction of teeth and of the disappearance of symptoms due to 'acid and putrid matters sometimes discharged from the teeth.'" (Rolleston).

The introduction by Lister of antiseptics and later of asepsis was a fatal blow to wound infection and altered the whole subject of surgery, but with this, as a therapist I will not deal. Nor with the discovery of general and local anaesthesia which have made operation and child-bearing painless. Perhaps antiseptics and anaesthesia have made operations too safe and easy and there may be a fly in the ointment, but this is for the surgeons to consider.

X. *Drugs.* It is instructive to note the fluctuations in the use of drugs as shown in history. At one time they are used to excess at another are almost ignored. Even the best have had their ups and downs.

For example; digitalis was in the London Pharmacopoeia of 1665 and several subsequent editions and was then dropped for over a hundred years. Then Withering heard of its virtues in dropsical conditions from an old wise woman and replaced it on its now firm pedestal.

Iodine has also shown the changes in fashion. The Greeks used to administer the ashes of sea-weed in the treatment of goitre. Pure empiricism to be sure but they got results. A century ago scientific medicine no longer acknowledged the value of the ashes but held in high esteem the chemical, iodine. In a small treatise written in 1824 a Dr. Gairdner of London urged the treatment of goitre with iodine. "Yet," says a writer in a recent Spectator, "until the other day we of the present century had forgotten iodine in its most valuable uses, and thought of it merely as an excellent local antiseptic, or agent for local painting over some local inflammation."

The more one delves into the history of medicine the more he is struck with the fact that many discoveries are really rediscoveries. J. K. Fowler very truly wrote, "If you want to be original you must not read too much."

In this short and very incomplete glance at the history of treatment I have repeatedly referred to the healing power of Nature, to the *vis medicatrix naturae*, but lest we should rely too much on this it must be remembered that Nature is neutral and would as lief that a man die as that he should survive. When a cancer becomes implanted in the tissues Nature encourages the growth, and nothing but the surgeon's active interference will save him. In the same way, it is in accordance with Nature's laws that a tape worm

flourishes in the intestine, or the *acarus scabei* infects the skin. Both will continue indefinitely unless they be treated medicinally.

Nature may be compared to an absolutely unbiassed judge, who dispenses the laws and exacts the penalties. And the laws are not made but come from her. A man poisons himself with alcohol, and the Court decides that he shall suffer and perhaps die. Another shuts himself up in a bad atmosphere, and there, burning the midnight oil, wears himself out working, perhaps, in order that his loved ones may live. But the verdict is that the tubercle bacillus, which following natural laws, has emplaced itself in his depressed tissues shall win. The Court is indeed one in which the natural laws are fairly administered, but where sympathy and pity are unknown.

It would be wrong for us to consider that the therapeutic edifice is near completion. Our views of the present are but bricks in the building, some no doubt bad bricks that will be rejected by our successors, and some good which will be retained and will form part of the great structure that is slowly and by successive layers advancing to the level of,—not perfection; that would be too much to hope for, but of improvement so that man in his pilgrimage through life may be helped to live longer and to live more healthily than did his ancestors.

Drug Imports Into Canada Decrease

Ottawa.—Morphine imports into Canada increased from 4,883 ounces in 1935 to 5,256 ounces in 1936 but imports of opium decreased from 750 pounds in 1935 to 435 pounds last year and codeine from 35,669 ounces to 22,909 ounces, Health Minister Power told the House of Commons today in answer to a question from H. R. Fleming (Lib. Humbolt.).

Printer Asks Doctor to Bid on Operation

"It seems that a printer somewhere in Texas got slightly peeved at a letter from a doctor who wanted bids on several thousand letter-heads and statements, different sizes different grades of paper and printed in various colours, with the request that the forms be kept standing for possible reprint orders," ran a story in Forbes Magazine.

"So Mr. Printer diagnosed the case carefully and answered something in this manner. 'Am in the market for bids on one operation for appendicitis—one, two and five-inch incision, with and without nurse. If appendix is found to be sound, want quotations to include putting same back and cancelling order. If removed, successful bidder is expected to hold incision open for about sixty days, as I expect to be in the market for an operation for gallstones at that time and want to save the cost of cutting.'—*Annapolis Spectator*, Jan. 21.

Appendicitis in the Small Rural Hospital

L. R. MORSE, M. D. Lawrencetown, N. S.

THIS disease is the most common surgical condition met with by the surgeon and general practitioner. According to statistics the number of cases is rising yearly and the number of deaths increasing. Perhaps the diagnosis is more accurate at the present time but the fact remains that there is a steady rise in the mortality from appendicitis. In Massachusetts in 1900 there were 243 fatal cases, but in 1932 the number was 623. In U. S. A. there are 600,000 cases yearly with over 18,000 deaths. In Canada the conditions are much the same although no statistics are available to the writer. All classes and ages are liable to be seized by this serious disease. It occurs in the rural districts with as great regularity as in the cities; the problem is wide-spread and it may be interesting to inquire how the condition is handled in the rural hospitals which have increased the number and bed capacity in the last decade especially in Nova Scotia.

One hundred and twenty-five consecutive cases taken from the records of a small rural hospital, Soldiers Memorial, Middleton, N. S., (25 beds) will represent a cross section of appendicitis as it occurs in the different ages and classes of this area. Although this list is not large, representing a three-year period, it will be possible in a short time to present to your readers, a further and fuller list which will give about 500 cases.

An attempt has been made to give a clear view of the mortality and treatment as carried on in the small hospital.

Mortality Rates. The average death rate in the United States is 3% of all cases.

Chronic cases have a mortality of $\frac{1}{2}$ of 1% while the acute have 5% and the purulent 20%. Another list given by DeCourcy in Surgery, Gynaecology and Obstetrics gives the following mortality from appendicitis at the Good Samaritan Hospital, Cincinnati.

Acute	400 cases	.....	deaths 16	mortality	4%
Sub-acute	177 cases	.....	deaths 0	mortality	0%
Perforated	35 cases	.....	deaths 4	mortality	11.4%

Combining the acute and perforated cases this would give a mortality for acute cases of 4.59%; all types, 612 cases with 20 deaths—3.25%. In New York City, according to Kresch's analysis of 4542 cases in 14 hospitals, acute appendicitis has a mortality of 7%.

In our series, in a small rural hospital, 125 consecutive cases have a mortality of 2.4% in all cases acute and chronic. Acute cases including purulent and ruptured have a mortality of 2.6%.

Mortality

Our series all cases, 125 3 deaths 2.4% mortality.
 Acute and sub-acute 3 deaths 2.7% mortality.

Sex Incidence. In this series, there were 56 males and 69 females, which is not according to general surveys of the disease in which the percentage of males is greater than that of females. The mortality among males in this series is greater; the three deaths were all males.

Sex Incidence

All cases, males (all types) 56
 females 69

Age Incidence. Average of all patients, 23.0 years.

Decade	No. of Cases	Percentage
1st.	12	9.76
2nd	53	42.75
3rd	32	25.8
4th	12	9.76
5th	8	6.5
6th	6	4.85
7th	1	0.80

The usual age incidence in statistical reports is 70% of all cases occurring in the 2nd and 3rd decades. In this series 68.5% of the cases were in this period of life. The average age of all patients was 23.0 years.

Incision. The Battle Kammerer Incision with inward displacement of the right rectus muscle has been usually preferred and found satisfactory, especially with female patients in which an exploration of the pelvis is done. The McBurney incision has been used about 20 times and considered useful in cases in which there was no probability of adhesions and in male patients. It has been found a difficult incision to get a free exposure of the inflamed area, in acute cases. We found it easier to close than the straight right rectus incision.

Drainage. Nineteen cases in this series were drained. These were purulent and all had perforated. Cigarette drains were the only ones used. At present there is considerable debate on the question of drainage and the general opinion is that it is used too much. Some operators close up the abdominal wall in all cases. The safest course seems to be to drain purulent cases and localized abscess cavities. There is no doubt that many cases formerly drained do well with tight closure of the incision.

Post Operative Hernia. No cases of hernia post operatively has been reported in this series of 125 cases.

Average no. days in Hospital. The average stay in hospital for all cases was 13.2 days.

Complications. There were only three infections of the wound which had been closed without drainage. One case (case no. 2) developed an abscess in the abdominal wall which necessitated return to hospital for six days, two months after operation.

Case No. 18 had all the symptoms of intestinal obstruction. It was found at operation that the adherent appendix was tightly constricting the terminal end of the ileum which it encircled like a ligature.

Case No. 60 female aet. 20, developed acute mania a few days after operation. She was admitted to N. S. Hospital and made a good recovery after few months.

Case No. 58 aet. 32, male, had acute attack with perforation and drainage. After a stormy recovery he was discharged but re-admitted 19 days after with a secondary pelvic abscess which was evacuated per rectum. He made a good recovery.

Case No. 72, aet 54, female, was found to have a sub-acutely inflamed appendix in the sac of an inguinal hernia.

Case No. 65, female, aet. 54, with pain in right side and rigidity of abdominal wall was found at operation to have carcinoma of bladder. The right sided pain was apparently due to blocking of right ureter.

Faecal Fistula. Two faecal fistulae developed in this series, one (Male aet 56) closed spontaneously; the second (male aet 45) was closed by operation one year later and gave no further trouble.

Dilatation of Stomach occurred in one case (male aet 18) which was relieved by gastric lavage.

Post operative ileus was present in two cases, case No. 93, male aet 45, a purulent case which had perforation before admission was very much distended with pain and green vomitus for several days. He was unrelieved by enemata of ox-gall, etc., duodenal tube, until he developed a faecal fistula when symptoms subsided.

Treatment of the Stump. In the large majority of cases the stump of the appendix was ligated with chromic catgut and inverted but it is a question whether a purse string and inversion are necessary. A simple amputation and legation with cauterization by electric cautery or carbolic and alcohol or iodine seem safe enough.

Mistakes in Diagnosis. Yes, they have occurred occasionally; the case No. 93, a young woman aet. 35, suffering from severe abdominal pain, vomiting and constipation, had fever and tenderness in right side. Operation showed a dilated caecum due to malignant growth obstructing the splenic flexure of the colon,—caecostomy was done and later the growth was removed; she still has a faecal fistula but is well three years after.

Chronic Appendicitis. Chronic appendicitis which some writers say is non-existent, is often diagnosed in those difficult neurotic patients who complain of obscure abdominal pains, and have some indefinite resistance in right lower quadrant. They are often constipated and with coated tongues. Operation is advised, in a moment of weakness, and a fairly normal appendix is removed which on being sent to the pathologist may be reported as being normal or otherwise, but might just as well been left where the Creator intended it to be. Such cases with these bizarre symptoms are often classed as mucus colitis but are often neurasthenic.

The diagnosis of acute appendicitis is another story—under the heading "Diagnostic Wisdom", Bastianelli, the famous Italian surgeon says, "(a) when physicians are discussing whether the case is appendicitis or not; it is (b)

when they are inclined to admit the possibility of appendicitis, without being perfectly sure of it, it not only is but is about to perforate. (c) when the diagnosis is sure, there is already perforation with a more or less circumscribed peritonitis”.

This seems at first to be an exaggerated statement about the diagnosis of appendicitis but in children and young adults it states the case with a great deal of truth.

Treatment. It is impossible to distinguish between those cases which will run a benign course or those destined to run a grave course hence it is safer and better to operate immediately on making the diagnosis of appendicitis. A free incision, gentle handling of all tissues and a careful unhurried operator will have good results.

Post Operative Care. Post operative care is very important and *here* is where serious cases are lost. The small hospital has the advantage of having no internes and each case has the personal supervision of the operator and graduate nursing which is much superior to student nursing. An important point is the state of the patient's tongue, which should be watched in every patient. A dry tongue is a danger sign indicating fluids to be given orally or subcutaneously or intravenously to correct the dehydration and administration must be carried out promptly as occasion arises.

Distention is also a danger sign and must be relieved. Most cases are helped by various enemata particularly ox-gall, in conjunction with pituitrin or pitressin. Vomiting and distress are immediately relieved as soon as the peristaltic current is re-established. The duodenal tube is employed if these fail; it is used by leaving the catheter in situ for 24 hours, draining off fluids every hour and clamping during the intervals, or it may be used by continuous siphonage of Wangenstein. If these fail, ileostomy is suggested by some; this met the situation in a young boy aged 10, although he had a long serious time with a small bowel fistula which was eventually closed by operation.

Summary. An attempt has been made to present the appendicitis problem as it is met in the small rural hospital. The series is small but will be large enough to give some idea of the type of case and treatment as carried out in the country. The small local hospital has evidently come to stay and can successfully handle the appendicitis problem. There is an advantage to the patient here over the larger hospital in that every patient is a private case and enjoys personal supervision of the operator and is cared for by graduate nurses. The mortality of this series compares favorably with that of larger centres. In this series it is found to be for all cases 2.4% and in acute cases 2.6%, while in larger cities as New York it varies from 5 to 7%.

Sub-Acute Bacterial Endocarditis

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WE are all familiar with the different types of Endocarditis, but this type forms the most characteristic clinical picture of any of the Endocarditides. It is, as the title of this paper suggests, a sub-acute, low grade vegetative inflammation of the lining membrane of the heart, induced by organisms of low virulence. These organisms are more or less constantly discharged into the blood stream.

The symptoms and clinical picture are due to the low grade character of the infection, to embolic phenomena, and the cardiac damage.

In the great majority of cases the organism which is the causative factor in this disease, is a non-haemolytic streptococcus. These streptococci (different strains) are normal inhabitants of the mouth and intestinal tract of man, and many animals; and are often found in pure culture in apical dental abscesses. But while in most cases non-haemolytic streptococci are found, other bacteria, such as haemolytic streptococci, (e.g., streptococcus erysipelatis,) staphylococcus aureus and albus, gonococcus, meningococcus, phenumococcus, etc. are the etiologic agents.

The endocardial lesion in this disease is the important one; because here, the bacteria grow, and from here are distributed to all parts of the body.

It will not be necessary to go into a detailed description of the pathology of this disease. However one may say that the lesion consists of cauliflower-like growths, extending over the surface of the mitral valves, often down on the chorda tendineae and in fifty percent of cases up over the wall of the left auricle and maybe even more extensive.

Now these vegetations, (microscopically) appear to be made up of fibrin containing living bacteria. The process going on may be described as destructive and reparative; for there is often found cellular reaction with vascularisation, but this is relatively small compared with the loss of tissue, (ulceration). With the healing process there is a progressive destruction of tissue.

A knowledge of the pathology in this disease helps one to understand the process going on in the endocardium and valves of the heart. The clinical picture stands out very clearly. From this focus (the endocardium and valves) living bacteria, elaborate their toxins, discharge them into the blood stream and these toxins going to every part of the body poison every tissue. Also by the mechanical action of the valves opening and closing, portions of the vegetations become detached, setting free emboli, which, being carried in the blood stream, may cause an immediate disaster according to the size of the plug and the organ involved; or if we get an occlusion of terminal vessels the resulting infarcts are large. Most commonly these are found in the brain, spleen, lungs, and sometimes in the liver, intestine, and limbs. The case which I shall report shows these accidents in an unusual degree.

In most cases petechiae are common in the skin and mucous membranes, or we may find haemorrhages in the retina. When these small embolic lesions

occur in the joints, or in the sensitive pads at the ends of the fingers or toes, they are often extremely painful.

As a rule we do not get effusion into joint cavities, nor signs of inflammation, neither do the infarcts suppurate. This is explained in part by the low degree of virulence of the micro-organisms, and the high degree of immunity of the tissues in which the bacterial emboli lodge.

Small emboli in the walls of blood vessels, (chiefly arteries) or in the vasa vasorum may set up a focal arteritis resulting in aneurysm, which may rupture into important organs and bring about death in this way.

Another characteristic lesion is glomerular inflammation of the kidneys due to emboli lodging in some of the branches of the glomerular tufts; but it has been pointed out that, only a fraction of the total glomeruli are involved, and also only a portion of the capillaries of each glomerulus is implicated. Consequently, though there is extensive renal damage there is usually no serious disturbance of kidney function.

The case I now present was seen in the course of my practice.

Mr. C. aged 50, white, married, very obese.

Previous illnesses: Had never had any serious illness other than after attaining manhood contracted diphtheria. There is no history of rheumatic fever, tonsillitis, St. Vitus Dance, or any venereal disease. He had always been greatly over-weight, perhaps caused in a large part by over eating and lack of exercise. He had never been able from boyhood to indulge in sports requiring physical strain, and was easily fatigued. He had led a more or less sedentary life.

Present illness: He consulted me complaining of feeling tired and somewhat short of breath; he did not complain of pain in the limbs or joints.

Physical examination: Man of medium height, very much over-weight, somewhat pale, pulse rate 110 per minute at apex. There were no heart murmurs in any area though that organ was somewhat enlarged and there was a marked auricular fibrillation. His blood pressure was 155/80, urinalysis showed a slight trace of albumin, negative for sugar.

He was put to bed and a course of digitalis instituted. Five days later he was seized with a violent pain in his left leg and was unable to walk. When I saw him he was in a state of collapse, body bathed with cold perspiration and suffering exquisite agony from pain up and down his left limb. His pulse was 170.

Examination revealed no pulsation in popliteal artery, limb useless, devoid of sensation and very white and cold. A diagnosis of block from embolus at bifurcation of popliteal was made; morphia grain three-quarters was necessary to subdue pain and an attempt was made to digitalise the heart to control racing pulse. Next morning pulse was 140 and in a day or two came down to between 80 and 90. The limb was cleansed and wrapped in sterile dressings. A diagnosis of sub-acute bacterial endocarditis was considered and a specimen of blood under sterile conditions was collected and placed in sterile broth at the bedside and forwarded to laboratory. The report from laboratory gave a pure culture showing heavy growth of staphylococcus pyogenes albus.

After the first week he began to improve, his temperature became normal, pulse good, though irregular, appetite good, the limb became warm and show-

ed signs of improvement in circulation. He continued to improve for two weeks, so much so that, one began to suspect one's diagnosis was too gloomy, when suddenly he was again seized with stabbing pains, this time in his chest, catching his breath. He was in a state of collapse and bathed as before in cold perspiration, his pulse was 140, respirations from 40 to 50, temperature 104, his heart showed greater enlargement, due to dilatation and a distinct murmur was heard over area of mitral valve. (Previous to this there had been no murmur.) He had a stormy passage for a week or ten days, coughed up clots of blood, but the condition subsided and he felt quite well. Diagnosis pulmonary embolus.

This period of well being was suddenly cut short by another embolic accident. Once again he was stricken with violent pains in both limbs and in the abdomen, showing the same picture of collapse as on other occasions.

Examination revealed both limbs cold and white, no pulsation, and devoid of sensation, though in a few hours the circulation was restored in the right leg. Some hours later he developed an intestinal obstruction. Abdomen became distended. There were black vomit and hiccough. He passed neither flatus nor faeces. All food was withdrawn and appropriate treatment instituted. His obstruction cleared up within a week. His hiccoughs were most trying but this eventually subsided. These phenomena gave the picture of an embolic shower involving popliteals and mesenteric arteries.

His general condition again improved, he said he felt well, enjoyed his food, his pulse came down to safe limits, though there was now a more definite murmur and greater enlargement of the heart. His temperature at this time was very moderate and at times remained normal.

From now on he had increasing pain in his left leg, the last embolus had practically cut off the whole supply of blood from the limb and it was now in a state of gangrene, though aseptic.

The question of amputation arose. Against amputation was the past history. He had had several embolic accidents and he might have another embolus at any time, making amputation useless, on the other hand he was suffering extreme pain in the dying limb, it was possible, though improbable, he might not have another embolus, at least for some time; his condition now was fair, and he was extremely anxious to have the operation performed. For these reasons it was decided to remove the offending limb, which was done under spinal anaesthesia. He stood the operation well. However, on the following day a further embolus embarked in the circulation blocking the popliteal artery of the left leg. One's hopes were not realized and one seemed now to be in a worse position than before. He had to run the gamut not only of the effects of the operation, but this additional blow, with its attending shock, pain, and sepsis as well. His pulse climbed to 160, hiccoughs developed as before. For the first time he became irrational, due to cerebral involvement or toxæmia and from this time on there was increasing tachycardia, loud murmur in mitral area and increasing dilatation of the heart. His pulse for days at a time running between 140 to 160 per minute, he was now definitely on the down grade. There were further emboli into the stump of his right leg, which cut off the blood supply to the flaps, causing sloughing; pain in both limbs was very severe.

The right leg was now practically dead. Morphia was used generously to relieve his agony, his anaemia was progressive, red cells falling below three millions; the whites were between six and seven thousand. His blood pressure

which was 155/80 was gradually falling, until a few days before exitus, it was 90/80. There was still only a trace of albumin in the urine, the liver was somewhat enlarged, but the spleen was not palpable. From this time on he had longer and more frequent periods of irrationality, he was drowsy and at times only semiconscious, he had an occasional nystagmus.

While one was looking for the end he suddenly cleared up, his mind became clear, pulse dropped to 110, temperature around normal, his appetite returned and he relished his food. He remained in this state of well being for ten or eleven days and felt so well, he made plans for the coming winter. However, his optimism was short lived. His temperature rose again, pulse mounted to 185, he had cold sweats, vomiting, again became irrational, picking at the bed clothes, nystagmus appeared once more. He had difficulty in swallowing and complained of pains in his limbs. However, strangely enough, after four or five days, temperature once more became normal, pulse ninety-six, though his respirations continued over forty. Again he said he felt better, but this was only for a short time, his mind began to wander. For the first time he complained of numbness and pain in the finger tips, it was the only time petechiae were observed throughout the whole course of his illness. From now on he became more and more irrational, disorientated and stuporous, his pulse rose to 180 and remained so for a few days, when he finally died, his illness lasting three and a half months.

The usual story of a person with sub-acute bacterial endocarditis, is that sometime during his life he was told he had a heart murmur, though in this case there was no heart leak, there was an auricular fibrillation. There was no history of acute rheumatic fever, how he got his infection must remain unanswered.

To make a diagnosis of this disease in the absence of petechiae and tender nodes in the skin, is difficult; but a person with a heart murmur, presenting septic manifestations, such as continued chills and fever, should have a thorough investigation. In the case described this patient seemed surprisingly well and free from complaints, he had been at his work continually. True, he complained of being tired and somewhat short of breath, and four days after being put to bed he suffered his first embolus. As stated before, during the course of the disease the liver enlarged some, but the spleen was never palpable. He had some albumin in the urine, and renal complications in this disease are to be looked for; but one feels that, in the absence of severe albuminuria or haematuria, his mental state was due to his moribund condition, and not to kidney complications, such as uraemia.

One or two points in this man's infection seem to stand out prominently. The outstanding characteristics are; the embolic phenomena, the absence of petechiae, (one usually but not always finds them, as stated previously these were observed only shortly before death.) The massive size of the emboli, any one competent to cause the patient's death forthwith, and the great resistance of the patient to withstand so long the frequent embolic shocks with the accompanying severe toxæmia.

Another feature was the remarkable reserve and strength of the myocardium to withstand such sustained tachycardia, the pulse rate being around 180 for two weeks at a time. The explanation of course being that the heart muscle was not seriously involved in the vegetative process, though it must have been profoundly affected by the toxæmia. A further interesting fact observed in this case is the minimal amount of blood which is necessary under conditions

of rest and warmth to maintain the integrity of a limb. It is surprising for how long a time a part may be preserved and kept healthy when a large supply of blood is cut off. Another interesting feature of this disease, when extended for any length of time is the periods of well being enjoyed, the temperature becomes normal, pulse rate down and the appetite improves, giving the patient a false sense of security, he feels he is on the upgrade, but even though he has these periods of parole the course is progressively downward.

One did not mention treatment. There is only this to say, the treatment instituted was symptomatic, an attempt was made to build up the patient's reserve with tonics, easily digested and nutritious foods, fresh air and sunlight. There was no attempt to make use of vaccines, transfusions, or antiseptic solutions, as the consensus of opinion is against the use of these agents, being useless, expensive, and do not contribute to the comfort of the patient. (Recently a typical case with streptococcus viridans blood stream infection and multiple embolic phenomena has been reported as arrested and symptom free for almost a year following intravenous administration of an autogenous bacteriophage.)

When one recognizes that the vegetations are thick masses of material in which the bacteria are actually growing and that many of the bacterial agglomerations are situated at a considerable distance from any circulating blood, it is difficult to understand how any therapeutic agent introduced into the blood stream can have very much, if any, bactericidal action throughout the entire course of the vegetation.

Infusions of saline were given with the idea of diluting the toxins in the blood, but no good effect was observed.

Effects of Some Drugs on Gastric and Intestinal Motility

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THE drugs discussed in this paper comprise morphine, codeine, papaverine, some barbiturates, posterior pituitary extract and histamine. Most of the results apply to laboratory animals such as cat, dog and rabbit. Before discussing the effects of drugs on the intestine one should consider some of the factors influencing movements of the alimentary canal. There are, for instance, differences in the origin of certain movements, some being myogenic, such as the segmental contractions of the circular coat; other neurogenic, such as peristalsis; the intrinsic nerve supply of which Auerbach's plexus is of chief importance and is sufficient for the carrying out and co-ordinating of gastric and intestinal movements for no disturbances are noticeable in animals in which the extrinsic nerve supply, the vagus and sympathetic nerves have been cut; such factors as pressure on the intestinal mucosa, the reaction of the stomach and intestinal contents, presence or absence of food; the water and salt content of blood and tissues. All contribute to modify intestinal motility. To cite two instances: saline cathartics are ineffective in animals deprived of water for any length of time; loss of plasma chlorides lead to atony, which is promptly removed on injecting hypertonic sodium chloride solutions.

It must be remembered that the interpretation of laboratory results on animals often differs from clinical results, probably because laboratory experiments are largely objective, while clinical interpretations are often based on symptoms and tend to be subjective. A good illustration of this is offered by morphine. Whenever morphine is given to a patient constipation results. The clinical interpretation of its effects on the intestine is that it relaxes the stomach and intestinal musculature. Actually the opposite is the case, as several experimenters have found. Experimentally, too, morphine causes constipation. Briefly, one may summarize the effects of morphine as follows: in the stomach there is a tonic contraction of the pyloric sphincter as well as a tonic contraction of the circular coat of the pylorus. This often leads to obliteration of the pyloric canal. The result is that food taken into the stomach instead of passing through the pylorus into the duodenum in three to five hours stays in the stomach from twelve to twenty-four hours. Gastric digestion proceeds further than usual. Small amounts of food enter the duodenum at longer intervals than normal. Intestinal absorption is more complete than usual, but actually the rate of passage of food down the intestine is accelerated until it reaches the ileocolic sphincter, where the delay in entering the large intestine is increased many times above the usual one hour, owing to a tonic contraction of the ileocolic sphincter. Actually intestinal movements under morphine are stronger, and if anything, more frequent. The real cause of constipation lies in the large intestine and may be described as follows: the

water content of the food is less, owing to more complete absorption in the small intestine. Antiperistalsis in the proximal colon is increased. There is a tonic contraction of the circular coat combined with an increasing tonus of the internal anal sphincter. Finally the depressant effect of morphine on the nervous system leads to a depression of the defaecation reflex. Codeine has effects similar to those of morphine but is only one-eighth as active.

Papaverine on the other hand relaxes all the muscles of the stomach and intestines, but does not give rise to constipation. It lowers tone but does not interfere with movements. It does not seem to be used for this relaxing effect in tonically contracted conditions of pylorus and intestines.

Hypnotics such as chloral hydrate and chloretone relax smooth muscle; but barbiturates, of which amytal, phenobarbitone and evipan may be cited have not this depressant action. It has been found that with a slow rate of injection, of big doses, or small doses given rapidly, the stomach and intestines actually contract. Big doses given rapidly can produce depression of movements in the alimentary canal, but this depression is of short duration. What is of interest, is that the reaction of the stomach and intestines to drugs remains unaltered except possibly in the case of pilocarpin and eserine and possibly adrenaline. Immediately after administration of amytal in big doses, vagal effects can be weakened or may be absent. The claim that amytal can reverse the inhibitory effects of sympathetic nerve stimulation on the stomach has not been satisfactorily proved. The depressant effects of barbiturates cannot be so severe for it does not seem to be observed clinically, where thousands of cases receive some barbiturate as a basal narcotic.

Histamine and pituitary extract are drugs which stimulate involuntary muscle throughout the body, but it must be borne in mind that their actions differ in some respects. For instance, pituitary extract exerts its most powerful action on the pregnant uterus, the non-pregnant uterus is less sensitive, but even this organ will be stimulated by concentrations of pituitary extract which have no action on the intestine. Analysis of the action of pituitary extract on the stomach and intestine is of some interest. Usually the statement is made that it stimulates involuntary muscle. Some authorities even claim that its action on different parts of the small intestine varies, being weakest on the duodenum, and strongest on the lower ileum. Experimental findings on dogs and cats give a different picture. This may be stated as follows: the body of the stomach relaxes, the pylorus contracts, giving rise to increased tone, and bigger movements. Throughout the small intestine pituitary extract in small doses causes a relaxation of the muscle with a decreased amplitude of movement; big doses cause a fall in tone and abolition of movements for a period of several minutes. Following this there is a recovery phase, during which the movements and tone not only return to normal, but exceed the pre-injection level. These improved contractions usually last from ten to fifteen minutes. In the large intestine pituitary extract produces a pure stimulation not preceded by any relaxation. Animal experiments point to a stimulant action of pituitary extract on the pylorus and large intestine and a relaxation followed by a recovery in the small intestine. It seems of doubtful value when used in atonic states of the small intestine.

The tolerance of the intestine to the pituitary extract on repeated injections is of longer duration than that of the uterus.

Histamine actually is a better stimulant of intestinal movements than pituitary extract. It causes contraction of all parts of the stomach wall,

particularly the pylorus; it stimulates the small and large intestines producing both improved tone and improved contractions.

It should be remembered that morphine and histamine if given immediately after atropine will not produce stimulation; but half an hour or more after the injection of atropine, histamine and morphine will stimulate. This may seem to add confusion to the action of these two drugs. Actually it can be claimed that a closer study of the different factors influencing intestinal motility will lead to more rational use of drugs.

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

VOL. XVI.

FEBRUARY, 1937

No. 2

On the Writing of Case Histories.

RECENTLY the writer attended a Medical Society meeting at which a history was presented in which it was stated the patient had complained of three things, two of which were diabetes and nephritis. The type of history taking that listed a disease under the heading of complaint was questioned. The opinion expressed was that a complaint is the thing that directs a patient to the physician's consulting room. It must of necessity be some form of distress which may vary from vague discomfort to definite pain; some inconvenience such as having to get up frequently during the night to urinate, an observation such as the discovery of blood in the stool, or that the vision is failing.

A few years ago a patient came to me complaining of a lesion. One enquired "What is a lesion?" Needless to say it was nothing more or less than unusual sound she had overheard and which she had imitated. It was suggested that words be used that both could understand with the result that she said she experienced "difficulty in swallowing". Very recently to the question "What do you complain of" the reply was "brain tumour". When one said "Whisht woman, what do you know about brain tumours; tell me what discomfort you have or what have you noticed or whatever made you think of a doctor rather than a grocer, tinsmith or tailor, the answer to my original and fundamental question was forth coming, "terrible headaches which made me sick at my stomach." An astigmatic error was corrected and relief followed.

My point is that to place under the heading complaint such sounds as diabetes, nephritis, appendicitis, goiter, cancer, hydronephrosis, pain in the stomach, sinus disease, or cataract is wrong, because such are not complaints but highly questionable opinions, and from a diagnostic standpoint worse than useless because they may actually make the physician believe he is making progress towards a diagnosis. A patient may have discovered a lump in her breast and that is what she complains of—a lump, nothing more nor

less—she may fear cancer but that is quite different from complaining of cancer. Fear is an emotion and may in itself be a complaint, but cancer is a structural change in a tissue, of which the patient knows nothing and consequently is in no position to express an opinion.

Having elicited in the patient's own words just exactly for what relief is being sought, be it headache or backache, stuffy nose, running ear, deafness, poor sight, shortness of breath, lumps, constipation, pain in the belly, cold feet, hoarseness, dizziness, spitting blood, or whatnot, the next question should relate to the duration of the complaint; has this worrisome thing existed for a day, week or month. Then must be considered the nature of the onset, did it develop suddenly like an acute glaucoma or strangulated gut or gradually like many digestive disturbances or the headaches associated with defective elimination, anaemia, or chronic accessory nasal sinus disease.

The all important preliminaries having now been recorded the clinical history may now be enquired into, although it may be said that physicians place varying estimates on the value of the patient's story. Sir Jonathan Hutchison would hastily thrust a thermometer into the mouth of any lady who attempted to tell him about her illness. This is the place to note that treatment had been received for diabetes and that nephritis had once been suspected by the medical attendant, and to enquire as to syphilis, accidents and babies. At this point it is quite in order to ask if the patient has anything to offer in explanation of the complaint. The reply may be suggestive. In cases of gastric trouble Mr. Sherren has remarked that when the dresser, the house surgeon and the first assistant obtained similar histories the disease was organic, but if these differed the disease was probably functional and conveyed a warning to the operator not to be too hasty with his treatment.

The art of conversation having yielded and secured its quota, the examiner may now pass to the physical examination and record what his eye, ear, and fingers have to add. With all this accumulated information laid out the argument now follows. What may it be, why this is considered and that discarded and then the conclusion that is the diagnosis.

If still in doubt and further evidence deemed desirable, the bacteriologist, pathologist, or roentgenologist may be asked to lend a hand. Remember, however, that clinical evidence comes first. And in saying this one does not minimize the value of the laboratory aids to diagnosis but would emphasize the word aid nevertheless. In a word a pathologist will hesitate to express an opinion unaided by a brief resume of the clinical investigation. The laboratory findings usually sparkle best when they reflect the light shed by the clinical history and examination.

If the matter must needs be followed to the bitter end the post mortem examination yields the absolute.

One believes it to be very interesting to conclude with illuminating comments. These may direct particular attention to special features of the case under consideration, their frequency and significance and any worth while observations that may have been made by others on identical or similar cases.

H. W. S.

Our Profession

“RENDER therefore to all their dues, tribute to whom tribute is due, custom to whom custom, fear to whom fear, honor to whom honor.”

It is proper, fitting and valuable too, that one should pause occasionally and step aside from the daily grind and demands of this complex life one lives and from the side lines, as it were, get a somewhat clearer picture of the part one plays in his business and professional life.

For many of us life began in 1914, not that we first saw the light of day in that year, but the events occurring in and arising out of the great war, have so revolutionised our ideas, ideals and modes of thought, that we have lost the ability to some extent at least, to appraise and appreciate real worth. The post war years were feverish with activities of repair, reconstruction and rehabilitation. Industry strove to recover its losses, recapture and extend its trade. Individuals, no less intent, sought diligently those things we can see and handle, until the crash of 1929 brought us all once again face to face with start grim tragedy and reality.

Who can estimate the privation and suffering in the years since the great collapse and the crises through which we have passed and verily the dangers that yet beset us? The physical suffering has been and is appalling; while the mental anguish and humiliation have been no less real. Our own profession has not escaped, many sharing the want and fear that gripped the souls of men.

Throughout these years of human suffering, pain and need, great alleviating and constructive forces have been operating. While not denying the contribution of others, our profession, as has ever been true since the dawn of medicine, has been faithful to its traditions; standing in the gap, pouring in the oil and the wine, whenever and wherever there have been pain or human need. The contribution of the family Doctor in these years of emergency can scarcely be measured. It is with feeling of sadness and poignant loss, we witness the passing of the old family Doctor. These truly great men of our profession, often unheralded and unsung, one by one lay down their tasks. Time is a grim reaper and will not be denied; and where time does not operate the accidents and vicissitudes of life remove our friends and classmates from us. We keep their memory green.

Mourning for those who have passed on, we are happy in the thought we have left in our ranks a goodly number of the older men who, having done a good days work, are still making their contribution to the profession they serve so well. Recently it was the writer's privilege to be present at a banquet in honor of two distinguished gentlemen of our calling on the occasion of their completing 50 years in active practise. It was an inspiration to witness the genuine affection and respect with which these men were regarded. Not because of their achievements, though they rank high in the profession, but for their innate goodness; their service to humanity, and their brotherliness towards their fellow practitioners.

In these days of regimentation, unrest, and maladjustment, we hear clamorous voices shouting for state medicine. The practise of medicine can never be successfully allotted as is a dependency of some petty ruler.

Pain, fear and the great emotions that fill the human heart cannot be fitted to a state system; no more can the response to that need be prompted

by the *must* of a civil servant; but only from the compulsion that comes from within, that legacy from our profession to which we are all heirs.

There are men in our profession everywhere, young and old going about quietly doing the daily work, often unappreciated, unrecognised, unrewarded. Only a few may receive special recognition, the reward of others will be the knowledge of work well done.

O. R. S.

THE response from the Valley Branch was excellent and you will note the overflow constitutes a large part of the present issue. It was intended to publish the Cape Breton Society number in February, but your Editors hope that March will see sufficient material on hand. With probably more varied clinical material than any other part of this fair Province, the Society expects great things from a Branch with so able and experienced a membership. May the Editors remind all other Branches of the inevitable and to prepare themselves against that day.

NOTES FROM THE DALHOUSIE MEDICAL LIBRARY.

Osler once said in his typical epigrammatic fashion that "to study the phenomena of disease without books is to sail an uncharted sea." Historically it is interesting that the nucleus for our present library was the collection of books which belonged to the late Dr. C. Cogswell. The clause of bequest in the will, dated 13th. May, 1890, reads as follows:

"To the Medical Society of Nova Scotia twenty-five pounds towards the expense of preparing and printing a catalogue of the Library then attached to the Halifax Medical College, and if the said catalogue shall have been completed and printed to the satisfaction of, and a copy thereof presented to my trustee or trustees within a year from my decease then I give to the said Medical Society the further sum of one thousand pounds to be invested by them in British or Colonial Government inscribed stock or securities and I declare the interest dividends and annual income thereof shall be applied at their absolute discretion partly towards the salary of a Librarian to the said Society and partly to such other purposes for the benefit of the said Library as the said Society shall see fit, and the receipt of the Treasurer of the said Society shall be a sufficient discharge to my trustee or trustees for the said legacies of twenty-five pounds and one thousand pounds—and I strongly recommend that it be made a rule that no book shall be allowed to be taken out of the library without the special written permission of the Trustees of the said Medical Society or other persons connected with the management of the said Library."

A room was first provided for the library in the Halifax Visiting Dispensary on Brunswick Street. It was removed to the Halifax Medical College in the year 1896. The catalogue was prepared by J. Ross Millar in 1902. The library reached its present location in the Forrest Building of Dalhousie University in 1916. The custody and administration of the library provided some difficulties which were only settled in 1915 through a friendly court action seeking to interpret the intent of the Will. On the 11th. August, 1915, Mr. Justice Ritchie rendered his decision after Dr. A. Stanley Mackenzie, then President of Dalhousie University, had temporarily become lawyer for the defense. This judgment stated in effect that, (1) the Governors of the

University were owners of the Library. (2) the Medical Society of Nova Scotia was the trustee of the Cogswell bequest (£1000) and was authorized to expend income toward the upkeep of the library. (3) the Library was to be open freely to all duly registered medical practitioners of the province of Nova Scotia who might use the Library as well as the students of the College.

Since the date of 1915 the character of the library has changed very greatly indeed. The original collection of books has lost its identity and become antiquated. The University has been contributing appropriations ten to twenty times the annual income from the Cogswell Bequest toward the maintenance of the library. Large capital expenditures have been made in the past to purchase back files of important journals. There is now a reference library of 17,000 volumes, more than half of which consists of volumes of medical journals. The list of current subscriptions numbers more than one hundred.

This library however is still open to the members of the profession in the province. The conditions governing the loan of books and journals might conveniently be repeated here.

(1) Any book in the general section may be borrowed for a period of two weeks, conditional on the payment of postage by the borrower if resident outside of Halifax.

(2) Any book in the special section (new books) may be borrowed for a period of two days by practitioners resident in Halifax. This regulation applies only during the college term, Sept. 9th. to May 12th. Otherwise these books come under section 1.

(3) All numbers of volumes of journals, excepting the current number, may be borrowed for a period of one week under the conditions of section 1.

The library has been mailing books and journals to all parts of the province for several years and it is hoped to continue this service. Whenever new accessions to the library warrant it an occasional note will be published in these columns calling attention to new books or editions.

WOMEN'S HOSPITAL

United Church of Canada Mission

Neemuch, Central India,
16. 12. 36.

Dear Doctor Grant:—

I want to thank the Medical Society of Nova Scotia through you for your Honorary Membership card of June 30th, and for the Nova Scotia Medical Bulletin. I have found the Medical Bulletin very interesting and helpful, and am grateful to you for your kind thought in sending it. Our U. C. C. has five Women's Hospitals in Central India. Our largest hospital is at Indore. This is one of the smaller ones and has forty beds. We have a daily out-door clinic and two small village dispensaries in connection with it. I have an Indian Medical assistant and one pharmacist, and one graduate Indian nurse.

At present our finances do not allow of a whole graduate nursing staff, so I take one class of undergraduates in nursing and pharmacy, and the teaching occupies quite a bit of my time. I have had no Canadian Nursing Superintendent for two and a half years, as there are not sufficient on our Mission staff to supply our smaller centres. We try to pass on to our patients the Good News of Salvation through Christ, as well as to care for their physical needs. Usually they are eager to hear the Gospel message and in part of our field there have been a number of baptisms. Our work is general, both in surgery and medicine, and we have quite a large percentage of abnormal maternity cases to deal with. Last year it was 40%. As yet most of the normal cases prefer treatment at home.

Thanking you again and wishing you all a Happy New Year,

Yours sincerely,

(Sgd). MINA MACKENZIE.

WOMEN'S HOSPITAL
 Baptist Church of Canada Mission

16. 12. 38

CASE REPORTS

Nasopharyngeal Fibroma

Patient V. P. male, age 15.

This boy consulted me on June 20th, 1936, for difficulty in breathing and an obstruction in his throat.

On examination, a large smooth mass was visible, protruding from above downward, behind the soft palate. Both nostrils were occluded, polypoid looking material being especially evident in the right nostril. Clinically, the condition was that of a large post-nasopharyngeal fibroma.

This growth was of more than two years duration, he having previously been treated at a hospital, where a diagnosis of fibroma had been made, histologically. An operation had been performed, in which part of the tumor had been removed. But complete removal was abandoned, on account of the vascularity accompanying these conditions. Some time later he had had quite a large hemorrhage from the mouth, and the possibility of metastases in the lungs was considered, and a course of deep x-ray therapy given.

As the boy was in a very bad condition, both from partial suffocation and advanced secondary anemia, we thought it advisable to provide any measure of relief that was possible.

His blood picture was that of severe secondary anemia. Hemoglobin count being forty percent and red blood cell count three million. X-ray plates of the chest failed to disclose any infiltration of the lungs.

As this growth does not form metastases, is histologically simple, but clinically malignant, an attempted removal was decided upon; after preliminary building up, including a blood transfusion. Intratracheal anaesthesia was given, and the patient placed in the Trendelenburg position. Both nostrils were well packed, the fibroma was seized with heavy forceps, passed by the mouth and removed with a twisting pull, according to the method used by Sir St. Clair Thomson. A violent copious hemorrhage resulted, which was controlled by a heavy nasopharyngeal packing, held in position by the fingers. A post-nasal plug was then inserted and tied in situ. A large saline infusion was given intravenously and the patient made a good recovery.

Two weeks later the right antrum was opened, explored and found clear. A remaining stump of the fibroma was removed, from the right middle turbinate, and a spongy well defined mass was discovered in the right side of the soft palate, pushing the right tonsil into the throat, which we were temporarily unable to explain. The tonsil was removed and the mass was found to be external to the fossa and not involving the tonsil.

It was decided that as his breathing was now free, a period should be taken to build up his general condition, and this mass be attended to, at a later date.

On December 4th, 1936, the patient had gained thirty pounds. His blood picture was practically normal, but the lump in the soft palate had increased in size materially.

A third operation was done under tracheal anaesthesia and in the Trendelenburg position. An incision was made in the soft palate and a large firm lump, the size of a small egg, was encountered and dissected back. It ex-

tended by means of a pedicle upward and backward for some three inches through the soft tissue to the right posterior maxillary area. It was apparently another off-shoot of the fibroma, which was growing down from the right lateral nasopharynx, beneath the musous membrane. It was seized with stout forceps and twisted off, in much the same manner as the former. A severe hemorrhage resulted, which was controlled by packing and post-nasal plugs. He made a good recovery, and at examination on December 31st, showed a free airway, and no evidence of growth.

These are rare, but interesting and serious cases. Splendid results are obtained today, by treatment with radium, which if available, is much the method of choice, on account of the severe hemorrhage encountered, with surgical removal.

J. P. McGRATH,
Kentville, N. S.

Wilm's Tumor of the Kidney—A Case Report.

Female baby, five months old. Complaints—Abdominal enlargement. Patient had a normal and easy birth and appeared to be perfectly normal and healthy in every way. Since birth a normal gain in weight. At no time has it appeared that the baby was in pain. About three weeks previous to hospital admission, mother noted that the abdomen was becoming larger. This rapidly became more noticeable and she took the baby to her doctor (Dr. Chute). A large right-sided abdominal mass was discovered and the baby sent to hospital. There was no history of haematuria.

Examination:

Baby rather pale but of good nutrition and development. The abdomen is definitely enlarged especially on the right. A smooth round mass, the size of a large grapefruit can be felt filling the whole of the right side of the abdomen, the right flank and the right loin. No nodules felt. The mass is fixed and moves very little with respiration. It appears to be definitely retroperitoneal.

Remainder of physical examination showed nothing abnormal. There was a moderate anaemia. Urine neg.—No albumin or R. B. C. Pylograms were not taken. A diagnosis of right renal tumor was made.

Operation: Oct. 28/36. Right nephrectomy.

A long right rectus incision was made. A large retroperitoneal tumor presented. The caecum and ascending colon were displaced well over to the left side of the abdomen. The left side of the abdomen was palpated to determine the presence or absence of a left kidney. The left kidney felt normal in every way. The peritoneum was incised over the tumor and lateral to the ascending colon. The caecum and ascending colon were displaced medially and the peritoneum peeled from the tumor. The tumor was well encapsulated and it was easy to shell it out. In no place had the tumor infiltrated and there was no evidence of extension along the pedicle. The pedicle was easily freed and clamped and cut. A mass ligature was tied around the vascular pedicle. The ureter was freed, tied and divided with the cautery. The peritoneum was repaired over the tumor bed and the wound closed in layers.

Gross appearance of tumor:

Size of a large grapefruit and smooth. Capsule peels easily like an ordinary kidney capsule. Part of surface brownish while other parts are a whitish gray. Surface covered with small spider like vessels. Cuts easily and very soft. The cut surface bulges from its capsule. Most of tumor white and laminated like fish flesh. There are a few islets of brownish tissue appearing like kidney. Calacies and pelvis filled with a thick grayish, almost calcified material.

Pathological Report:

The gross and histological appearances here are those of a typical nephroblastoma (Blastocytoma, Embryonal adenomyosarcoma, or Wilm's tumor.) Although the adenomatous character predominates, some abortive glomerular formation, sarcomatous areas and very scanty areas of muscle fibers are seen.

Only a small portion of normal kidney tissue is left.

The baby left the hospital in two weeks after an uneventful recovery. Examined recently by one of us (Dr. Chute) there was no evidence of recurrence or metastasis. The child appears healthy in every way.

F. CHUTE, Canning.

V. D. SCHAFFNER, Kentville.

An Interesting Experience with Methylene Blue

On entering the hospital Thursday morning, January 7th, 1937, one of my confreres was at the phone. He handed the receiver to me saying, "Here, Benvie, take this call!" It was long distance from Pleasant Valley and the message was with difficulty understood.

However, we could hear enough to know that a man had been overcome by fumes from his car in a closed garage—CO poisoning.

About four years ago, I read an article which stated that experiments had shown that methylene blue given intravenously would break up the combination of carbonmonoxide with the haemaglobin and was effectual even in late cases. I showed the article to the hospital superintendent, Miss Boa, who, realizing how important this might be in a coal mining district, not without its explosions, promptly ordered a supply, but up to that time it had remained uncalled for and unused.

In a few minutes I was "en route" equipped with an intravenous set ready for use. A flask of distilled water (not "fire water") and two 50 cc. ampoules of 1% methylene blue.

I arrived at my destination about 10.15 a. m. and found my patient lying on a sofa in the kitchen, with the door open. The day was bitterly cold. He was unconscious and could not be roused. His pulse was full, regular, beating 78 per minute. His respirations were very shallow. His lips were "cherry red".

About nine o'clock he had gone to the garage to start his car. His wife, working about the house, noted that he had been successful but wondered why he was remaining so long inside. Finally she investigated. On opening the "side-door" she was met by a cloud of acrid smoke and she saw her husband lying still on the floor. She immediately seized him by the feet and dragged

him into the open. This caused him to vomit. She then rushed to the house and gathered an armful of bedding and covered him; then she telephoned a neighbor, who drove over and the patient was carried into the house and the doctor called.

I immediately placed the flask of sterile water and the ampoule of 1% methylene blue in a basin of hot water. While the neighbour bared the patient's arm I unpacked the intravenous set. In ten minutes, we had the intravenous going. At 10.15 the patient opened his eyes but did not respond to questions. However, I left at 11.15 leaving word to have him removed to the hospital as soon as possible. On admission, about 2.30 p. m. he was quite normal excepting for a feeling of weariness and a severe headache. His first consciousness was at 12.15 p. m. when he recognized his young son on his return from school.

He had no further symptoms and left for home the following morning. There was a slight blueness of his mucous membranes and, of course, his urine was loaded with methylene blue.

R. M. BENVIE, Stellarton.

Abstracts from Current Journals

MEDICINE

Religion in Medicine.—J. M. T. Finney, *New England Journal of Medicine*, January, 1937.

AN unusual article in a medical journal is an address, printed in full in the above number, by Emeritus Professor of Surgery J. M. T. Finney, Johns Hopkins University. It was delivered recently in Boston at a special service for physicians and medical students. He discusses, very consciously of his own shortcomings, the advantages that may come to busy practitioners from taking religion and what it means into their everyday professional lives. He says it is a "plain heart to heart talk with you, my fellow practitioners, as an older brother to his younger brothers and sisters about the things of the spirit and about developing and that right early, a philosophy of life, a plan that you can follow, a chart and compass by which you can steer when the clouds lower and the storms begin to gather".

There is a prevailing impression that doctors as a class are irreligious. But this indifference on the part of medical men and scientists is not universal by any means. Many living and dead were active earnest members of the church. To mention a few, Lord Kelvin, Agassiz, Sydenham, Rush, Pasteur, Weir Mitchell, William Osler, etc. Destructive forces are abroad in the world today. Thinking men are gravely concerned and the burden of their cry is "Back to Religion". He urges the pulpit, pew and home alike—unite in honest confession "that we have done those things we ought not to have done, and have left undone those things we ought to have done"—and then determine to do better in the future.

This eminent surgeon concludes his address as follows: "Fellow medical men, young and old, physicians, surgeons and medical students, co-members of a guild that prides itself, and rightly so, upon its high ideals of service to sick and suffering humanity, a profession sworn to give of its best, even life itself, in caring for the physical and mental ailments of its fellow men, I challenge you to an even higher service—But may I remind you that in order to be able to do this, in addition to keeping up with your strictly professional studies, you must like Saint Luke, study the life and teachings of the Great Physician, learn of him and pattern your lives after His. Thus and thus only will you be able to experience the fullness of joy that comes with perfect service to God and man."

Gentian Violet Treatment of Leg Ulcers.—*N. E. Journal of Medicine*, January 1937.

An interesting report of 15 patients with chronic leg ulcers whose lesions had ranged from one to twenty years is presented in above Journal. The whole gamut of therapy had been applied, which in some cases comprised ultra violet radiation, rest in bed, Unna's paste, intravenous sclerosing solutions,

pressure bandages, various local applications as scarlet red, ichthyol, etc. All of the cases reported had a comparatively rapid and successful response to gential violet 2% solution. A definite sequence of characteristic results was observed. Pain and irritation subsided after the third or fourth application, usually disappearing after two or three days. The exudate from the ulcer was also controlled in short time. Once a firm dry adherent crust had formed no reinfection occurred, as the gential violet was a protective covering. Complete healing of all fifteen cases took place within three weeks to seven months. The resulting scars were thin and flexible and in some cases difficult to distinguish from the surrounding skin.

Unsuccessful results were seen in oedematous ulcers as the serous exudate washes away the stain.

During the entire period of treatment each patient was up and about.

L. R. MORSE.

“Stone walls do not a prison make Nor iron bars a cage.”

Winter is a jailer who shuts us all in from the fullest vitamin D value of sunlight. The baby becomes virtually a prisoner, in several senses: First of all, meteorologic observations prove that winter sunshine in most sections of the country averages 10 to 50 per cent less than summer sunshine. Secondly the quality of the available sunshine is inferior due to the shorter distance of the sun from the earth altering the angle of the sun's rays. Again, the hour of the day has an important bearing: At 8.30 A. M. there is an average loss of over 31%, and at 3.30 P. M., over 21%.

Furthermore, at this season, the mother is likely to bundle her baby to keep it warm, shutting out the sun from Baby's skin; and in turning the carriage away from the wind, she may also turn the child's face away from the sun.

Moreover, as Dr. Alfred F. Hess has pointed out, “it has never been determined whether the skin of individuals varies in its content of ergosterol” (synthesized by the sun's rays into vitamin D) “or, again, whether this factor is equally distributed throughout the surface of the body.”

While neither Mead's Oleum Percomorphum nor Mead's Cod Liver Oil Fortified With Percomorph Liver Oil constitutes a substitute for sunshine, they do offer an effective, controllable supplement especially important because the only natural foodstuff that contains appreciable quantities of vitamin D is egg-yolk. Unlike winter sunshine, the vitamin D value of Mead's antiricketic products does not vary from day to day or from hour to hour.

Workmen's Compensation Act

For the benefit of our members we are publishing below the statement presented to the Royal Commission to inquire into the administration of the Workmen's Compensation Act by Dr. H. K. MacDonald and his committee on January 7th of this year.

“To the Chairman and Members of the Royal Commission to inquire into the administration of the Workmen's Compensation Act in Nova Scotia.

Gentlemen:—

We, the Committee on the Workmen's Compensation Board affairs of the Medical Society of Nova Scotia, beg to present the following statement.

1. Primarily, we are here to ask for a revision of the Act so far as the thirty-day period is concerned. In this Nova Scotia is unique in that every other Province in Canada has no such limitation. Ever since the Act has been in force this feature has been unsatisfactory to the medical profession in Nova Scotia, and generally misunderstood by the workman. We have repeatedly, through Committees of the Medical Society of Nova Scotia, brought our dissatisfaction in this regard to the attention of the Workmen's Compensation Board and have always been met by the contention of the Board that they were bound by the Statute, and that we should devote our efforts to having it amended. As this is the first occasion on which the administration of this Act has been the subject of independent inquiry, we wish to take this opportunity of pressing for the elimination of the clause relating to the thirty-day period of medical aid. We would call to your attention the unfairness of this clause, both to the workman and the medical attendant. It is true there has been an amendment recently to the effect that this thirty-day period for medical aid may commence within thirty days of the accident, instead of the date of the accident as formerly; but, nevertheless, the period that medical aid is furnished by the Board remains rigidly the same.

2. We would respectfully draw to your attention that the medical fees paid by the Workmen's Compensation Board of Nova Scotia are, in general, considerably lower than the fees paid by the Board of any other Province in Canada. Furthermore, we find that the average amount paid per case for medical aid in Nova Scotia for the year 1935 is \$15.30, the lowest figure of its kind in any Province of Canada.

Herewith, we submit two tables:

- (a) Comparative schedule of fees paid in seven provinces in Canada in 1935. (We were unable to secure the schedule of fees from British Columbia in time for this report.)
- (b) Comparative statement of the average cost per case of medical aid in the various provinces of Canada.

We feel that these facts will be given due and fair consideration by this Commission in their contemplation of the matter of medical aid. We wish to make it clear that the Medical Society of Nova Scotia is not here to defend or

condone fraudulent practices on the part of anyone. We deem it to be the proper function of the Workmen's Compensation Board to detect and prosecute fraud which may be practised by any of the parties with whom they deal—employers, employees, or doctors.

In conclusion, we wish to acknowledge that in our relations as a Medical Society with the Board we have always met with courtesy and an evident desire on their part to give fair consideration to such complaints as we have had to make from time to time. We wish to repeat, however, that this fair consideration has been continually hampered by the so-called rigidity of the Act, and we take this opportunity of making a request on behalf of the Medical Society of Nova Scotia for remedial action on the points enumerated, and also for the provision of more discretionary power to the Workmen's Compensation Board in its administration of the Act.

(Sgd.) H. K. MACDONALD, M. D.,

Acting Chairman of the Workmen's Compensation Board Committee of the Medical Society of Nova Scotia."

"Halifax, N. S.,
7th January, 1937."

(b) Average Cost for Medical Aid in Eight Provinces of Canada

Province	Number of Accidents Reported	Amount Paid for Medical Aid	Average Amount paid per Accident
Nova Scotia, 1935.....	9,225	\$ 141,156.05	\$15.30
New Brunswick, 1934.....	7,858	195,826.94	24.92
Quebec, 1935.....	39,007	619,222.21	15.87
Ontario, 1935.....	58,546	1,172,287.91	20.02
Manitoba, 1935.....	9,907	188,054.31	18.98
Saskatchewan, 1935.....	3,424	70,669.97	20.64
Alberta, 1935.....	11,058	205,891.70	18.62
British Columbia, 1935.....	26,280	475,491.93	18.09
Total.....	165,305	\$3,068,601.02	\$18.56

(a)

SCHEDULE OF FEES

	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta
AMPUTATIONS							
Finger or toe.....	\$10.00	\$10.00	\$ 15.00 (\$5 each add)	\$ 15.00	\$ 15.00	\$ 15.00 (\$5 each add)	\$ 15.00
Arm, forearm or wrist.....	30.00	40.00	50.00	50.00	50.00	50.00	50.00
Disarticulation of hip.....	80.00	90.00	100.00	100.00	100.00	100.00	100.00
FRACTURES							
Finger or toe one or two.....	10.00	10.00-1 (\$5 each add.)	8.00-1 (\$15 more than one)	10.00-1 (\$15 more than one)	10.00-1 (\$5 each add.)	8.00-1 (\$15 more than one)	10.00 (\$5 add. over 2)
Femur.....	50.00	65.00	75.00	75.00	100.00	75.00	100.00
Humerus.....	30.00	40.00	50.00	50.00	50.00	50.00	50.00
Tibia and Fibula.....	40.00	50.00	60.00	60.00	75.00	60.00	50.00
Ribs (1-3).....	10.00	10.00	10.00	10.00	5.00 to 20.00	10.00	10.00 (1 or 2) (\$5 each add.)
Clavicle.....	15.00	20.00	25.00	20.00	25.00	25.00	25.00
DISLOCATIONS							
Finger or toe one or two.....	5.00	5.00	8.00-1 (\$10 more than 1)	8.00-1 (\$10 more than 1)	5.00 any or all	5.00	5.00
Elbow.....	15.00	15.00	20.00	20.00	20.00	20.00	25.00
Shoulder.....	15.00	20.00	20.00	20.00	20.00	20.00	25.00
Semilunar cartilage.....	10.00	.....	15.00	15.00	.....	15.00	10.00
EYE							
Removal.....	40.00	40.00	50.00	50.00	50.00	50.00	60.00
HERNIA							
	60.00	60.00	60.00	60.00	60.00	75.00	75.00
ANAESTHETICS							
Major.....	10.00	10.00	10.00	10.00	10.00	10.00	10.00
Minor.....	5.00	5.00	5.00	5.00	5.00	5.00	5.00
MILEAGE							
	75c. per mi. one way. \$15 limit	\$1.00 per mi.	75c. per mi. one way. 20 mi. limit	50c. per mi. one way. \$20 limit	\$1.00 per mi. one way	\$1.00 per mi. one way up to 20 miles.	40c. per mi. plus \$3.00 per hour loss of time if over 5 mi.

Department of the Public Health

PROVINCE OF NOVA SCOTIA

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

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

Chief Health Officer - - - - DR. P. S. CAMPBELL, Halifax.
 Divisional Medical Health Officer - - DR. J. S. ROBERTSON, Sydney.
 Divisional Medical Health Officer - - DR. J. J. MACRITCHIE, Halifax.
 Director of Public Health Laboratory - - DR. D. J. MACKENZIE, Halifax.
 Pathologist - - - - DR. R. P. SMITH, Halifax.
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MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

ANNAPOLIS COUNTY

Hall, E. B., Bridgetown.
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 Kelley, H. E., Middleton (Mcpy. & Town).

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

ANTIGONISH COUNTY

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 MacKinnon, W. F., Antigonish.

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

CAPE BRETON COUNTY

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

CUMBERLAND COUNTY

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

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

GUYSBORO COUNTY

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

HALIFAX COUNTY

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

HANTS COUNTY

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

INVERNESS COUNTY

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

KINGS COUNTY

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

LUNENBURG COUNTY

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

PICTOU COUNTY

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

QUEENS COUNTY

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

RICHMOND COUNTY

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

SHELburne COUNTY

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

VICTORIA COUNTY

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

YARMOUTH COUNTY

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

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

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

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

Report on Tissues sectioned and examined at the Provincial Pathological Laboratory from January 1st, 1937, to February 1st, 1937.

During the month, 202 tissues were sectioned and examined, which, with 32 tissues from 6 autopsies, makes a total of 234 tissues.

Tumours, simple.....	29
Tumours, malignant.....	30
Tumours, suspicious of malignancy.....	1
Other conditions.....	142
Tissues from 6 autopsies.....	32

Communicable Diseases Reported by the Medical Health Officers
for the month of January, 1937.

County	Chickenpox	Diphtheria	Cerebro Spinal Meningitis	Influenza	Measles	Mumps	Paratyphoid	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. Pulmonary	Tbc.-other Forms	V. D. G.	V. D. S.	Whooping Cough	Septic Throat	Impetigo	German Measles	TOTAL
Annapolis.....	9	..	..	..	9	..	..	1	..	..	..	..	..	..	..	..	..	..	19
Antigonish.....	5	..	..	..	5
Cape Breton....	..	20	..	..	..	..	..	..	31	..	..	..	..	..	..	..	..	..	51
Colchester.....	..	1	..	4	1	..	..	..	..	..	..	..	2	..	7	..	..	..	15
Cumberland....
Digby.....	5	2	..	1	..	2	..	6	..	..	..	16
Guysboro.....
Halifax City..	2	6	..	..	..	..	..	2	7	..	1	..	..	..	2	..	..	..	20
Halifax.....	1	..	..	..	..	..	..	2	..	..	..	..	..	..	1	..	..	..	4
Hants.....	2	12	..	..	..	..	..	..	..	..	..	6	..	..	..	20
Inverness.....
Kings.....	13	..	..	..	2	..	..	2	..	5	..	15	1	1	..	39
Lunenburg....
Pictou.....
Queens.....	10	..	..	..	..	2	..	..	..	..	1	20	..	..	..	33
Richmond.....
Shelburne....
Victoria.....
Yarmouth.....
TOTAL.....	12	27	..	29	22	..	..	10	44	..	4	..	9	1	62	1	1	..	222

Positive cases Tbc. reported by D. M. H. O's. 30.

RETURNS VITAL STATISTICS FOR DECEMBER, 1936.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis.....	14	13	10	12	9	0
Antigonish.....	12	11	7	6	8	0
Cape Breton....	130	127	109	73	51	2
Colchester.....	24	33	19	22	20	1
Cumberland....	39	44	40	13	25	1
Digby.....	17	18	12	15	15	0
Guysboro.....	22	24	10	9	8	1
Halifax.....	92	76	58	27	37	6
Hants.....	24	13	20	19	17	0
Inverness.....	21	21	15	13	16	1
Kings.....	42	13	24	11	12	1
Lunenburg....	18	27	40	38	31	0
Pictou.....	40	38	29	30	32	0
Queens.....	21	13	11	12	11	1
Richmond.....	14	11	14	5	6	1
Shelburne....	24	21	9	11	9	1
Victoria.....	4	11	7	3	5	0
Yarmouth.....	20	18	3	14	16	0
	578	532	437	333	328	16

Society Meetings

Regular meeting of the Halifax Medical Society held at the Victoria General Hospital on November 18, 1936.

The meeting opened at 8.40 P. M. with Vice-President Dr. R. P. Smith in the chair. The Minutes of the last meeting were read and approved. The Secretary-Treasurer read a letter from Mrs. H. C. S. Elliot thanking the Society for their greetings and good wishes to her husband, Dr. Elliot, who has been seriously ill for several weeks.

Scientific Programme.

Dr. H. K. MacDonald presented a case of gangrene of the great toe in a man aged forty-four. The history, as given by Dr. Holland, revealed that about five years ago some circulatory disturbance developed in the patient's feet and hands. Diabetes was subsequently discovered and at one time a diagnosis of Raynaud's Disease had been made. Gangrene arising in a toe of the right foot necessitated amputation of the digit, and soon afterwards the spreading infection necessitated a supracondylar amputation. Patient has been on diet and insulin treatment for the past three years. Two months ago infection about the nail of the great toe was treated by removal of the nail. Ulceration and gangrene followed. The blood-sugar shows a moderately severe diabetes. On diet and insulin the urine is sugar-free. The toe is black in its distal half and an area of duskiness extends to the metatarso-phalangeal joint. Pulsation in the popliteal and arteries distal to it is not palpable. Dr. MacDonald discussed the treatment. In view of the fact that the right leg was amputated, he felt that the condition should be treated conservatively, that is, by controlling the diabetes, and waiting for the gangrenous tissue to separate.

Several of the members participated in the discussion, and all agreed in the matter of treatment.

Dr. Mader presented a fifty year old male admitted in August with a history of increasing constipation for six weeks and vomiting for three days. Intestinal obstruction was diagnosed and a tender movable mass palpated. At operation an annular growth of the sigmoid colon was found, and a small gland in the mesentery. A caecostomy and colostomy were performed. The growth was subsequently removed by cautery. The pathological report was scirrhus carcinoma. The post-operative course has been satisfactory.

Case II. A young adult female with acquired syphilis, involving the nasal septum and causing a flattening of the nose. Plastic operation using a portion of costal cartilage was performed a few months ago. The result was an excellent one with marked improvement in function as well as appearance. Operation had been performed when the disease was declared thoroughly treated. The comparison of the patient's appearance with a photograph taken prior to operation was so striking as to draw forth applause from the audience.

Dr. Curry presented two cases of goitre.

Case I. Twenty-one year old female. Symptoms developed a year ago, and the clinical picture now is a typical exophthalmic goitre.

Dr. Curry discussed the preoperative treatment. It is important to decide whether operation should be done in one, two or three stages. Pulse rate of 140 or more is an indication for multiple stage operation; other guides are, loss of weight, duration of the disease over one year; if patient is over fifty; a high B. M. R. Other preoperative measures are, rest, Lugol's solution, high caloric diet. The multiple stage operation is (1) Tying vessels: (2) six weeks later, remove one lobe: (3) six weeks later, remove other lobe. Operative risks are (1) injury to recurrent laryngeal nerve: (2) removal of parathyroids. The prognosis in the case shown is good.

Case II. Nineteen year old female: lump in neck noticed a year ago: this gradually increased and during the past three months dysphagia has been troublesome. On examination there is a large adenoma on the right side. The absence of symptoms and signs of thyrotoxicosis justify a diagnosis of non-toxic adenoma. Treatment, surgical removal. Indication, dysphagia. These cases tend to become toxic; cystic degeneration may occur in the adenoma, or malignant degeneration in rare instances. If the B. M. R. is normal, the only preoperative treatment is rest and no Lugol's solution.

Dr. Kinley showed a sixty-six year old miner, who two years ago injured one of his knees. Some weeks later both legs became useless. Investigation by lipiodol injection resulted in a diagnosis of spinal cord tumour at the level of the second lumbar vertebra, but clinically the signs pointed to the tenth dorsal. Operation was performed September 29th under avertin and local anaesthesia. The laminae of the seventh, eighth and ninth dorsal vertebrae were removed, and then fifth and sixth. A pedunculated subdural tumour was removed. There was little post-operative shock. Patient is now walking quite well. Massage treatment is being employed. Dr. Smith, commenting on the pathology, said the tumour proved to be a meningioma of the simple type.

Dr. Gosse presented a fifty-six year old man, admitted the previous day with a sore great toe of three weeks duration. History revealed trouble with this foot for a year, pain in foot and leg. Sometimes the hands were white and then red. Examination reveals a painful cyanosed toe. Differential diagnosis (1) Raynaud's disease: (2) syphilis: (3) diabetes: (4) arteriosclerosis: (5) Buerger's disease. Dr. Gosse took up the various differentiating points, and felt that this case suggested thrombo-angiitis obliterans. He then described the aetiology and pathology. Treatment is (1) prophylactic: (2) to promote dilatation of the peripheral vessels. Ganglionectomy of second, third and fourth lumbar ganglia and sympathetic nerve is reported to be giving good results.

Dr. A. L. Murphy showed a thirty-seven year old man admitted two months ago with an infected finger. Distal phalanx had been removed but wound did not heal. Then the middle phalanx had been removed, but no healing occurred. Since admission the proximal phalanx, and head of the metacarpal were excised. Each time the incision broke down. The personal history and physical examination are negative. Kahn negative, but Hinton positive. Patient has been getting potassium iodide in large doses for four

weeks. Dr. Murphy presented the case as a problem in diagnosis and treatment.

An interesting discussion followed, a feature of which were some welcome remarks on the value of the Hinton test by Dr. D. J. MacKenzie. At the conclusion of the scientific programme the meeting adjourned to the nurses dining-room where a delightful supper was served. A vote of thanks moved by Dr. Woodbury seconded by Dr. Stoddard was acknowledged by the Superintendent, Dr. MacIntosh, who said he was always pleased to welcome the Society to the Victoria General.

Meeting adjourned at 11.10 P. M.

Members present: Drs. Corston, Payzant, Curry, Noble, Murray, G. H. Murphy, V. O. Mader, H. K. MacDonald, Lessel, G. A. MacIntosh, Reid, Gosse, Schwartz, O'Brien, P. S. Campbell, D. J. MacKenzie, Winfield, Woodbury, H. G. Grant, Jones, J. C. Acker, Granville, Weld, K. M. Grant, McCurdy, Kinley, Smith, K. A. MacKenzie, Bethune, Hawkins, Marshall, Barton, Colwell, Stoddard, J. W. MacIntosh, E. F. Ross, P. A. MacDonald, A. I. Mader, Holland, and seven internes.

C. W. HOLLAND, Secretary-Treasurer.

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Your mechanism may be bent,
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And you skip and skid and slide
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Personal Interest Notes

Dr. Audley A. Giffin, Dalhousie 1931, has established practice in Bridgetown.

At a recent meeting of Dalhousie graduates at Yarmouth organized by Major John Roper, chairman of the reunion committee of the University, Dr. T. A. Lebbetter was elected president. This is the first of a series of Alumni groups to be organized by Major Roper in preparation for the reunion planned by Dalhousie University for 1938.

Dr. T. R. Johnson, county medical officer for Colchester, in his annual report stressed the need of a tuberculosis annex to the Colchester County Hospital. Another item included in Dr. Johnson's reports was the improvement in sanitary conditions about the schools. Dr. Johnson also emphasized the importance of having the advice of the Provincial Government engineer in matters of general sanitation throughout the county.

Dr. Charles L. Baxter of Moncton, N. B., has left for London, England, where he will do post-graduate work at the British Post-Graduate Medical School.

The report of the Eastern Kings Memorial Hospital shows great volume of work during the past year. The annual meeting of the Eastern Kings Memorial Hospital corporation was held at Wolfville on January 28th, when H. A. Trote-Bullock was elected President. The other officers are as follows: Honorary President, Dr. J. G. MacDougall, Halifax; Vice-President, Dr. Lalia B. Chase; Secretary, W. D. Withrow; Treasurer, R. Creighton; auditor, R. L. Sproul. The retiring trustees, G. A. Boggs, George A. Chase and H. A. Tryotye-Bullock, were re-elected. The report of the superintendent, Miss V. Bengston, shows that the hospital has had the busiest year since its opening. There were 770 patients admitted during the year, and 447 surgical operations were performed. The work done in the X-ray department was almost doubled. The average bed patients per day were $26\frac{1}{2}$; the maximum number at any time 40.

Dr. and Mrs. G. W. T. Farish of Yarmouth have returned from a visit to Montreal.

Dr. J. S. Munro of North Sydney is giving a series of lectures to the scout masters, scouts and instructors in connection with the St. John's Ambulance course at North Sydney.

Dr. Gordon R. Mahaney has returned to his practice in Granville Ferry after a visit to New York and other cities where he devoted his time to post-graduate study.

Dr. George L. Covert has returned from an extended post-graduate course at Edinburgh.

Dr. Edmund P. Lewis, Assistant Professor of Psychiatry at the Toronto Medical School Addresses the Nova Scotia Society of Mental Hygiene at Halifax.

Dr. E. P. Lewis, Psychiatrist of Toronto gave a most interesting address before a special meeting of the Nova Scotia Mental Hygiene Society at Halifax during the latter part of January. Some of the facts mentioned in Dr. Lewis' address make us realize the importance of this subject. Dr. Lewis stated that the number of patients in mental institutions in the Dominion now totals thirty thousand, a greater number than those in all other general hospitals in Canada. He also stated that 35% of the people suffering from organic diseases in mental hospitals in Canada were curable. The Doctor also stated that the average physician in Canada did not have a proper conception towards mental disease, and that in his opinion the training in psychiatry in medical schools was in general inadequate.

Dr. L. N. Morrison formerly of Mahone Bay has accepted a position with the Dominion Government as ship's doctor on the C. N. S. "Lady Nelson".

Dr. George R. Cox of New Glasgow, accompanied by his two daughters, Misses Isobel and Edith, former students of Dalhousie University, has left to spend the winter at St. Petersburg, Florida.

Glance Bay Branch of Canadian Legion Endorse Tuberculosis Annex as Temporary Move.

At a meeting of the Glance Bay Branch of the Canadian Legion held on February 7th the recommendation of the Nova Scotia Government to erect annexes in conjunction with the two hospitals at Glance Bay was endorsed. The Legion is at present following up this matter with the town of Glance Bay and the Boards of both hospitals in an effort to have these annexes built.

Dr. and Mrs. H. J. Pothier of Weymouth have returned from a visit to New York.

S. U. P. 36 In The Treatment of Influenza

Experience over a period of upwards of ten years has demonstrated conclusively that S. U. P. 36 possesses the power to shorten considerably the duration of an attack of influenza.

Evidence to this effect was reported (Brit. Med. Journ., October 12th, 1929, p. 663) as follows: '...if the treatment be used in influenza epidemics on a wholesale scale and early enough it is the most valuable agent that we at present have discovered for combating these epidemics.' A more recent report (Brit. Med. Journ., February 18th, 1933, p. 290.) states '...it has given complete satisfaction as a drug on which one can rely for positive results, with no ill-effects or contra-indications. I used it only in cases which appeared which appeared to be more severe than the average; in almost all one dose was sufficient to bring the temperature down to normal in twenty-four hours.' Literature on request from The British Drug Houses (Canada) Limited, Terminal Warehouse, Toronto.

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OBITUARY

WE regret to learn of the death of Dr. W. S. Phinney of Yarmouth who passed away at his home on February 4th. Dr. Phinney had not been well for some months: shortly after Christmas he visited Boston to seek medical advice but apparently returned to Yarmouth without having secured relief. Dr. Phinney was born in Bridgetown, N. S. and graduated from Dalhousie Medical School in 1902. He started to practice in Yarmouth, but after some years he moved to the West. Later he returned and after taking a post-graduate course in diseases of the eye, ear, nose and throat in New York in 1915, he devoted all his time to that specialty. Dr. Phinney was an active member of his local Medical Society and also the Medical Society of Nova Scotia. He took a keen interest in fraternal organizations, and held high office in the Masonic Order. Dr. Phinney is survived by his widow, formerly Miss Etta Messenger, one daughter, Mrs. Richard Dobson, a graduate in medicine from McGill University, and one son, Dr. Willoughby Phinney of London, England, and his father, who is residing at Lawrencetown, and who is over ninety years of age. The funeral service was held on Saturday afternoon at the Yarmouth North Baptist Church, and was largely attended.

After an illness of several month's duration there passed away at his residence on Quinpool Road, Halifax, on January 13th, Dr. Walter H. Pentz, at the age of forty-seven. Dr. Pentz first graduated from Dalhousie University in pharmacy, and carried on a business in the north end of Halifax for a number of years. He then returned to the University and graduated in medicine in 1928, and since that time has practised medicine in Halifax. Dr. Pentz is survived by his widow, the former Miss Elizabeth Barteaux of Nictaux Falls, two daughters, one brother and five sisters.

The BULLETIN extends sympathy to Dr. J. W. T. Patton of Truro on the death of his only son, Huntley, on January 11th.

Old Way...

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: *The Golden Bough*, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

New Way...

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NOWADAYS, the physician has at his command, Mead's Oleum Percomorphum, a natural vitamin D product which actually prevents and cures rickets, when given in proper dosage.

Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets, regardless of degree and duration.

Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

Mead's Oleum Percomorphum is not advertised to the public and is now obtainable at drug stores at a new economical price in 10 c.c. and 50 c.c. bottles and 10-drop capsules.

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LINES TO A SKELETON

This is the usual title applied to the following poem, although the original title under which it was published in the *European Magazine* and *London Review* for 1816, was "A Fragment Found in a Skeleton Case". It was signed solely with the initial V. There has been much dispute as to who was the author but it is now regarded as definitely proven that it was written by Miss Anna Jane Vardill, the author of several other poetical works. She was the daughter of the Reverend John Vardill, who was born in the American Colonies but, being a Tory, went over to England at the outbreak of the Revolution. Miss Vardill was born in London, married James Niven and died in Yorkshire in 1852.

We owe our information to the kindness of Mr. William Abbatt, of Tarrytown, who sent it with a copy of the poem to the *Annals*.

Behold this ruin! 'Twas a skull
Once of ethereal spirit full;
This narrow cell was Life's retreat,
This space was Thought's mysterious seat.
What beauteous visions filled this spot,
What dreams of pleasure, long forgot!
Nor hope, nor love, nor joy, nor fear,
Has left one trace of record here.

Beneath this mouldering canopy
Once shone the bright and busy eye;
But, start not at the dismal void,
If social love that eye employed,
If with no lawless fire it gleamed,
But through the dews of kindness beamed,
That eye shall be forever bright,
When stars and suns are sunk in night.

Within this hollow cavern hung
The ready, swift and tuneful tongue;
If falsehood's honey it disdained,
And where it could not praise, was chained;

If bold in Virtue's cause it spoke,
Yet gentle concord never broke
This silent tongue shall plead for thee,
When time unveils eternity.

Say, did these fingers delve the mine?
Or with its envied rubies shine?
To hew the rock, or wear the gem
Can little now await to them.
But if the page of truth they sought,
Or comfort to the mourner brought,
These hands a richer meed shall claim
Than all that wait on Wealth or Fame.

Avails it, whether bare or shod,
These feet the paths of duty trod?
If from the bowers of Ease they fled
To seek Affliction's humble shed;
If Grandeur's guilty bribe they spurned,
And home to Virtue's cot returned,
These feet with angel's wings shall vie,
And tread the palace of the sky.

Many years ago I clipped from the pages of the *Canadian World Wide* a poem addressed to a skeleton and filed it in my "Cunningham". The foot note was to the effect that it had been discovered in the museum of the Royal College of Surgeons by Sir Arthur Keith, who in turn passed it to *The Times*. This paper, it was said, made a determined effort to discover the author but without success. Recently one bethought himself of this poem and wrote to Sir Arthur Keith who in his reply said—"At first I thought I had never heard of such a poem, but am less certain now and first chance will inquire of the Librarian at the Royal College of Surgeons." A few days later a letter was received from Mr. W. R. LeFanu who not only gave me the correct title, "Lines to a Skeleton", but the reference to where it could be found, "*Annals of Medical History*", 1921, Vol. 3, page 135, with a note as to its supposed author. I feel sure our readers will appreciate the trouble taken by these gentlemen in answering my inquiry. A copy of the *BULLETIN* will be forwarded with the compliments of our members.

H. W. S.

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OVER THE FENCE IS OUT

The money that we spend for foreign-made goods goes "over the fence" and we are "out" just that much, for very little of that money will ever return to us. This fact is not appreciated by the people of the Maritimes as much as it should be. Here we with an abundance of natural resources, have very few local plants manufacturing them. Would it not be to our advantage to patronize those industries which we have whose payrolls and supplies are spent and purchased in such a way as to benefit the whole community.

Trade with those who will most readily trade with you. Buy things made or produced near home, buy Maritime products whenever what you want is made in the Maritimes, failing that, seek to buy within Canada and if what we want is not made within our Dominion we shall surely find it made within the Empire.

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Middlemen.

The country lawyer had always had a great dislike of doctors. One morning he was seen hurrying along the street, with a look of despair on his face, and an acquaintance asked him whether anything was wrong.

"I'm afraid there is," said the lawyer. "My wife is very ill, and I am hurrying to fetch the undertaker."

"The undertaker!" exclaimed the other. "You mean the doctor, don't you?"


"Certainly not," was the reply. "I never could abide these middlemen."

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