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Pediatric Acceptance of DEXTRI-MALTOSE is Constantly Increasing

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1934

"The question of carbohydrate is one of individual tolerance. Personally, I like Dextri-Maltose."—*L. Fischer: Pediatric progress during the last fifty years, Arch. Pediat. 51:207-218, April 1934.*

1934

"Cow's milk has a caloric value of 20 calories per ounce. Dextri-Maltose, commonly used, has 120 calories per ounce. As an example let us say that we have a well baby four months of age weighing 14 pounds. According to the rule, he should have 45 calories per pound per day, or 630 calories. Sugar requirements will be 1½ ounces—that is, 180 calories. Then deduct this from the 630 calories needed for the day and this leaves 450 calories to be supplied from the milk. 450 divided by 20 calories makes 22½ ounces of milk needed. The baby will probably take 7 ounces at each feeding and five feedings will be needed or a total of 35 ounces. This will leave 12½ ounces of water to be added and your formula will be:—

22½ ounces of cow's milk
12½ ounces of water
1½ ounces of Dextri-Maltose

Divide into five feedings of 7 ounces each and feed every four hours."—*B. F. Thomas: Infant care and feeding, J. M. A. Alabama 3:348-351, April 1934.*

1934

"Within a week it became necessary to place the baby entirely on a milk formula. This was a mixture of milk, water, and dextrimaltose, and he thrived on it."—*J. M. Higgins: Acute lymphatic aleukemic leukemia, Pennsylvania M. J. 37:818-819, July 1934*

1934

"The dietetic treatment of pylorospasm yields gratifying results, the use of a thick farina formula usually proving successful. This is prepared as follows:

Skimmed milk..........10 ounces
Water..........12 ounces
Farina.......... 5 level tablespoonfuls
Dextri-maltose No. 1 3 level tablespoonfuls

"Mix the milk and water together and bring to a boil. Then sprinkle in slowly 5 level tablespoonfuls of farina and boil over a direct flame for five minutes, stirring continually. Transfer to a double boiler and cook for one hour. After the mixture is cooked add the dextri-maltose."—*C. S. Raue: The dietetic treatment of nutritional disorders in infancy, Hahneman. Monthly 69:522-528, July 1934.*

1934

For pyloric stenosis, "He was given atropine sulphate grains 1/1000 before each feeding and this was increased to grains 1/500 before vomiting was controlled. The formula consisted of cow's milk 16 ounces, water 16 ounces, dextri-maltose 2 level tablespoonfuls and uncooked farina 6 tablespoonfuls. He was fed 6 tablespoonfuls every 4 hours, 6 feedings a day. . . . In 5 days time there was a gain of 25 ounces. He was under treatment for a period of 5 months and 26 days during which time there was a gain of 14 pounds and 7 ounces."—*R. D. Hostetter: Pyloric stenosis, Ohio State M. J. 30:505-508, Aug. 1934.*

1934

"The mother's breast feedings were complemented by a mixture of three quarters milk, water and dextrimaltose. After a loss of 5 ounces (175.1 Gm.) during the first three days, the child gained steadily, weighing 7 pounds and 5 ounces (3,316.9 Gm.) by the eighth day."—*S. S. Brown, M. Morrison and D. A. Meyer: Anemia of the new-born without erythroblastosis: Observations at autopsy, Am. J. Dis. Child. 48:335-345, Aug. 1934.*

1934

"A formula of cow's milk, water, and dextri-maltose was given. The feedings were well taken, and the stools were normal."—*J. L. Rothstein: Low calcium tetany in the newborn, J. Pediat. 5:341-351, Sept. 1934.*

1934

"Dextri-Maltose is, of course, the best sugar but expensive.* Cane sugar gives fairly satisfactory results except in very advanced cases, when dextrimaltose must be given."—*K. C. Chaudhuri: Marasmus and its treatment, M. Digest 2:246-249, Oct. 1934.*

1934

"Meads Dextri Maltose is preferred, as it is not advertised to the laity. It contains dextrins and maltose in almost equal amounts, and in the three varieties varies only in the amount of sodium chloride and potassium bicarbonate they carry."—*G. Wiswell: Proprietary foods in infant feeding, Nova Scotia M. Bull. 13:483-485, Oct. 1934.*

1934

"To be sure, one can still raise well infants, using commercial granulated sugar, but one has a distinctly safer feeling, in the presence of disease, when a combination of sugars, such as dextrins and maltose, can be employed."—*L. C. Schroeder: The treatment of pneumonia in infants and children, M. Clin. North America 18:811-826, Nov. 1934.*

1934

In pyloric stenosis, "Finally, if the stools are inclined to be hard and dry and the fluid intake falls below 2.5 to 3 oz. per pound body-weight, additional fluids, preferably in the form of a solution of one of the dextrin-maltose preparations, between feedings, will usually be sufficient."—*C. C. Fischer: Constipation in infancy and childhood, Hahneman. Monthly 69:913-918, Dec. 1934.*

1934

"A sugar of the dextri-maltose type seems to be the most consistently and universally satisfactory."—*H. D. Lynch: Fundamentals of infant feeding, J. Indiana M. A. 27:571-574, Dec. 1934.*

(to be continued)

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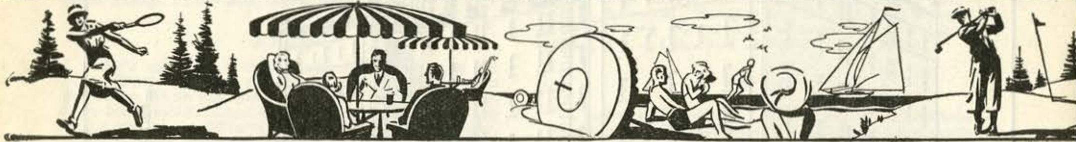

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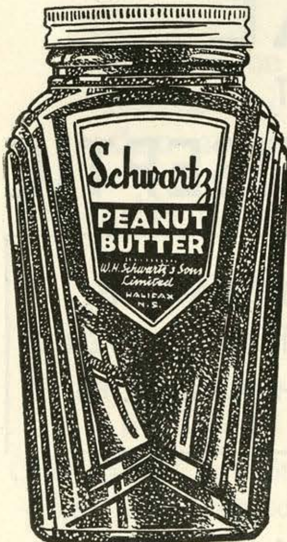

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The Chronic Adult Tonsil

C. K. FULLER, M.D.(Tor.),F.R.C.S.(E),F.R.C.S.(C).
Yarmouth, N. S.

The chronic adult tonsil should be and generally is as much a daily problem with the general practitioner as with the specialist, for every patient, if he still has his tonsils, should either have them removed or should not.

I know I have innocently been placed by the general practitioner where I was most agreeably surprised at the beneficial result of a tonsillectomy and I also admit I have placed myself where I was just as thoroughly disgusted with the result.

If we never left a tonsil that should be removed or, on the other hand, never removed one that might as well remain, how high would be the Status of tonsillectomy and how ideal would be the relationship of the physician, the specialist and their patient.

Time and space will not permit me to discuss at any great length the tonsil problem, the direct or indirect symptoms, the pathology, the obvious cases but merely to superficially discuss that large number of adult patients who naturally fall in one of four classes.

A. Those with general symptoms who complain of their throats.
B. Those with general symptoms who do not complain of their throats.
C. Those without general symptoms who complain of their throats.
D. Those without general or local complaints who are seen in routine examination.

Naturally the history and the examination of the throat must be carried out in a routine manner and I would like to draw attention to a few things that anyone can and should carefully consider.

(1) The size of the tonsils is not very important but it is important whether or not they are embedded and if so, are they adherent or or non-adherent.
(2) Whether or not the tonsillar gland is enlarged and tender.
(3) Whether or not deep pressure on the Transverse process of the cervical vertebrae is tender.
(4) Immediately behind the posterior pillar on the posterior wall of the pharynx are often seen bands of inflammed lymphoid tissue. They are generally about one-quarter inch wide and vary in length and thickness. Their presence or absence should be carefully noted and also their condition. Are they most marked superiorly or inferiorly?
(5) The condition of the posterior wall of the pharynx should also be noted.
(6) Whether or not the tonsil is inflammed.
(7) Whether or not pus or dessicated secretions can be expressed from the tonsils.

I do not want to appear dogmatic but if any man will co-relate these seven pillars and fit them into the whole picture of his patient's case, his results should, on the whole, be excellent. It is not the easiest matter in the world

to always arrive at the correct co-relation but perseverance will certainly do a lot. My results undoubtedly leave much to be desired. I have modified my opinions from time to time and, undoubtedly, will do so in the future. I have been very fortunate over the years in that the physicians with whom I work are highly skilled and very observant and if I have bettered my position in this problem certainly a great deal of the credit lies with them. As I have said, the size of the tonsil is not as a rule very important nor as a rule is the tenderness very great, it is not the degree of tenderness that particularly interests us, if it happens to be present, but its position whether or not it is in the tonsillar gland or the deep cervical glands. If a patient has an infected tonsil and there is no local reaction then we can expect a systemic reaction sooner or later, but on the other hand, if there is a local reaction we must decide whether that local reaction is completely controlling the condition or whether we should expect a systemic reaction as well.

Then there is the embedded tonsil. The mere fact that a tonsil is embedded is of no particular significance, the important point is, are they adherent and do they limit the movements of the pillars or, in other words, is the embedding the result of an inflammatory reaction and then again is that reaction over and past or is it active.

Taking everything into consideration I would like to consider some types of cases and the results of tonsillectomy. Naturally there will always be border-line cases which are difficult to place but experience and judgment should make them comparatively few.

Let us consider the patient with general symptoms who complains of sore throat either more or less constant or intermittant. Embedded or not, pus or no pus, adherent or not adherent, if the tonsil is inflammed removal will give you loval relief in whole or in part, but unless the post pillar bands of inflammed lymphoid tissue are present and heavier below than above, you will get no general relief. If, on the other hand, the tonisl is not inflammed and the post pillar band is heavier above than below, then local relief will not be obtained by removal even if the tonsil is embedded, adherent or if there is pus present, but in this type of case if pus is present you should get an excellent system effect.

Then there is the patient who has general symptoms but as he says "never knows he has a throat." Removal should only be considered in two types. The first is where you can express pus from the tonsil then the general relief is often very marked and secondly, in the embedded adherent tonsil where you find the tonsillar gland somewhat enlarged and tender. Unless this tenderness and enlargement are present, both you and the patient are going to be disappointed.

A third type of patient has no general symptoms but is complaining about his throat often being sore. If there is pus, naturally the tonsil should be removed as a prophylactic measure against systemic infection but the specialist's present interest is relief of a local condition and he must see some local reaction to the pus such as a post pillar band heavier below than above, or a tonsil that is more or less adherent or a tonsil that in itself is reacting as shown by the openings of the crypts. It doesn't help the surgeon or the patient to remove a purulent tonsil to cure a sore throat due to a chronic pharyngitis that is due, for example, to an infected sinus. I am always very charry in these cases when deep cervical tenderness is present. I have to be.

Then there is the fourth type of patient who does not complain of anything, who you find on routine examination has pus in his tonsils. It is really

surprising how often there is no local reaction that you can see but you will often find the tonsillar gland larger on one side than the other and slightly sensitive. This patient certainly should have his tonsils removed because some day sooner or later he's going to get something he doesn't want if he keeps them. A great many of these patients have embedded tonsils and very often they are adherent but this is certainly no indication for removal.

In conclusion I would like to mention one other type of tonsil that comes very frequently to our attention. The newspapers and magazines with their advertisements of beautiful women with "Halitosis" must be read by men as well as by the women for it is surprising how many of both sexes find they have "large tonsils from which they can squeeze big chunks of matter." I am referring, of course, to this type when it is causing no local irritation. Personally, I have never found their removal any aid to "Halitosis" or anything else but they really are a problem for most of the patients are convinced they should be removed and once so convinced are going to remain so. At present the only solution I see to this particular problem is to at least let the patients find these tonsils for themselves.

Aid to the Arthritic.

While the systemic treatment of arthritis demands some knowledge of the cause, at the same time local palliative treatment is usually an essential.

The causes of arthritis fall into three major categories: infectious, metabolic and traumatic. Probably most cases are in varying degrees combinations of these three major causes. Treatment, then, involves the elimination of all possible foci of infection and the identification and correction of metabolic and postural abnormalities and the systemic treatment of the established inflammatory changes in the articulations.

For the local treatment, many physicians find the application of a hot Antiphlogistine dressing a very distinct aid, both in relieving the pain and discomfort and in stimulating healthy reaction of cells and capillaries. If applied only at the *site* of the disturbance, the results are quite noticeable. However, if the dressing is extended well above or mesial to the involved joint, the effect may be very marked. If the dressings are changed at eight to twelve hour intervals, the beneficial effects are distinctly augmented.

A Case of Nephrosis

L. M. Morton, M.D.
Yarmouth, N. S.

"TIDY states in his 'Synopsis of Medicine' (1934) that *Nephrosis* is a condition characterized pathologically by changes confined to non-inflammatory degenerative lesions of the renal tubules, and clinically by oedema, albumenuria and hyper-cholesterolaemia, with absence of haematuria, of cardiovascular changes and of decreased renal function and by tendency to recovery."

Some authorities are of the opinion that it is of a different nature from other types of renal disease, while others maintain that it is merely a variety of subacute nephritis, which of course, it closely resembles. Whether it is a distinct disease or a variety of renal infection, it is not my purpose to discuss but the differential diagnosis is of practical value as far as treatment and prognosis is concerned. In fatal cases, death is usually from intercurrent infection rather than from Uraemia, also during the course of nephrosis absolute failure of the excretory power of the kidney rarely develops.

The following case report is presented as the clinical picture was typical of the above symptomatic syndrome, and I was able almost from the onset to give an optimistic prognosis.

Boy age four years—Always well except for occasional gastro-intestinal upsets. Saw patient first time on November 28th, 1936, when the mother stated that the child had had tonsillitis two weeks before which cleared up after three or four days and that for the past week there had been some swelling of eyelids and puffiness of face.

Examination—Fairly well nourished boy weighing forty pounds—Temperature and pulse normal—Tonsils slightly inflammed—Adenoids present—Lungs clear—and Heart normal—Abdomen negative—Urinalysis—showed small amount of albumen, no blood cells and no casts. Fluid intake and output chart was started at once and fluids accordingly restricted.

Diet—At first given milk and tomato juice equal parts up to amount of urine excreted which at first was thirty-two ounces. This amount gradually decreased as the oedema progressed until eight to ten ounces of tomato juice was only fluid and nourishment given in twenty-four hours.

Urine—From the onset of the illness the urine gradually decreased in amount from thirty-two to eight ounces in twenty-four hours. The albumenuria increased until after two weeks it was four plus or practically solid on boiling. No blood and no casts in urine at any time. Specific gravity average of 1030.

Oedema—The oedema progressed from the onset until it was extreme. The skin over abdomen and thighs ruptured in several areas and there was much oozing of fluid. Also the scrotum and penis became enormously distended.

Lungs—Developed moisture in bases of both lungs but there was no evidence of pleural effusion at any time.

Heart—Blood pressure 90 systolic—and pulse at all times regular and never over 110.

Temperature—Varied from normal up to 101°

Treatment—Hot packs were given every eight hours and with the exception of occasional remission were kept up during last two weeks of the acute illness. Magnesium Sulphate given daily to secure two or three movements in twenty-four hours. On general principles 30 grs. of Potass Citrate was given daily.

Complications—On December 19th, 1936, developed Erysipelas over pubic area and thighs due to irritation of urine which was constantly dribbling away. Temperature rose to 104.5 and pulse 130. Gave three daily injections of foreign protein (sterile milk) and condition cleared up.

The illness as stated was first recognized on November 28th, 1936, and steadily and persistently progressed until January 1st, 1937. On this latter date there was a slight change; there was an increase in the amount of urine of two ounces over the previous daily average. Each day the child voided increasing amounts and there was definite decrease in the oedema—finally after ten days the kidneys were excreting fifty ounces daily and the oedema had practically all disappeared.

The transition from the maximum swelling of the whole body to the cadaverous looking little boy that was left behind seemed almost miraculous. There has been no recurrence of oedema since January 10th, 1937. The amount of albumenuria has varied from clear up two plus. This has been due chiefly to his mother's eagerness to increase the diet. Since February 1st, 1937, on high protein—carbohydrate and low fat diet has been free from albumen—gaining weight, very active and showing normal signs of recovery. Tonsils and adenoids removed on February 22nd, 1937.

Summary—Case of albumenuria; extreme generalized oedema persisting for five weeks; no haematuria; no casts; no cardio-vascular symptoms. Terminating by almost spontaneous diuresis with no recurrence of symptoms. Probably due to tonsillar infection; treated in the country with mother having sole charge of nursing care throughout.

Cod Liver Oil as a Local Antiseptic

A. R. CAMPBELL, F.R.C.S.(E).
Yarmouth, Nova Scotia.

DURING the past two years numerous articles have been published in Central European journals on the use of cod liver oil as a dressing in such conditions as sloughing ulcers, infected hands, osteo-myelitis, sinuses, etc. Apart from reviews of these articles very little has been written in British or American literature.

In selected cases it appears to give brilliant results as compared with our ordinary antiseptic dressings. Within 24 hours the flow of pus has almost ceased, and after another day the floor or wall of the infected area is covered with healthy granulations and the skin will be noticed to be growing inwards over the marginal area.

Any cod liver oil of high vitamin content, supplied by a reputable drug firm, may be used. The higher its vitamin content the better, without this it is valueless. The oil is sterile as it comes from the bottle, but should be used from sterilized a dish or syringe.

The principle objection to its use is that all clothing and bed linen soiled by it must be washed separately, otherwise all the hospital will be quickly contaminated with the odor.

Of the ten cases that I have seen treated by this method during the past six months, the two here reported are good examples.

Case 1. S. A., male, age 88, thin and active, admitted to hospital Sept. 24/36, suffering from a large carbuncle of the right loin, and having the flexor surfaces of both forearms thickly spotted with boils that had not yet pointed. He also complained of intolerable itching of his whole body and was constantly scratching.

Examination showed all systems normal except the skin, which was glossy and glazed with a thick layer of keratinized epithelium. Under this glaze were numerous brown freckles, which on examination with a reading glass were seen to be coiled up hairs,—the cause of the itching. This condition, common in the aged, was cleared up by daily scrubbing with a nail brush, soap and water, etc. He was given several injections of "foreign protein" (milk), which helped to cause the lesions on the arms to slowly vanish without breaking or developing into carbuncles. Hot antiseptic dressings were kept on all lesions. After a week of this treatment the skin over the carbuncle had sloughed over an area 6″ x 4″ leaving an ulcer with dirty base and edges undercut for 1″ or 1½″, and pouring out pus. The unhealthy edges looked as though they were going to slough also. On Oct. 5/36 the dressing was changed to a daily saturation with cod liver oil. After about 24 hours the flow of pus stopped. On Oct. 9/36 the ulcer was granulated level with the skin, and ¼″ to ½″ new epithelium had grown in from the edges, which were now healthy, and he was permitted to sit up for half an hour. He was discharged from the hospital on Oct. 27/36 with arms normal and ulcer more

than half covered with new epithelium. Under daily dressings with cod liver oil at home, healing was complete after three weeks.

Case 2. G. S., male, 38, admitted to hospital Nov. 19/36, cellulitis back of hand and forearm to elbow. T., 100.5, P., 128, R., 28. Had been in auto accident 5 days previously, and a 1½" skin wound on back of wrist had been sutured. Infection developed and on admission the skin over the whole of back of hand was floating on pus, which was pouring from the reopened wound and from sloughed holes over two knuckles. All this skin was spotted with sloughing areas and appeared about to slough completely. He was given 1500 units A. T. S. and 2 c.c. milk. The hand was syringed out with cod liver oil until all pus had been evacuated, and a dry dressing applied. Next day the hand presented a most odd appearance. All swelling had subsided from the back of it while remaining in fingers and forearm. There was very little pus. Highest chart readings were T. 99.3, P. 89, R. 20. The hand was syringed again with oil. On following day (48 hours), sloughing spots were thickly peppered with red granulations, and it was not possible to force oil under the skin. The healing of back of hand was rapid, but it was three weeks before his temperature remained normal and swelling disappeared from forearm. Any of the recognized methods of treatment would, I believe, have cost him the loss of this area of skin and caused more serious disablement.

Used experimentally as a dressing in several cases of diabetic gangrene, where there was only a black patch on toe or foot, it quickly caused the disappearance of inflammation in the marginal tissue, eased the pain, and caused the slough to separate much more quickly than other forms of treatment have done.

In acute or chronic osteo-myelitis, after suitable surgical drainage is provided, the lesion is syringed with oil and packed with gauze. On removing the dressing after several days, the wound is well granulated and the flow of pus is negligible.

Septic sinuses, when syringed daily through a soft catheter passed to their base, often show after 24 hours, a marked diminution in amount and foulness of discharge. After 48 hours the return flow of oil is blood stained, (from granulations), and rapid healing may occur.

Should this common household remedy after trial, prove its value in the treatment of sepsis, as did "foreign protein" in the form of boiled milk, it will indeed be a boon to the profession.

The Defects and Benefits of the Refresher Course

J. E. LEBLANC, M.D.,C.M.
West Pubnico, N. S.

THE subject of this paper may astonish our readers, more so the promoters of the Refresher Courses who have done so much for the Profession for the last fifteen years; but at certain times of the year, we get circulars asking us our comment upon the Courses, so well made and organized. We feel that we should give expression to what we may summarize as the "defects and benefits of the Refresher Course," in a more formal way than by a circular letter in order that our good friends may better understand our comments which are given with a very unbiased mind and free from any criticism of a destructive nature.

Of the "defects", we do not see many. Perhaps here, we may say that our distinguished visitors and lecturers are outstanding in mastering their subject matter. Our old professors follow the same line of conduct—but at the clinics, furnished with very good material, do we not witness the fact that the lecturer relies a great deal more on the material brought to him from the ward than upon himself. He gives a very concise and precise history of the case on hand! All the laboratory findings, etc., but are we not, his students, entitled to have some more description of the case:—some definition—a clear and simple exposition of the nature of the problem before us—For instance, when we see a burn, a cancer, or a fracture, is it not proper that before the lecturer goes on with the treatment, we should have some pathological knowledge about the conditions, classification, etc. Some will object that no time is alloted for that: Still a few moments would introduce us to the subject matter and give us a clear insight of the case.

Next to this, we come to a very important section of the Refresher Course: and that is,—practical surgery—that subject which seems to rule supreme in all our medical conventions and congresses. In our refresher courses, may we not expect from our head surgeons some practical work or operation done in our presence? Is it too much to sit one or two mornings for practical surgery in the operating room, where we can see the Surgeons at work and have a glance at their technique and methods of operating? When we go to the Lahey Clinic in Boston, we are always invited to attend the operations done at the New England Deaconess and the New England Baptist Hospitals. Dr. Lahey will gladly explain in detail his operations if one so desires. The same applies to Doctor H. M. Clute's surgical clinics at the Massachusetts Memorial Hospital. At Halifax, we appreciate the surgical clinics given to us at the Refresher Course, the wealth of material and the selected cases, but how more profound and lasting would be an operation done in our presence in the operating room.

The same principle applies to obstetrics—the "Science of Science" for the general practitioner. We are often told of being too rash in our technique,

of rupturing the uterus, in some cases of instrumental labor, of hastening labor. Do we stop to think that sometimes the general practitioner is all alone attending upon these cases. Not only has he got the abnormalities of labor to combat but also the moral atmosphere of the home, the anxieties of the family, of relatives and friends.—Hence the situation is infinitely much more complex and difficult than in the hospital. Would it not be proper therefore, with the above facts staring us in the face, to ask our directors of the Refresher Course to endeavor to give us, (if possible, of course) some practical work in obstetrics. That would be worth a great deal to us. Still we quite realize the tremendous extra labor it would entail upon the specialist in this particular field but if that was feasible, how well would he be repaid for the services rendered to those who are so eager to learn and master the "terrific" abnormal conditions which are thrown upon us when we least expect them.

We come now to the "benefits" of the Refresher Courses. They are numerous and we cannot state them all in a short paper such as this. We must admit that they are magnanimous. The title itself is inspiring—a refresher course—a study—a return to our books—a stop in our medical journey throughout life—an oasis in the desert—because how many of us feel the necessity at least once a year of re-juvenating our mind, of refreshing our memories upon the "new things" in medicine as upon the old scientific "dogmas". They are legion.

I am a firm believer in our Universities and in the Institutions which they create for the good and welfare of our profession. They do much more than provide machinery for imparting learning. They have been the means of not merely uplifting man but of forming and creating character. In that great work it is not merely the official teachers who contribute the most but also the fellow-students, the man with whom as teachers we are thrown in daily contact. That is as great a source of training and education as anything which books can possibly offer.

When we look back upon our University experience as a distant but happy memory, we may full well remember that what we cherished the most was the personal intercourse between teacher and pupil, lecturer and student, also the action and reaction of mind, the influence of a common life; the joy of common memories, the feeling of brotherhood in a great institution to which we once belonged and are still proud to belong—an institution such as Dalhousie in whose triumphs we share and in whose future we believe and hope.

Dalhousie's Refresher Courses accomplish all that—and in no small degree. The lectures and demonstrations in medicine, surgery and obstetrics have given results, and will continue to give results. Those responsible are to be highly commended upon the way they have organized the courses and it is gratifying to note that all have met with a magnificient response.

"Where there is no vision, the people perish"—Where there is no effort, no mental concentration, there is no art, no progress. If Louis Pasteur had not incessantly labored in his laboratory, we would not have bacteriology, or his great discoveries. If Edward Jenner had whistled away his time, the world would be without vaccination. The noble vision of those who founded the Refresher Courses is easily seen in the results obtained each year. We all want to be 'polished' up each year upon the many intricate problems of medicine, upon the numerous advances made in surgery and obstetrics. This alone is sufficient to warrant the existence and permanency of the Courses.

"Where there is no vision the people perish"—where, in other words no efforts are made to promote good health-laws governing the conservation

of health, the people perish. "As you sow, so shall you reap." Crime will not abound in a locality where the laws are rigidly enforced. Disease will not thrive in a community where the laws of cleanliness and sanitation are properly observed. Give the human body as much attention as you do the vines you start and you will find that the grapes of health will ever cluster around the trellis of the home. Sowing the seed of neglect and ignorance cannot help but produce a harvest of disease and poverty. The seeds of cleanliness properly sown and nurtured will produce in abundance the fruits of health and strength, a priceless heritage to be handed down to our children. We must sow therefore that disease may not prosper but health and longevity be produced for there in lies the secret of happiness, peace and the progress of the nation. And here lies the ultimate aims of the directors of the Refresher Courses.

One of our recent graduates has written in asking for a locums for the month of June. Anyone requiring a locums for that month will kindly communicate with the Secretary.

My Books

(By Francis Bennoch)

I love my books as drinkers love their wine;
The more I drink the more they seem divine;
With joy elate my soul in love runs o'er,
And each fresh draught is sweeter than before.
Books bring me friends where'er on earth I be—
Solace of solitude,—bonds of society!

I love my books! they are companions dear,
Sterling in worth, in friendship most sincere;
Here talk I with the wise in ages gone;
And with the nobly gifted of our own.
If love, joy, laughter, sorrow please my mind,
Love, joy, grief, laughter, in my books I find.

—*Liverpool Advance.*

Historical Section

History of the Early Medical Men of Yarmouth and Conditions in the Early Days.

C. A. WEBSTER, M. D., Yarmouth, N. S.

THE Spanish were the first Europeans who really settled in America after its rediscovery by Columbus. They occupied the tropical parts of North and South America and the West Indian Islands. This would be in the 1500's. In the 1600's the English occupied the Eastern Atlantic Border of North America from Florida to Maine, while the French at the same time, occupied the Maritime Provinces, and the St. Lawrence River.

The Spanish have priority in the settlement, while between the English and French there is no difference as to which has a prior right, for neither has. The claims of sovereignty to the land, and attempts by the different nations to place settlers in America led to almost constant war between Spain, England and France.

It is shown that in 1508 the French were engaged in fishing on the Grand Banks and the English in 1527, frequenting Newfoundland and Nova Scotian Harbors. Murdock Chisolm's History of Nova Scotia mentions that in 1583, 56 fishing vessels of different nations were lying at anchor in St. John's Harbor in Newfoundland at one time; and in 1605 Savalotte had made 42 voyages fishing, with Canso as his headquarters.

In the 1600's and 1700's, New England fishermen were accustomed to using the vicinity of Yarmouth and Chebogue and the Tusket Islands for fishing and there preparing the fish during the summer seasons, but they made no settlements and none brought their families.

The vessels of these fishermen who evidently also traded in furs were often seized by the French who claimed exclusive rights to fish and furs, even at times when France and England were not at war.

After 1755 when the Acadians were deported, the New Englanders induced many of their people to settle in Nova Scotia and gave them large grants of land.

At that time, the County of Yarmouth had not been set off, but the whole district was called the Town or Township of Yarmouth. Most of the newcomers settled at Jebogue, and the first road was built there and called the Main Road of Yarmouth, and a point on the river was called Town Point. The first church was also built there, and the first burying ground laid off.

The present Town of Yarmouth was called Cape Force or Forcu.

The best account of the settlement of Yarmouth Township is that given by the Rev. Jonathan Scott as he gives it in the "Church Records of Jebogue." It is as follows:—

> "The Town of Yarmouth was inhabited by a few French families before the English inhabited it. These French families settled and lived on the River called Jebogue or Tibogue as it is called by some. Their improvements were on and about the Hill in Jebogue: the whole of their improved land, both tillage and pasture, exclusive of the Marsh, did not exceed 100 acres. The rest of the land was a wild uncultivated wilderness."

"The English came in 1761, only three families. One family settled at Cape Forcu and two families at Jebogue. Soon after came another vessel, which brought a number of families to settle most of which set down at Jebogue."

"Some of these families that came in the last vessel returned back in a few years after they came."

The Rev. Jonathan Scott came to Yarmouth in 1764 and was able to give a true picture of conditions when the English first settled here. He was granted land on the eastern side of the Jebogue River and his house stood on the west side of the road leading to Pinkney's Point, somewhat north of the Kinney Farm, where Nathan Andrews lives at present, (in what is now called Melbourne).

Mr. Scott was a voluminous writer and besides the Church Records, kept a diary of current events, which is very interesting and perhaps our only source of the early history of the Township of Yarmouth.

The settlers seemed to have attended to the needs of their souls long before they did to the needs of their bodies. Within two or three years after occupying the country, various ministers and preachers were attending to their religious welfare, but there is no account of there being any medical aid in the community for a good many years.

Scott mentions many cases of illness and death, but in none of these is there any word of a medical man attending any of the sick. His short description of some of the cases shows plainly what the trouble was, especially so in some cases of insanity, of which there seem to have been an unusual number and mostly with women. Homesickness, new surroundings, loneliness, anxiety and privation are always factors tending to affect the nervous and mental condition. Add to this the stern old type of religion with public confession of sins and the dread of hell fire, and you have many factors leading to insanity.

Apparently this state of having no medical aid continued for 13 years when Mrs. Scott put her jaw out of joint. Mr. Scott gives an account of it in his "Diary" and I give it to you in his own language.

> "1774 June 26—This evening as we were about to go to bed, dear Mrs. Scott put her jaw out of joint by gaping and could by no means get it in place again. She had such fear and pain that she could rest but little. Her jaw was extended downwards and she could not get her teeth together, and it was twisted aside also, so that she could not bring her jaws and teeth to range with each other; nor could she speak plain, or take any food that wanted chewing, and the pain was tedious to bear.
>
> June 27—I went early this morning and brought up Mr Josiah Beals to help Mrs. Scott, but all his endeavors to set her jaw were in vain. I sent then to Mrs. Durkee, and she came immediately but could do nothing for her relief, and she spoke very discouraging.
>
> June 28—It does not appear that I can get any help for Mrs. Scott in this place and therefore I went this day and hired Mr. Joshua Trefry to carry me to Halifax in his vessel.
>
> June 30—Yesterday and today I have been preparing to go to Halifax. We had the assistance of a number of our neighbours and friends preparing to get ready for the journey. Capt. Barnes readily lent me ten dollars to bear my expenses, which I took very kind.

July 4 at 10 o'clock—The wind being favourable we leave Yarmouth and put to sea for Halifax, Mrs. Scott and I having breakfasted at Esq. Crawley's. Dear Mrs. Scott is very seasick although the weather is pleasant. I am so well myself that I am able to take care of her and myself too. In the evening I have no place to lay down except the hold of the vessel.

July 8 at 3 o'clock—We arrive safe at Halifax. Esq. Crawley, Mrs. Scott and myself go ashore, and by the direction of Deacon Fillis of Halifax, Mrs. Scott and I got lodgings at Mrs. McClure's. Esq. Crawley and I go to Dr. Hill and acquaint him with Mrs. Scott's case, and he comes to see her and brings Dr. Fletcher with him, but nothing is done for her.

July 9—Prayed and breakfasted in the family, and then sent for Doctors Hill and Fletcher who came at 11 o'clock who after about a quarter of an hours trial, they put Mrs. Scott's jaw in its place.

July 15—Doctor Hill visits me today and demands six dollars for setting Mrs. Scott's jaw."

This woman's jaw was out of joint for 13 days and the nearest medical aid was over 200 miles away. To-day we can hardly imagine people living for thirteen years and not arranging for medical care in illness, and yet we find that this state of affairs continued for 22 years or until 1783. It would be interesting to know if the Dr. Fletcher here mentioned, could have been the Army Doctor, Richard Fletcher, who came to Yarmouth in 1809.

This brings us up to the time of the American Revolution of 1775. After that came the settlement of the Loyalists at Shelburne in 1783. These Loyalists included the official class of the American Colonies who occupied the various civil positions before the Revolution. Many army officers were included among the 16,000 people who settled in Shelburne, and among them was an army doctor named Joseph N. Bond. In a few years many of these Loyalists, finding conditions at Shelburne furnished very few opportunities, began to leave for other places.

1. The first doctor to settle in Cape Forcu was Dr. Jesse Rice. He was born in New Hampshire, was a Loyalist who was proscribed and banished. On June 27, 1783, Samuel Sheldon Poole and John Crawley made an application for the escheatment of unimproved and deserted lands. The name of "Jesse Rice, single, a Refugee and a Physician" is an applicant for a grant of land about this time.

On November 21st, 1792, we find the name "Jesse Rice, doctor" as one of a Committee who represent "The People of Cape Forche in Yarmouth" that waited on the Rev. Jonathan Scott for him "to preach with them six months next ensuing and also to settle with them in the work of the Gospel Ministry." Except the above, I can find no other particulars regarding his medical work.

II. In 1787 Dr. Joseph Norman Bond moved to Yarmouth from Shelburne and appears to have been the second doctor to settle in Yarmouth. He was a Surgeon with Cornwallis at the surrender of Yorketown in 1781. He practiced at Yarmouth until his death in 1830, aged 72. Besides his medical duties, he seems to have held all the Government appointments, being Customs officer, Deputy Sheriff, Justice of the Peace, Colonel of Militia, Health Officer and Surveyor of vessels. He was born in England. His brother Stephen was also a doctor, practicing in England and a friend and contemporary of

Dr. Jenner. Dr. Stephen secured some vaccine from Jenner and sent it to his brother Dr. Joseph, who vaccinated in 1786 his son James, then two weeks old, being the first person vaccinated in America. Dr. Joseph Norman Bond had two sons who practiced medicine in Yarmouth later.

III. In 1803 Dr. Henry Greggs Farish came to Yarmouth. He was born in Brooklyn, N. Y. and had been taken to Shelburne in 1785 by his parents. He studied with a Dr. Perry and became a surgeon in the British Navy. He married Sarah, then 16 years old, daughter of Dr. Joseph Norman Bond, thus uniting the two medical families of Yarmouth and becoming a brother-in-law of both Dr. James and of Dr. Joseph Blackburn Bond. I understand he was a large, stern, baldheaded man, a capable practitioner, and very arbitrary. He followed in the footsteps of his father-in-law by acquiring most of the public offices in the community. In Campbell's History it states, that "he was Naval Officer, Collector of Excise, Registrar of Deeds, a Magistrate, Land Commissioner, Judge of the Court of Common Pleas, Customs of the County and Post Master." He had great force of character and demanded that the people should wipe their feet and take off their hats in the presence of the King's representative, even in getting their mail. The customary greeting when one entered the Post Office was, if the hat was not already doffed, a stern gruff command "take off your hat, sir." It is told, however, that the Irish (while they would kneel in the dust to the Pope, would not lift their hats to an English King) raised a rebellion and finally compelled this custom to become obsolete. The "war" had been watched by the town with much interest. Dr. Henry Greggs Farish died in 1856. He had three sons who studied medicine and two of these practiced at Yarmouth.

IV. The next name to appear as a doctor in Yarmouth (the fourth) was that of Dr. Fletcher.

Dr. Richard Fletcher was a surgeon in the British Army. In 1791 he married Mary, the daughter of Col. Ranald MacKinnon of Argyle, Yarmouth County. He retired from the Army in 1796 and settled at Shelburne, where he resided until 1809 when he removed to Yarmouth. He bought a farm at the Dyke, Overton, where he lived until his death in 1818. It was he who discovered in 1810 the so-called Fletcher or Norse stone on his land. This stone with its undeciphered inscription now rests in the Yarmouth Library. Some of his great grandchildren, living in Yarmouth at present, believe that he retired on pension and did not practice his profession after settling here.

V. The fifth practitioner was Dr. James Bond, a son of Dr. Joseph Norman Bond, born in 1786, and the first person vaccinated in America. He began practice in Yarmouth about 1810.

He practiced his profession in Yarmouth until 1839, when he became the first manager of the Bank of Nova Scotia in Yarmouth. He died in 1854.

VI. Another son, and brother of last mentioned was Dr. Joseph Blackburn Bond. He was born in 1802. He studied in London, England and Philadelphia and practiced in Yarmouth from about 1826 until incapacitated by apoplexy some years before his death in 1882. This Dr. Bond is the one best known, and who practiced the longest among the people. As far as I can learn, the Bonds were a pleasant, kindly people, and well liked throughout the community. They were rather small men with brilliant dark eyes which seemed to be a family characteristic. At present the name is practically extinct in Yarmouth.

VII. The seventh doctor was Thomas J. Wilson. In 1832 the cholera was raging in Upper and Lower Canada and the U. S. Atlantic sea-ports, and the following notice appeared in the Yarmouth Telegraph and Shelburne Advertizer, the first newspaper ever published in Yarmouth, viz.—

Provincial Secretary's Office—
Halifax, 17th. April, 1832.

His Excellency the Lieutenant Governor in Council has been pleased to appoint the following Gentlemen to be Health Officers at the undermentioned Ports, viz.—

Halifax, Dr. W. B. Almon.
Liverpool, Dr. A. Webster and Dr. Grieve.
Lunenburg, Dr. Jacobs.
Pictou, Dr. Skinner and Dr. Joseph Chipman.
From Yarmouth including that Port to the Western side of Jebogue Harbor, Dr. H. G. Farish.
Eastern side of Jebogue Harbor, including Tusket and Argyle, Dr. Thomas J. Wilson.
Sydney, Cape Breton, Dr. Thomas I. Jean.

His Excellency has also been pleased to appoint David Watson, Esq., Superintendent of Quarantine at Halifax.

The fee for the Health Officer visiting a vessel carrying a signal of having come from an infected Port or lying at the Quarantine Ground including boat hire £1-10-0.

The efforts of the Health Officers must have been successful, as no case of cholera occurred here.

In the same paper appears the following advertisement,
"Yarmouth, January 5th, 1832.

Mr. Thomas J. Wilson, Surgeon, requests as a particular favour, that all those who are indebted to him, will come forward immediately and pay their accounts."

These two items in an old newspaper are all the particulars I can find regarding Dr. Wilson, although I remember that the old house on the north-east corner of Main and Barnard Streets was always called the Dr. Wilson house.

All the early years of the 1800's, the Bonds and Dr. Henry G. Farish had the practice of medicine in their own hands, a monopoly. It was an ideal arrangement for the doctors, and became known as "the family combine" a little later.

Fortunately for the community these men were men with high ideals, of strict integrity, and well qualified for the work of their profession. The people received good care, and I do not believe they were exploited, as none of the doctors became very wealthy. The Bonds were well liked and popular, but an overbearing and arbitrary manner prevented Dr. Farish being very popular, notwithstanding his ability.

VIII. The eighth doctor, and the first one to break in on "the family combine" was Dr. Frederick Augustus Webster, a son of Dr. Isaac Webster of Kentville. He was born in 1807 and settled at Yarmouth in 1833. He had spent four years in Scotland and was a graduate of the University of Edinburgh, a large powerful man (6 feet, 1 inch), with blue eyes, a somewhat violent

temper and a loud voice. He was well fitted to practice medicine at that time. In spite of strong opposition, by sheer ability and force of character, he was able to establish himself firmly in practice, and secured the confidence of the whole country, which continued until his death in 1879. He had natural mechanical aptitude which was of great use to him as a surgeon, and gave him an advantage over his confreres. The two Bonds and Dr. Henry Farish were not very cordial with the interloper as could be expected, so that Dr. Webster had to play a lone hand, one against three. Soon two more well prepared young doctors appeared on the field, sons of Dr. Henry, and reinforced the "combine", so that it became five to one. It was a strenuous time, but Dr. Webster was in his element and enjoyed the engagements, and I wonder if he did not lose some of the zest of living, when cordial relations were finally established in later years. I think it must have been "that stern joy that warriors feel, in foemen worthy of their steel".

IX. The ninth doctor located in his home town about 1835. He was Greggs Joseph Farish, son of Dr. Henry Greggs, and born in 1809. He died in 1881. He studied at the University of Pennsylvania, and was an M.R.C.S. of London. He became School Inspector and did not practice medicine in his later years.

X. About 1839 another son of Dr. Henry Greggs Farish started practice in his native town. This was Dr. James Collins Farish, born in 1814 and died in 1889. He studied in London and practiced very successfully.

An account of the last three men has already appeared in the N. S. MEDICAL BULLETIN of February, 1927, in a sketch of the "Yarmouth Doctors of the 1870's", so that nothing more needs to be said regarding them. I do not think any new doctors appeared until after 1850. Yarmouth was unusually fortunate in its early medical men. The breath of scandal never sullied their names, their integrity was never impeached, and they did not grind the faces of the poor. They were gentlemen by birth and education and upheld the best traditions of culture in a new raw land.

I give their names in chronological order below.

1—Jesse Rice.......................................1783
2—Joseph Norman Bond.......................................1787
3—Henry Greggs Farish.......................................1803
4—Richard Fletcher.......................................1809
5—James Bond.......................................1810
6—Joseph Blackburn Bond.......................................1826
7—Thomas J. Wilson.......................................1832
8—Frederick Augustus Webster.......................................1833
9—Greggs Joseph Farish.......................................1835
10—James Collins Farish.......................................1839

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and the Secretaries of Local Societies

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

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IT must be particularly gratifying to the Editorial Board of the BULLETIN to see the response made by the Branch Societies (in the publication of Articles and Case Histories) for the various numbers they have sponsored. The Western Nova Scotia Medical Society wishes to congratulate these Branches on their fine efforts.

The writer would like to particularly call the attention of the members to the very fine contribution made to Historical Medicine in our Province by Dr. C. A. Webster's Article, "History of Early Medical Men in Yarmouth," appearing in this Edition. As a member of the Society's Historical Medicine Committee, we feel this work deserves special praise. Dr. Webster's efforts took him far afield. His search through the early records of the Parish of Jeboque, dated back to 1765, and brought to light the interesting fact that one Dr. Jesse Rice practised in the Village of Cape Forchu (Yarmouth) and his name as such is inscribed in a call sent forth for a local clergyman in 1783.

We feel not only the medical history of our Province profits by such a contribution but the Provincial Archives are definitely enriched. By such painstaking efforts grains of gold are garnered from the sand.

T. A. L.

American College of Surgeons to Visit Maritimes

Fellowship Pledge

RECCGNIZING that the American College of Surgeons seeks to develop, exemplify, and enforce the highest traditions of our calling, I hereby pledge myself, as a condition of Fellowship in the College, to live in strict accordance with all its principles, declarations, and regulations. * * In particular, I pledge myself to pursue the practice of surgery with thorough self-restraint and to place the welfare of my patients above all else; to advance constantly in knowledge by the study of surgical literature, the instruction of eminent teachers, interchange of opinion among associates, and attendance on the important societies and clinics; to regard scrupulously the interests of my professional brothers and seek their counsel when in doubt of my own judgment; to render willing help to my colleagues and to give freely my services to the needy. * * Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking, and commercialism as disgraceful to our profession; to refuse utterly all money trades with consultants, practitioners or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation. * * Finally, I pledge myself to co-operate in advancing and extending, by every lawful means within my power, the influence of the American College of Surgeons.

WITH pleasure the BULLETIN and the Fellows of the American College in the Maritimes announce to the doctors of this province, and our brethren of New Brunswick and Prince Edward Island, that the sectional meeting of the College, scheduled for this year, will be held in Halifax during the two days of May 20th and 21st. The event is outstanding in many ways.

Since the time of the old Maritime Medical Association, whose passing many regret to this day, the sectional meeting of the College is the one medium through which the members of our profession, from every part of these three provinces by the sea, can meet in professional and social fraternity. While the Fellows are primarily concerned in these meetings the whole profession are invited, and they are extended every privilege and courtesy the College can command. So that virtually it is a get-together of all doctors, whether they are Fellows or not; and not only doctors, but hospital superintendents, public health officials, and prominent men and women both in Church and State, whose work enters, even indirectly, the sphere of curing and preventing disease.

The American College of Surgeons is in many ways the greatest surgical organization in the world. In its inception, it formulated the principle that scholarship and great erudition in the science and art of surgery were not enough. The hospital was the surgeon's workshop, and unless the equipment there, both human and material, was up to at least a minimum standard the best surgeon on earth would meet tragic failure where success should have been attained. And the principle covered more than the hospitals. It postulated that every agent, or agency, that contacts directly or indirectly with the surgical management of any patient comes within the College's sphere to examine into and to use means to insure that not a single link in the whole chain will fail to hold the strain. And so the College went out to standardize hospitals and organize surgical staffs so that surgeons could jointly look failure, as well as success, squarely in the eyes; if there were error there, to meet it bravely and frankly; to pluck it out, if possible, so that next time it would not be present.

How the College accomplished this huge programme is too long a story for this time. Enough to say the work was done, and done well; and the world of surgery and humanity itself know where the sprig of laurel should be pinned.

The College, while originating in the United States, knows no national boundaries. Canadian doctors have filled, in turn, the president's chair, as well as other important posts in the administrative and executive departments. The head of the great hospital organization was selected from the Canadian profession. The hospital world, almost everywhere, knows the resourceful, dynamic M. T. McEachern. He has carried the gospel of hospital standardization even to the Antipodes, and under the banner of the College, set up in Australia and New Zealand, the improved machinery for promoting hospital efficiency.

The Fellows of the College hail from all parts of this Continent, South America, Europe, South Africa, New Zealand and Australia. It is, therefore, a great scientific league of doctors and all persons interested in the cure and prevention of disease, extending around the world; moulded to a common purpose, active, aggressive, modern and undaunted.

This, very briefly, of course, is the organization that will be our guests in Halifax on May 20th and 21st. The College is sending some of its most noted men, and they come to work rather than to play. Those two days will be filled with various activities. We are setting forth the programme which owing to this rather early date may be tentative in part. The Halifax Fellows have formed themselves into a Board of Management, under the

chairmanship of Dr. John G. MacDougall. Besides, a number of sub-committees are being set up to deal with certain sections of the preparations.

We cordially solicit the co-operation of all Maritime Fellows. We hope they will attend, and we express the same wish with regard to members of the profession in general. They are all invited and welcome to partake of the good things in store for us all. A strong entertainment committee will look after the social requirements of the meeting. A large number of ladies will be present.

ANNOUNCEMENT

A general outline of the program is as follows:

Thursday, May 20

8.00– 9.00 Registration and general information for Fellows of the College, hospital representatives, and guests.

8.30–12.00 Operative and non-operative clinics at local hospitals, surgery and the surgical specialties.

10.00–12.00 Hospital conference.

12.30– 2.00 Medical motion pictures:
1. General surgery.
2. Eye, ear, nose and throat surgery.

2.00– 4.30 Hospital conference.

4.30– 5.00 Annual meeting, Fellows of the College.

7.00– 8.00 Medical motion pictures.

8.00–10.00 Scientific meeting, general surgery.

8.00–10.00 Scientific meeting, eye, ear, nose and throat surgery.

8.00–10.00 Hospital round table conference.

Friday, May 21

8.00– 9.00 Registration and general information for Fellows of the College, hospital representatives, and guests.

8.30–12.00 Special clinics:
(a) Cancer.
(b) Fracture.
(c) Eye, ear, nose and throat.

9.30–12.00 Hospital conference, panel round table.

12.30– 2.00 Medical motion pictures:
1. General surgery.
2. Eye, ear, nose and throat surgery.

2.00– 5.00 Scientific meeting, general surgery.

2.00– 5.00 Scientific meeting, eye, ear, nose and throat surgery.

2.00– 5.00 Hospital conference, demonstrations.

7.00–10.00 Medical motion pictures.

8.00–10.00 Community Health Meeting.

This meeting will be of interest not only to Fellows of the College but to the medical profession at large, and in addition, hospital trustees, superin-

tendents, nurses, and other hospital departmental personnel are invited to attend the hospital conference.

There will be no registration fee.

Tentative List of Speakers Who Will Participate in the Sessions at the Halifax Sectional Meeting.

Alfred W. Adson, M.D., Rochester, Minnesota; Professor in Neurosurgery, Mayo Foundation Graduate School, University of Minnesota.

Arthur W. Allen, M.D., Boston; Instructor in Surgery, Medical School of Harvard University.

Frederic W. Bancroft, M.D., New York City; Associate Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons.

George Crile, M.D., Cleveland; Chairman, Board of Regents, American College of Surgeons; Director, Cleveland Clinic Foundation.

William J. Engel, M.D., Cleveland; Surgeon, Cleveland Clinic Hospital.

Frank H. Lahey, M.D., Boston; Director, Lahey Clinic.

Montreal; Clinical Professor of Surgery, Department of Urology, McGill University Faculty of Medicine.

John Fraser, M.D., Montreal; Professor of Gynecology, McGill University Faculty of Medicine.

New Orleans; Professor and Director of Surgery, Tulane University of Louisiana School of Medicine.

Bowman C. Crowell, M.D., Chicago; Associate Director, American College of Surgeons.

Malcolm T. MacEachern, M.D., Chicago; Associate Director, American College of Surgeons.

CASE REPORTS

Encephalitis Lethargica, Simulating Leaking Cerebral Aneurysm.

Mrs. G. H., age 48, first seen evening of February 8th, 1937.

Past History—Has had no previous illness except ordinary diseases of childhood, and recurring attacks of "Rheumatism" (back, hips and spine). Has had eight children. All at present alive and well.

Family History—Father and mother both dead—apoplexy—(65-72). One brother A. & W. One dead (cause unknown). One sister dead (Malignancy).

Present illness—Arrived in Yarmouth 5 P.M., apparently perfectly fit. On her way to the (8:30) Cinema was taken suddenly ill with severe, lacerating pain back of head (Occiput). Fell down on the street. Carried home. Vomiting constantly. Seen by me on her arrival home. Vomiting was projectile, pain very intense. Following relief from pain, had her transferred to hospital. She was semi-conscious on admission with decided Cerebral irritation.

On examination—General appearance—is a very fat, middle aged female, weight 270 pounds. Temperature 99. Pulse rate 40 (very irregular and intermittent). Has normal movements of hands and feet. Later, when consciousness returned, was dull and apathetic between bouts of pain.

Head and Neck—Scalp negative. Ears—canals, drums negative. Hearing normal. Nose—negative. Mouth—upper and lower dentures. Eyes—photophobia—pupils small and contracted. No A. R. Dilated for opthalmoscopic reading, veins tortuous and dilated, edges of discs blurred and indistinct, eyegrounds otherwise normal.

Neck—No palpable glands or enlargement.

Throat—Tonsils normal.

Respiratory System—Chest movements uniform both sides. No increased areas of dullness. B. S. diminished left base—few scattered rales heard left base. Otherwise normal.

Cardio Vascular System—Heart, apex beat 5th space—9 cm. from m.s.l. No increase in A. C. D. Heart sounds very slow and weak. Rhythm irregular. Rate 40. B. P. S. 220/110. Palpable arteries not noticeably sclerosed.

Abdomen—No tenderness, no masses, no rigidity. All quadrants negative. Large areas of subcutaneous fat.

C. N. System—Cranial nerves apparently normal except 4th and 6th. Sensations and motor functions normal. Pateller reflexes on right side absent; increased on the opposite side. Co-ordination good. Abdominal absent. Babinski negative. Extensor and plantar reflexes absent both sides.

Extremities—No itching nor tenderness. Pain elicited on moving right leg at hip. A and P movements of the spine extremely painful. Forced flexion of chin on chest, or rotation of neck elicits acute pain.

Genitalia—Cervix normal. Adnexae normal; slight vaginal discharge.

Rectal—Normal, except for few scattered internal hemorrhoids.

Urinalysis—Color amber. Sp. Gravity 1020. Sugar plus. Albumen plus. Microscopic examination negative.

Spinal Fluid—Markedly increased pressure. Straw coloured fluid; negative. Blood cells present. Smears show slight excess of cells mainly mononuclear.

Blood examination—Hemoglobin 85%. R. B. C. 4,800,000 W. B. C. 8500. Kahn negative.

Progress—During first twenty-four hours in hospital patient had several severe gastric hemorrhages. This continued for twenty-four hours. Bleeding from bowel followed for three subsequent days. Temperature, on third day, 101. Pulse rate 90. Some paralysis developed of fourth cranial nerve (right eye). On eighth day in hospital developed paralysis of sixth cranial nerve (right eye). No further Hematemesis nor bleeding from bowel.

Opinion—For the first week (following the acute onset) considered this to be a case of Sub-arachnoid hemorrhage from a leaking Cerebral Aneurysm. Its sudden dramatic onset of "Oh my head," followed by unconsciousness confirmed later by blood stained spinal fluid, urine with transitory sugar and albumen, hypertension, rigidity of neck (this last symptom being due to irritation of the posterior roots of the cervical region by the extravasated blood) made it appear like a leaking Cerebral Aneurysm.

However, after three days the following changes developed—localized right sided paralysis of fourth and sixth cranial nerves, rising temperature, increasing somnolence, incontinence of urine and foeces, patient could be roused for nourishment and responded to requests rationally although speech slurry and monotonous. Briefly then, in view of the presence of asthenia, lethargy and cranial nerve paralysis, the clinical picture had become one of Encephalitis Lethargica, with an unusual mode of onset and vague, indefinite prodromal symptomotology.

March 8th—Four weeks since onset, patient still in hospital; fourth and sixth nerve paralysis present but much improved. Period of drowsiness less pronounced. Speech improving. Blood pressure normal. Urinary findings normal. Temperature and pulse rate normal. Patient decidedly improved.

THOMAS A. LEBBETTER, M.D.
Yarmouth, N. S.

Pyelitis in Infancy.

Yarmouth Hospital, No. 20093. Admitted: Jan. 22, 1937.

F. H. is essentially negative.

C. C. Vomiting.

P. I. Patient male baby born Nov. 13, 1936, delivery uneventful and discharged from hospital with its mother Nov. 26/36, gaining well on breast feedings and apparently with negative physical examination. At age of one month not seeming satisfied with breast, supplementary feedings of lactogen given with resulting satisfactory weekly gain in weight. Baby seemed fine and had no noticeable abnormal symptoms until Jan. 3/37, about three

weeks ago. At this time suddenly taken with severe crying spell, became pale and listless which lasted some hours. Following this, baby became fussy and irritable, feverish by spells, gradually lost desire for food, bowels became loose and greenish in type. This followed by vomiting, loss of weight, increased crying until vomiting became practically projectile in type. There were no other symptoms except during past week at times a whitish to yellowish discharge was noticed from penis and urine stained diapers a deep yellow. Because of rapid down hill course baby removed to hospital.

P. E. Baby of 9 weeks pale and very thin, crying constantly markedly dehydrated, and vomiting projectile in type, having been fed with breast an hour before admission. Temp. 99.4 rectally.

There seemed to be some retraction of the neck, but no rigidity and otherwise examination of the Eyes, Ears, Nose, Throat and Neck was negative. Chest—normal. Lungs—normal. Heart normal except very rapid, sounds weak and poor quality.

Abdomen—level and soft. I could find no abnormal masses, elicit no tender areas and palpate no organs. During the examination baby passed a small quantity of soft yellow fecal material. There was no discharge from penis at time of examination. Extremities—negative.

The differential diagnosis appears to me to be

(1) Infection of Kidney.
(2) Pyloric Obstruction.
(3) Meningitis.

The baby only lived about 10 hours after admission, vomiting practically constantly during this time, in spite of all efforts to control this symptom. There was nothing unusual in the type of death, the baby growing weaker and more drowsy and dying. We were however able to get a small specimen of urine before death which showed a very large trace of albumen and was loaded with WBC and many RBC. Not being satisfied with my understanding of this case I obtained an autopsy which revealed a very interesting condition. The stomach and bowels showed no abnormality at all. The kidneys were the site of pathological changes—the right kidney was larger than normal, and showed a marked pyonephrosis which practically destroyed whole kidney and was filled with pus. The ureter in this side showed a congenital stricture about 2 inches below the uretero-pelvic junction; the left kidney was about three times normal size and swollen red on section, although the pelvis appeared normal in size as well as ureter.

Baby apparently died as result of Pyelonephritis and Pyonephrosis.

Although pyelitis in young children is fairly common, pyelitis in new born or very young infants has been sufficiently rare in my practice to warrant reporting this case. It has been stated that pyelitis is most frequently encountered from the third to the eighteenth month of life, a period corresponding closely to the diaper age, the infection often being related to fecal contamination of the external genitalia. In new born infants pyelitis is more frequent in males, but as age advances it becomes more frequent in females; a series reported from the Mayo Clinic showing 14 in males, and 86 in females all under two years of age. Although pyelitis may be secondary to infections in other parts of the body, as the respiratory tract or skin, in primary pyelitis, the usual infecting organism is a member of the colon bacillus group. As to

whether the infection is blood born to the kidney or is ascending in type is still a disputed question with the evidence perhaps pointing more to the latter in these cases of young children.

The history of the disease is briefly a very acute onset, usually accompanied by fever and with absence of any signs pointing to the GU tract. This is followed by pallor, unexplained restlessness and expression of anxiety, later by vomiting and intestinal disturbances. Chills may or may not be present. If present they are very suggestive of kidney infection.

The presence of pus in a catheterized specimen of urine is necessary to establish the diagnosis. The course of the disease may be mild or severe as in the case reported, depending upon the degree of kidney damage, and end fatally, in which cases fever in young infants may be lacking and the severe vomiting, dehydration, weakness and coma predominate the clinical picture.

The interesting factors about the case reported are:

(1) The acute onset in an apparently well baby.
(2) The absence of any symptoms or signs referable to urinary tract until two weeks after onset.
(3) The rapid progress of the disease with severe gastro intestinal disturbances predominating.
(4) The marked pathological changes in the kidneys.
(5) The presence of a congenital stricture of the right ureter which undoubtedly was a factor in the pyonephrosis of the right kidney.

G. VICTOR BURTON, M.D.
Yarmouth, N. S.

Pleurisy with Abdominal Symptoms.

No. 2354, a girl of 8 suddenly complained of severe mid-epigastric pain which, within one hour shifted to the low abdomen bilaterally. Past history was negative except that she had recently recovered from a "Cold". Examination 4 hours after onset of the present illness showed definite low abdominal tenderness which was slightly more marked in the left iliac fossa. There was no rigidity or palpable mass. Temperature and pulse were 101 and 100 respectively. She had vomited once just previous to my arrival. Chest symptoms and signs were conspicuous by their absence.

As I had previously removed an acute appendix from a member of the family in which the symptoms were identical, even to the left sided pain and tenderness, I had the patient hospitalized for observation.

The following morning she was more comfortable with less tenderness and no rigidity. That evening a slight cough appeared and the temperature rose to 103. The next day her abdominal symptoms were entirely normal, the temperature 99 and slight dulness appeared at the left base accompanied by a few sticky rales. An X-Ray taken immediately revealed about $2\frac{1}{2}$ cm. of fluid at the left base.

Convalescence was very brief and uneventful under expectant treatment.

D. F. MACDONALD, M.D.
Yarmouth, N. S.

Missed Ectopic.

No. 356, a young married lady, was examined two weeks after a supposed miscarriage. There had been little or no discomfort and the flowing had almost ceased. The fundus was small and the right tube palpable and slightly tender.

Having four children, she had practiced birth control by the catheter method on six occasions, at least two being septic and the last one nearly fatal. In view of her determination to continue this practice, though she denied its use in this particular instance, I advised that she have an operation to render her sterile.

Several days later I did a curettage and laparotomy. The uterine cavity was small and practically no tissue was removed. The right tube was enlarged at its ampulla to about $2\frac{1}{2}$cm. x 1 cm. This tube was removed and the left tube tied and severed. A normal appendix was removed and a ventral suspension done. Examination of the tube showed the enlargement to be a blood clot containing a small embryo.

The results from this operation have been most gratifying, especially as regards the removal of the fear of pregnancy and the "necessity" of a self induced abortion.

D. F. MACDONALD, M.D.
Yarmouth, N. S.

An Unusual Case of Trigeminal Neuralgia.

Incapaciting Neuralgia of the left side of the face in a male teacher, thirty years old, not every day but strange to say, every other day as regular as the clock. Nothing that I could think of seemed to have any bearing on the trouble. Glasses fitted under a cycloplegic, sinuses all normal, perfect teeth perfectly erupted, no general disease, negative blood, urine and everything else, no tonsils, nothing except the Neuralgia. Had everyone in consultation I could think of and finally in desperation following the old adage "when you are doing nothing appear to be doing the most," I procured a steroscopic X-ray of the whole head. In going over this very carefully the twelve year molar on the left side looked different from the other teeth, no abscess or periodonitis or anything of that nature but just a little different texture in the tooth. More careful and detailed investigation in collaboration with a dentist, showed this tooth which seemed so perfect to contain "Pulp Stones" and on its removal the Neuralgia disappeared. All the other teeth appeared normal but eighteen months later the Neuralgia returned, exactly the same type as before. X-ray revealed that the tooth in front of the one we removed now had "Pulp Stones" and its removal brought immediate relief. Is this condition progressive and my patient eventually going to lose all his teeth? Is the underlying cause systemic or local and is there anything I can do in the line of Therapeutics or Dietetics or anything else to benefit this condition? It was at one time thought pulp stones were always the result of a local irritation but such an explanation in this case certainly does not seem reasonable.

Fish (University of London) and Harris (Cambridge) in 1934 suggested the condition to be connected with sub-scurry. The one considering it to be an

Odontoblastic reaction to lack of Vitamin C, the other that this lack affected the terminal blood vessels of the pulp and the pulp, being without true lymphatic drainage, reacted in this unusual manner.

Dr. J. S. Bagnell writes me that a few years ago he saw a full mouth X-ray of a young girl in her early twenties who had almost perfect teeth except that practically every tooth showed one of these formations. This naturally suggests pushing Vitamin C and a diet heavy with Vitamin C but does it suggest anything else that might be done.

CHAS. K. FULLER, M.D.
Yarmouth, N. S.

THE Staff of the Children's Memorial Hospital, Montreal will repeat the post-graduate course in the Medical and Surgical aspects of the Diseases of Children during the week of September 13th next. The course which was given last year met with unusual success. Many more applications were received than could be accepted. It is expected that this year applications will again far exceed the limited accommodation available. Those desiring to apply for the course are urged to do so without delay.

The registration fee is $15.00. This will include daily lunches at the Hospital for the duration of the course as well as other entertainment including a dinner at the Faculty Club when a prominent speaker will be the guest.

Abstracts from Current Journals

PUBLIC HEALTH

PREVENTIVE MEDICINE, A DEMONSTRATION

In a recent issue of the American Journal of Public Health, under the caption "A Triumph of Preventive Medicine", an editorial page is devoted to the Italian Army organization for the control of preventable diseases during the war in Ethiopia.

The editorial, based on a preliminary report of Professor Aldo Castillani, who was general advisor on sanitation in Eastern Africa, reads in part:

"There were in East Africa some 600,000 Italians, 500,000 soldiers and 100,000 workers. Each base hospital had a bacteriological laboratory. There were 55 ambulatory brigades of sanitation, 4 central laboratories, 12 brigades for disinfection, 6 brigades for sanitation of the soil, and 139 equipments for purifying water. The army was equipped with 20 hospitals and infirmaries along the coast and 8 hospital ships, but those necessarily could not do much for the soldiers in the interior in the way of prevention.

"To take care of the soldiers, there were 2500 physicians, the majority of whom had taken courses at the clinic of tropical diseases at Rome, 385 Red Cross Nurses, 200 religious sisters and 16,000 sanitarians and assistant workers. Considering the difficulties of transportation and the necessity of building roads, even with this large number of workers and the great amount of sanitary material provided, the success of the medical corps seems remarkable. There were 1,241 cases of pernicious malaria, with only 23 fatalities; 453 hospital cases of dysentery, the majority of which were amebic, with only one fatality; 17 cases of recurrent fever, with no deaths; 5 cases of dengue; and 1 case of Smallpox, which ended in recovery. There were no cases of Typhus, Scurvy, Leprosy, Plague or Cholera among the Italians".

In addition to general modern sanitary measures and liberal use of vaccines, each soldier was given three quinine tablets daily and the juice of a lemon every second day. If conditions of former colonial wars had obtained, it is estimated that there would have been upwards of 50,000 cases of disease with a good many thousands of deaths.

This surely is a "triumph" of modern preventive medicine and demonstrates that wars may be won or lost dependent upon good or bad sanitation and preventive measures in army quarters and on the field.

P. S. C.

Too Handsome for Anything.

"My dear friend" said I the other day to a mother who was expressing her anxiety that her son should be as handsome as herself,—"Believe me that if beauty be a fatal gift to women, it is an inconvenience for men. A handsome face is very much against a young gentleman destined for the learned professions. An attorney takes an instinctive dislike to an Adonis of a barrister. What prudent man would like Antinous for his family physician? The envy of our sex (much more jealous than yours) will not acknowledge wisdom unless it has a snub nose. When Apollo came to earth, the highest employment he could obtain was that of a shepherd."—From "*Acadian Recorder*", 1857.

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

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Moore, E. F., Canso.
Monaghan, T. T., Sherbrooke (St. Mary's Mcpy.)

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

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Bissett, E. E., Windsor.
MacLellan, R. A., Rawdon Gold Mines (East Hants Mcpy).
Reid, A. R. Windosr (West Hants Mcpy.)
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Bethune, R. O., Berwick (Mcpy.)
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Morash, R. A., Berwick.

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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 March 1st, to April 1st, 1937.

During the month, 210 tissues were sectioned and examined, which, with 66 tissues from 10 autopsies, makes a total of 276 tissues.

Tumours, simple	23
Tumours, malignant	33
Tumours, suspicious of malignancy	1
Other conditions	153
Tissues from 10 autopsies	66
	—276

Communicable Diseases Reported by the Medical Health Officers for the month of March, 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	Erysipelas	German Measles	TOTAL
Annapolis	..	..	..	28	39	1	1	..	..	..	..	..	..	..	5	..	..	..	74
Antigonish	3	..	..	260	..	..	..	..	1	..	..	..	..	..	..	..	..	..	264
Cape Breton	..	4	..	6	2	6	..	..	17	..	..	..	1	1	26	..	..	..	63
Colchester	9	..	..	229	1	10	..	2	2	..	..	..	2	..	19	..	..	..	274
Cumberland	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	4	5
Digby	..	..	..	13	..	..	..	2	..	..	2	..	..	..	..	..	..	..	17
Guysboro	4	..	..	1	..	..	..	..	2	..	..	..	..	..	..	..	..	..	7
Halifax City	4	4	..	..	2	..	..	..	18	..	1	1	..	..	4	..	..	..	34
Halifax	1	..	..	3	..	..	..	..	..	..	..	..	..	..	5	..	..	..	9
Hants	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Inverness	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Kings	..	1	..	45	..	..	..	..	..	..	1	..	4	..	..	..	..	2	53
Lunenburg	..	..	..	99	..	..	..	..	..	..	..	..	..	..	..	..	..	..	99
Pictou	..	..	..	206	..	..	..	..	2	..	..	..	..	..	..	..	..	..	208
Queens	..	..	..	350	..	..	..	7	..	..	..	..	..	..	..	..	..	..	357
Richmond	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Shelburne	12	..	..	232	..	..	..	1	..	..	..	..	..	..	5	..	..	..	250
Victoria	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Yarmouth	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	3
TOTAL	33	9		1472	44	17	1	12	43	3	4	1	7	1	64			6	1717

Positive cases Tbc. reported by D. M. H. O's. 21.

RETURNS VITAL STATISTICS FOR FEBRUARY, 1937.

County	Births M	Births F	Marriages	Deaths M	Deaths F	Stillbirths
Annapolis	15	17	8	14	17	1
Antigonish	11	14	3	22	8	2
Cape Breton	117	105	92	55	33	12
Colchester	24	26	14	19	16	2
Cumberland	40	41	21	35	23	5
Digby	26	29	7	20	18	3
Guysboro	17	16	9	9	9	3
Halifax	134	111	63	69	48	9
Hants	26	32	11	16	18	5
Inverness	25	24	6	26	20	1
Kings	42	33	9	25	19	0
Lunenburg	40	33	14	38	41	3
Pictou	39	41	20	28	28	9
Queens	12	19	4	6	15	1
Richmond	17	17	8	9	12	0
Shelburne	14	14	5	8	6	0
Victoria	8	9	0	6	8	0
Yarmouth	15	23	15	29	22	4
	622	604	309	434	361	60

OBITUARY

James Fraser Ellis, M.D. Western Univ., London, Ont., 1898.

At Ottawa, March 3rd, 1937, Dr. J. F. Ellis, senior member of the Canadian Pensions Commission, passed away, aged 65 years. Born in Upper Stewiacke, he received his early education in a section that probably turned out more school teachers than any other rural section of Nova Scotia. Pictou Academy prepared him for his professional studies. He graduated after the usual school teaching, from Western University, London, Ontario, in 1898, and at once began practice with his centre at Sherbrooke, where his work extended over a large field. But his many friends, would not permit him to remain out of politics, and in 1894, after but six years of general practice, he was elected to the N. S. Legislature. Re-elected in 1906 and 1911, in 1912 he was elected Speaker of the Assembly, which duties he discharged till 1916, when he went overseas.

He joined No. 9, C.S.H., St. Francis Xavier, Antigonish, and later joined the Dalhousie Unit, and was later M.O. at Bushey Park. Upon his return to Canada he was attached to Camp Hill Hospital, and later became D.S.C.R. Director of Medical Services, succeeding Col. Joseph Hayes. Later he became a member of the Federal Board of Pensions and in 1935 was placed at its head.

Dr. Ellis mingled very freely in the social life of the community, was a member of many clubs and societies and was a most unassuming and agreeable person to meet either officially or socially.

He is survived by his wife and two daughters now resident in Ottawa, and three sisters and two brothers.

Dr. Charles J. Fox died at his home on March 24, 1937. He was born at Bridgetown, Annapolis Co., on February 11, 1851. The family lived here for a number of years but when the boy was fourteen years of age, they moved to Barrington, N. S. After the young son continued his studies at school, he attended the Normal School at Truro when he was sixteen years of age and after a year came back to Barrington where he taught school for a number of years. This profession did not appeal to him very strongly—and he soon manifested a strong desire to enter into the Medical Profession. He then entered Dalhousie University and after having obtained his degree there, entered the University of Pennsylvania where he received his degree in 1876; in that year he came to Pubnico where he practised medicine for nearly sixty-one years.

Dr. Fox's life was one spent in the service of humanity. Entering into the field of medicine over half a century ago, he witnessed the hardships and tribulations which none of us have ever experienced. But the temporal disadvantages were quickly overcome by the wonderful philosophy of life he

always showed in every circumstance into which he was thrown. Only those who came in intimate contact with him know the lofty ideals he possessed. Of Oliver Goldsmith, we are told that "he touched nothing that he did not adorn"—Dr. Fox "touched" medicine and "adorned" it with all the energy of his noble heart. How often would he tell us we should never forget that medical philosophy is essentially and apart from other studies an ethical study and is intimately concerned about the ways by which it seeks to attain its moral aims; and that he who is in the right spirit devotes himself to the practice of medicine seeketh not his own but engages in the service of humanity.

Dr. Fox was twice married and leaves to mourn seven children, two sons and five daughters.

Should Cod Liver Oil Be Flavored?

It is a well-known fact that young infants shy at aromatics. Older patients often tire of flavored medications to the point where the flavoring itself becomes repellant. This is particularly true if the flavoring is of a volatile nature or "repeats" hours after being ingested. Physicians have frequently used the terms "fresh", "natural", "sweet", and "nutlike" in commenting upon the fine flavor of Mead's Cod Liver Oil. They find that most patients prefer an unflavored oil when it is as pure as Mead's.

Physicians who look with disfavor upon self-medication by laymen are interested to know that Mead's is one Cod Liver Oil that is not advertised to the public and that carries no dosage directions on carton, bottle or circular. Mead Johnson & Co. of Canada, Ltd., Belleville, Ont., will be glad to send samples and literature to physicians only.

No Greater Convenience

Any physician who has a bedside extension telephone will agree that it is one of the most convenient features of his home. It not only enables him to answer night calls without leaving his bed, but prevents disturbance of the other members of the household as well.

For a few cents a day you, too, can enjoy the priceless convenience of a bedside telephone. And it will be appreciated not only by yourself, but by everyone in the house. Call our local office for details and rates.

Maritime Telegraph & Telephone Company, Limited

EMMENIN

at the menopause

The value of Emmenin in the treatment of menopausal symptoms has been ably demonstrated by many clinicians. Several papers have been published on this subject and it is particularly interesting to note that the most distressing symptoms of the menopause,—the hot flushes, mental irritability and physical weakness—usually show a gratifying response to Emmenin. The fact that Emmenin is orally-active constitutes a decided advantage where other than oral therapy might cause an unfavourable reaction.

EMMENIN

in dysmenorrhoea

In this condition, where treatment should be continued throughout several intermenstrual periods, convenience of administration assumes considerable importance. As in menopausal symptoms, the oral activity of Emmenin permits a routine that is simple for the patient to follow. In general, treatment of at least three months' duration is necessary to produce a permanent degree of relief.

EMMENIN

in menstrual migraine

There seems to be little doubt that a definite relationship exists between menstrual migraine and ovarian function. Many observers have found that the employment of oestrogenic substances corrects the hormonal imbalance between the pituitary gland and the ovaries, with relief of the symptoms. Maximum response is obtained when Emmenin is taken throughout the whole intermenstrual period, and repeated if necessary.

EMMENIN

LIQUID
and
TABLETS

. . . the orally-active, oestrogenic hormone, is prepared and biologically standardized after the technique of Dr. J. B. Collip and supplied with the approval of the Department of Biochemistry, McGill University.

Emmenin Liquid is available in original 4-oz. bottles — Emmenin Tablets in bottles of 42.

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Biological and Pharmaceutical Chemists
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Personal Interest Notes

Dr. A. R. Reid suffered a severe injury when he fell to the ice during a curling bonspiel at Windsor the first week of April. Dr. Reid was taken to Halifax to the Victoria General Hospital, and has been under the care of his brother since that time. We are very glad that he is making a slow but sure recovery.

Dr. Grace Murray of New Glasgow, a graduate of Dalhousie 1936, is supplying for Dr. J. A. Langille of Pugwash, who has been laid up with an attack of Influenza.

Dr. J. B. March who over twenty-five years ago practised in Berwick and who now resides in North Brookfield, Queens County, was a recent visitor to Berwick.

Dr. Charles S. Morton of Halifax was unanimously elected President of the Halifax South Conservative Association at their annual meeting held April first.

Dr. H. deM. Haslam ("Mont"), Dalhousie '26, accompanied by his wife and their young daughter, Heather, of Concord, New Hampshire, paid a visit to Halifax recently and were the guests of Mr. and Mrs. G. B. Smith, the parents of Mrs. Haslam.

The many friends of Dr. Luther MacKenzie, one of our Nova Scotian physicians who has attained prominence in New York, will be glad to hear that he has made a satisfactory recovery from a recent operation.

We regret very much to learn that Dr. C. A. Donkin of Bridgewater is ill, a patient at the Dawson Memorial Hospital.

Dr. A. F. Miller of Kentville, accompanied by Mrs. Miller, has recently visited New York and other centres for the purpose of studying medical and surgical tuberculosis clinics.

Dr. J. W. MacIntosh of Halifax is paying a short visit to Boston and New York where he plans to visit various medical centres.

Dr. L. R. Meech of North Sydney is visiting New York.

Dr. and Mrs. S. W. Williamson of Yarmouth together with Dr. Jane Heartz Bell of Halifax are away on an extended tour. They plan to sail for Havana, then through the Panama Canal to San Francisco. Following this

they expet to motor through Southern California and will return home via Chicago and New York.

Dr. and Mrs. W. E. Pollett of New Germany spent the Easter holidays at Halifax, the guests of the latter's parents, Mr. and Mrs. G. C. Hatfield.

North Sydney asks for Free Clinics for the Treatment of Venereal Diseases

At the regular meeting of the Canadian Legion held on Monday, March 29th, Dr. L. R. Meech of that town stressed the necessity of having clinics established whereby people suffering from venereal diseases could obtain free treatment. He stressed the need of free clinics to take care of the alarming increase in the incidence of venereal disease at North Sydney. A meeting of the doctors has also been held when the matter was fully discussed, and help from the local authorities requested. A resolution was passed by the Canadian Legion and forwarded to the Minister of Health inviting his co-operation in the work.

Cape Breton Physicians make use of Airplanes in Practise

Recently a tiny patient was brought to Dr. J. S. Munro of North Sydney by plane, and we learn also that Dr. J. F. Macleod of Inverness travelled by plane to Baddeck to visit his father.

Dr. Joseph McKay of the Montreal General Hospital, Radiologist, came to Halifax the second week in March to consult with the Provincial Department of Health in reference to the application of the hospitals and medical men of Cape Breton for a better X-ray service for the Island. He is a son of the late Dr. John Hector McKay, for forty years a practitioner of medicine in Truro. He was accompanied by his wife, nee Miss Muriel Hennessy, also of Truro, who visited her parents while the Doctor was in the Province. After going to Cape Breton Dr. McKay spent a couple of days visiting his mother in Truro. Doctor "Joe" received a cordial greeting from all old friends who met him.

Dr. and Mrs. R. Evatt Mathers of Halifax have returned from a very pleasant visit to New York.

Dr. A. R. Cunningham of Halifax has returned from a visit to New York.

Tribute to the late Dr. C. M. Bayne

Dr. F. R. Davis, Minister of Public Health, in his report to the Legislature this session pays this tribute to the life and work of Dr. C. M. Bayne, formerly of Kentville and later of Sydney:—

> "During the year the Department suffered a distinct loss in the death of Dr. C. M. Bayne, who had been divisional Health Officer for the Eastern division of the Province since 1930.
>
> "In his chosen specialty, Dr. Bayne had few equals, hence it was that his counsel was continuously sought, not only by the many patients who were sent to him, but by his medical associates as well. His death leaves a vacancy difficult to fill and a memory which will, for many years, endure."

NEO-HYDRIOL

Iodised Oil of Poppyseed containing 40% of Iodine

A product of British manufacture.

For X-Ray Visualisation of the bronchi, spinal cord, kidneys, etc.

NEO-HYDRIOL is a preparation of high quality, suitable for the most delicate X-Ray work.

Supplied at moderate prices in bottles each containing 20 *c.c.*

Detailed literature will gladly be sent upon request.

CANADIAN AGENTS:

Laboratory Poulenc Frères

OF CANADA LIMITED—MONTREAL

350 LE MOYNE STREET - MONTREAL

Have You Made Out Your Income Tax?

RETURNS BY MEMBERS OF THE MEDICAL PROFESSION.

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Income Tax Division of the Department of National Revenue in the Annual Income Tax Returns to be filed, the following matters are set out:

INCOME

1. There should be maintained by the Doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

EXPENSES

2. Under the heading of expenses the following accounts should be maintained and records kept available for checking purposes in support of charges made:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income War Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income).

(c) Telephone expenses;

(d) Assistant's fees: The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given this year on or before the 31st March, but on or before the last day of February in each subsequent year on Income Tax Form known as Form T-4, obtainable from the Inspector of Income Tax. (Do not confuse with the individual return of income, Form T. 1, to be filed on or before 30th April in each year);

(e) Rentals paid: The name and address of the owner (preferably) or agent of the rented premises should be furnished. (See j);

(f) Postage and stationery:

(g) Depreciation on medical equipment: The following rates will be allowed provided the total depreciation already charged off has not already extinguished the asset value:—

PROTAMINE ZINC INSULIN

Investigations by Hagedorn and his collaborators in Denmark, and by Scott, Fisher *et al* in the laboratories of the University of Toronto have shown that preparations of Insulin suitably modified by the addition of protamine and a small amount of zinc have a prolonged effect upon being injected subcutaneously. These findings have led to the evolution of a product now designated Protamine Zinc Insulin which has been given intensive clinical trial during the past year.

For a considerable proportion of patients who require the use of Insulin in addition to the regulation of diet which is essential in all cases of diabetes mellitus, use of Protamine Zinc Insulin has proved to be advantageous. In cases where unmodified Insulin provided an inadequate control or required to be administered in several doses daily, Protamine Zinc Insulin makes satisfactory control practicable. Its use is often accompanied by a reduction in total number of units as well as in the number of injections required per diem; and lessening of fluctuations in blood-sugar levels has a gratifying effect upon patients' sense of well-being.

In materia medica, Protamine Zinc Insulin supplements rather than supplants unmodified aqueous solutions of the specific anti-diabetic principle such as have been in common use since 1922. In some instances the use of unmodified Insulin alone is desirable; in others, Protamine Zinc Insulin alone is now indicated; while in others, the use of both preparations gives best results.

Protamine Zinc Insulin (40 units per cc.) is now available in 10-cc. vial packages. Prices and information relating to the product and its use will be supplied gladly upon request.

CONNAUGHT LABORATORIES

University of Toronto

TORONTO 5 - - CANADA

Instruments—Instruments costing $50.00 or under may be taken as an expense and charged off in the year of purchase;

Instruments costing over $50.00 are not to be charged off as an expense in the year of purchase, but are to be capitalized and charged off rateably over the estimated life of the instrument at depreciation rates of 15% to 25%, as may be determined between the practitioner and the Division according to the character of the instrument, but whatever rate is determined upon will be consistently adhered to;

The residual value of instruments not heretofore fully depreciated will be depreciated along with instruments costing over $50.00 purchased subsequently;

Office furniture and fixtures—10% per annum;

Library—The residual value of library not heretofore fully depreciated will continue to be depreciated at 10% per annum for the years 1932, 1933 and 1934 as well as charging off the actual cost of books purchased in those years. After 1934, only the cost of new books will be allowed as a charge.

(h) Depreciation on motor cars on cost;
20%, 1st year; 20%, 2nd year; 20%, 3rd year; 20%, 4th year; 20%, 5th year. The allowance is restricted to the car used in professional practice and does not apply to cars used for personal use.

(i) Automobile expense; (one car): This account will include cost of license, oil, gasoline, grease, insurance, washing, garage charges and repairs;
(Alternative to (h) and (i)—In lieu of all the foregoing expenses, including depreciation, there may be allowed a charge of 8c. a mile for mileage covered in the performance of professional duties).
If Chauffeur is employed for business reasons, so that in the result he is substantially used for business purposes (although incidently used for personal or family use), the expense will be allowed.

(j) Proportional expenses of doctors practising from their residence—

(a) owned by the doctor;

(b) rented by the doctor;

(a) Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, depreciation and interest on mortgage (Name and address of mortgagee to be stated);

(b) Rented premises—The rent only will be apportioned inasmuch as the owner of the premises takes care of all other expenses.

The above allowances will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

Effective Iron Medication!

HEMATINIC PLASTULES

Three Hematinic Plastules Plain provide the average patient with an adequate daily dose of iron (ferrous sulphate) to show a marked increase in hemoglobin.

Hematinic Plastules supply ferrous sulphate and vitamins B_1 and B_2 in an edible oil in the form of a semifluid mass, enclosed in soluble gelatine capsules which quickly dissolve n the stomach.

Two Types—Plain and with Liver Extract.

Send for Samples and Literature.

JOHN WYETH & BROTHER, INC.

WALKERVILLE ONTARIO

MANDELIX

(Elixir of Ammonium Mandelate B.D.H.)

The administration of Mandelix in the treatment of urinary infections presents advantages over treatment with mandelic acid, inasmuch as the latter necessitates the administration of *'two somewhat unpleasant medicaments, one followed closely by the other, four times in the day'* (Lancet, April 4, 1936, p. 769). On the other hand, in cases treated with ammonium mandelate (Mandelix) a second medicament to procure acid urine was unnecessary and, in all the patients so treated, *'a sterile urine was effected in a week or less, though all had a chronic infection...'*

The conclusions reached, according to the above-mentioned report, were that *'...in the light of this short experience, together with what is already known of mandelic acid treatment, we feel justified in saying that ammonium mandelate, suitably prepared, is a convenient means of administering mandelic acid, and that in the majority of cases the use of ammonium chloride can thereby be obviated.'*

Stocks are held by leading druggists throughout the Dominion, and full particulars are obtainable from:

THE BRITISH DRUG HOUSES (CANADA) LTD.

Terminal Warehouse **Toronto 2 Ont.**

Mndx/Can/374

(k) Sundry expenses (not otherwise classified)—

The expenses charged to this account should be capable of analysis and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to the Inspector of Income Tax. (This is provided for in the Act).

The annual dues paid to governing bodies under which authority to practise is issued and membership association fees not exceeding $100.00, to be recorded on the return, will be admitted as a charge.

The cost of attending post-graduate courses or medical conventions will not be allowed.

(l) Carrying charges;

The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(m) Business tax will be allowed as an expense, but Dominion provincial or municipal income tax will not be allowed.

Professional Men Under Salary Contract

(3) The salary of professional men will be taxed without any deduction therefrom except as hereunder provided unless the individual is under contract which requires of him, in order to maintain his contractual position to operate a motor car of his own, in which case if the principal does not pay the upkeep, running expenses and depreciation, the individual will be allowed to reduce the salary by such expenses as the use of the car in the earning of his income may cost, on the same basis as above provided for, i.e. expenses and depreciation or alternatively 10c. a mile for mileage covered in the performance of professional duties.

The annual dues paid to governing bodies under which authority to practise is issued, and membership association fees, not exceeding $100.00 to be recorded on the return, will be admitted.

RESYL "CIBA"

A distinct advance in the treatment of Bronchial Affections

Creosote, although possessing certain very definite therapeutic properties, has disadvantages that interfere materially with its clinical employment. According to Sollmann, the introduction of guaiacol marked an advance, because "Guaiacol constitutes from 60 to 90% of the creosote and shares all its properties, with the advantages of constant composition." Unfortunately, guaiacol, itself, is irritating and possesses a taste that is difficult to mask.

On the other hand, **RESYL "CIBA", the glycero-guaiacol ether** is non-irritant, although having a definite antiseptic action. Resyl is freely soluble in water, and is available in easily-taken tablets for oral use, or in ampoules for intramuscular administration. Of even greater importance is the fact that Resyl "CIBA" is well utilized by the tissues, in marked contrast to potassium guaiacol sulphonate occasionally prescribed, which is excreted in the urine to a large extent unchanged.

TABLETS OF 1½ grs. IN BOTTLES OF 30
(Also in bottles of 500 for self-dispensing doctors and hospital use.)

CIBA COMPANY LIMITED

MONTREAL

Periodic Health Examination

(From The Health League of Canada)

Convinced that thousands of people in Canada are dying of disease which now, for the first time in history, can be prevented, officials of the Health League of Canada today announced that during the coming year their health education program would place special stress on the promotion of periodic health examination.

Claiming that many people are dying through lack of knowledge—dying unnecessarily—the educational director of the Health League of Canada said that by means of widespread dissemination of facts on the value of annual health examinations, it was hoped that many lives would be saved during the coming year.

There is nothing freaky or faddish about an annual health examination. It will not even cost much money. In fact, in the course of a lifetime, it will save patients a great deal of money in doctor's bills and by preventing loss of earning power and averting the expenses incidental to illness.

Health League officials said that the average person's attitude toward sickness and health is all wrong. The greatest physicians and surgeons in the world, they said, are agreed that many diseases have been made preventable through the advance of medical science. Not only can many diseases be prevented they claim, but a great many unhealthy conditions can now be detected in early stages and corrected.

Cancer, heart disease and bright's disease, are just a few of the diseases which, if treated in their early stages offer excellent hope of effecting a permanent cure. In 1935, 11,500 people in Canada died of cancer. A great many of these lives might have been saved by means of periodic health examinations.

Several leading Canadian life insurance companies are actually providing physical examinations free of charge for holders of large policies. Obviously, if this is financially profitable to the insurance companies, it is infinitely more profitable in terms of life itself, to the policyholders, and is a practice which should be adopted by every intelligent person.

Periodic health examinations, Health League officials explained, will in many cases enable a doctor to detect unhealthy conditions before they have a chance to do much damage. As a result of a physical examination, you may have to see a dentist, or modify your diet or take more exercise, or go out into the fresh air more often—but it will be worth it.

On the other hand, a periodic health examination may find you in perfect health, in which case the doctor's assurance to that effect will amply repay you for the trouble you have put yourself to in getting examined.

PHYSICIAN WANTED

The secretary has received two letters from Harcourt, N. B., asking aid in securing a physician to locate there. One of the writers has offered to guarantee an income of $1500.00 a year, provided they secure a suitable person. A Protestant is preferred. Further information may be had from the Rev. C. C. Walls of Harcourt United Church, Harcourt, N. B., or Mr. George E. Little, Councillor, Parish of Harcourt, Clairville, Kent County, N. B.

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E. B. S.

Each fluid ounce represents:

Calcium Glycerophosphate	12 grs.
Sodium Glycerophosphate	8 grs.
Iron Glycerophosphate	2 grs.
Manganese Glycerophosphate	1 gr.
Quinine Glycerophosphate	½ gr.
Strychnine Glycerophosphate	1/16 gr.

and the Digestive Ferments—Pepsin, Pancreatin and Diastase.

DOSE: One to two fluid drachms.

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

FREE FROM SUGAR. Clinical Sample on request.

Prompt Attention to Mail Orders.

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

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

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To Finance Home Improvements

FIRST decide what improvements you wish to make to your home—then get an estimate. Plumbing, heating and electrical contractors; builders, painters, decorators, architects and supply firms all stand ready to help you determine the cost. With your estimates ready, call at any branch of The Royal Bank and discuss your plans with the Manager. Loans to finance home repairs, improvements or extensions can be arranged by anyone of good credit standing, able to repay out of income.

THE ROYAL BANK OF CANADA

OVER 600 BRANCHES IN ALL PARTS OF CANADA

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

"I never want to go to another party!"

"BUT, dear, tell Mother—what *is* the matter?"

"They wouldn't let me play with them. They let me be by myself all the time. They—they *laughed* at me."

What should Mother do? Denounce the other children as ill-raised little barbarians? Prevent further contact with the youngsters who should be the child's playmates, and the neighborhood that should be her happy little world?

Those would be natural and understandable reactions for any mother. But unfortunately, they would tend only to make matters worse.

When a child is "different" or "difficult," the most sensible thing to do is to get the help of your doctor. And the reason is that the underlying cause, while occasionally psychological, is usually *physical*.

For instance, a child can be slow and awkward at childhood games, because anemia is robbing her of energy. A child can appear backward because a glandular disorder is causing sluggishness, because faulty hearing prevents her from catching questions, or because faulty eyesight prevents her from reading correctly. A child can be sulky or ill-tempered, not because it is her nature to be so, but because some physical derangement is *making* her act that way.

The tragedies these disorders heap upon little heads are very real tragedies. But even more serious is their possible influence on the child's future. The "laughed-at" child so often becomes the crushed and morose adolescent. And the morose adolescent frequently becomes an embittered man or woman in an unfriendly world.

If your child's present and future happiness is being threatened, see your doctor You will find him a helpful and understanding friend.

PARKE, DAVIS & COMPANY
WALKERVILLE, ONTARIO

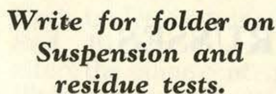
The World's Largest Makers of Pharmaceutical and Biological Products

BARIUM SULPHATE

Mallinckrodt

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

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



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Makers of Fine Medicinal Chemicals

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Dr. COLLECTEM

The Medical Audit Association specializes in the collection of past-due accounts for physicians, dentists and hospitals ONLY.

And, because we do specialize, we collect past-due accounts which could not be converted into cash by any other means. That's what your colleagues have been telling you for years. You will thoroughly appreciate our service, too!

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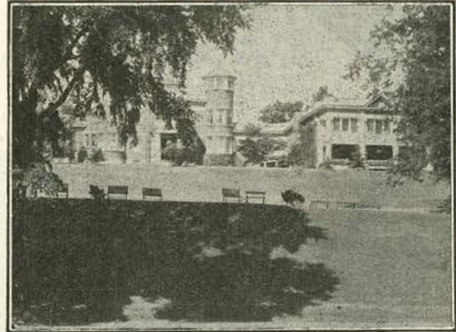

Nervous cases including Hysteria, Neurasthenia and Psychasthenia.

Mild and incipient mental cases.

Selected habit cases will be taken on advice of physician.

For rate and information, write

HARVEY CLARE, M.D.
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The largest stock of SERUMS and VACCINES (Parke, Davis & Co. Shermans and Nicholsons.) East of Montreal—Always at your service

ABDOMINAL BELTS, TRUSSES

For Urinary Infections

MANDELIX and MANDELIX OUTFITS (B.D.H.)
SYRUP ANDELATE (Abbotts)

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HALIFAX BEDFORD SHEET HARBOUR KENTVILLE

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