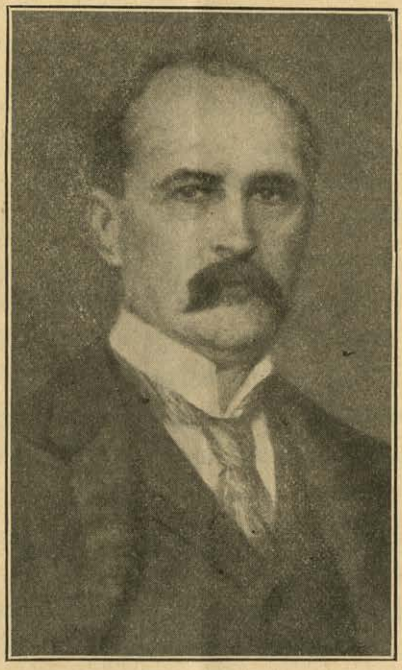
Translation from the Gaelic of the Preface to a Work on Medicine by the Irish Celt in 1345.

MAY the merciful God have mercy on us all. I have here collected practical rules from several works for the honor of God, the benefit of the Irish people, for the instruction of my pupils and for the love of my friends and of my kindred. I have translated them into Gaelic from Latin books containing the lore of the great leeches of Greece and Rome. These are things gentle, sweet, profitable and of little evil, things which have often been tested by us and by our instructors. I pray God to bless those doctors who will use this book; and I lay it on their souls as an injunction, that they extract not sparingly from it; and more especially that they do their duty devotedly in cases where they receive no pay (on account of the poverty of the patients). I implore every doctor that before he begins his treatment, he remember God, the Father of health, to the end that his work may be finished prosperously. Moreover, let him not be in mortal sin, and let him implore the patient to be also free from grievous sin. Let him offer a secret prayer for the sick person and implore the Heavenly Father, the physician and balm-giver of all mankind, to prosper the work he is entering upon.



SIR WILLIAM OSLER.

The General Practitioner and Urological Problems

By Dr. Frank G. Mack, Halifax, N. S.

BECAUSE of the encyclopedic scope of modern medical and surgical knowledge, and because of the high degree of perfection of present day instruments and apparatus of precision, requiring for their satisfactory use much manual dexterity and large experienc, eno one person can be expert in all branches. Specialization, therefore, is inevitable despite much recent outcrying against it. Nevertheless, the general practitioner is invaluable to the community, as at present constituted, and it is difficult to see how he can be dispensed with.

To him, usually, the patient with urinary disorders goes first and it is his duty and privilege to proceed carefully with the investigation of the case so that the condition may not be allowed to progress without every effort being made to establish a definite diagnosis. All too often the patient himself is careless and dilatory, so that vigilance and action on the part of the doctor are urgently called for.

It is necessary for the practitioner to remember the pathological possibilities underlying the symptoms and to understand the diagnostic methods of to-day. Urology is now one of the most exact and highly developed specialties and it is usually impossible for the man in general practice to apply its highly technical methods in their entirety. The occasional cystoscopist is not apt to meet with success and often falls into grievous error. On the other hand the urologist does not claim to be infallible, and does not always find it possible to determine the nature of the disorder in one rather hurried examination, as he is sometimes expected to do. The nervousness of a patient, or the obscuration of landmarks by pathological processes, may make repeated examination necessary. General anaesthesia is not desirable although sometimes necessary, especially in children. I have found the method of caudal anaesthesia, produced by the injection of novocaine solution into the sacral canal, a very valuable aid making possible a painless cystoscopic examination in the presence of severe tuberculous ulceration of the bladder.

The study of the symptoms and history of an intelligent patient and a thorough physical examination, general as well as local, may enable a careful diagnostician to form a fairly accurate opinion as to the nature and site of the disease in many cases. However, the signs and symptoms of widely different conditions may be much alike and may be very misleading. Very frequently the answer to the diagnostic

problem cannot be revealed by the most careful weighing of the ordinary clinical evidence.

All too often the early symptoms are treated lightly by the patient and even by the too optimistic physician. A depressing feature of hospital work is the frequency with which patients give a history of haematuria, or other warning symptoms, occuring months before and treated medicinally. As Bransford Lewis has recently said, "In the presence of haematuria the first duty of the practitioner is one of diagnosis, not of treatment." The bleeding will probably stop spontaneously, whether treated or not, and may not recur for months but the underlying condition of which it is a warning may be steadily advancing.

At the present time a careful history taking and physical examination are but preliminary to a complete urological examination. The cystoscope, the X-ray and the laboratory combine to make a very thorough examination of any urological condition possible. One of these only, or any two of them may give most inadequate and misleading information.

By the use of the cystoscope and allied instruments the bladder and urethra may be carefully inspected, under good illumination, for obstruction, inflammation, ulceration, diverticula, neoplasm, calculous formation and disturbance of innervation of the sphincter, and the ureters may be catheterized. By means of the ureteral catheters the urine from each kidney is obtained separately for chemical, microscopic and bacteriological examination, and the functional activity of the two kidneys is compared by the appearance-time and quantitative output of the dyes, indigo-carmine and phenolsulphonephthalein, after their intravenous injection.

The cystoscope and the ureteral catheters give invaluable information, but, whenever possible, must be supplemented by the use of the X-ray or valuable information will often be missed. Used alone the X-ray may be most misleading as the shadows of phleboliths, calcified glands and even gall stones may be mistaken for those of renal or ureteral calculi. On the other hand certain calculi, especially those of pure uric acid, may cast no shadow. It is customary to carry out the cystoscopic examination as indicated above, and then, leaving the ureteral catheters in place, to have a single X-ray exposure made covering the whole tract and using, if possible, the Potter-Bucky diaphragm. This first film shows the outline of the kidney and the position of the ureteral catheters, which are usually opaque to the rays. Any deviation from the usual position of the catheters as in nephroptosis, and the relationship of shadows to the catheter and, therefore, to the ureter will be shown. A solution opaque to the X-ray, preferably Sodium Iodide, is then injected in suitable quantity into the kidney pelvis through the catheter. Stereoscopic films are made at this stage, which enable one to form a very accurate and vivid impression of the size, shape, position and relations of the renal pelvis and ureter, when these two films are viewed in the stereoscopic viewing box. The

opaque solution frequently flows down into the ureter at this stage, but in order to outline it more certainly the catheters are withdrawn nearly to the bladder and a small amount more of the Sodium Iodide solution is injected and a fourth film is made. This completes the X-ray examination.

A striking example of the necessity for combining the use of the cystoscope and the X-ray is found in a case seen several years ago when pyelography was very little used. A man of about fifty developed some rather dull, aching pain in the left loin and began to pass blood with the urine at times. An ordinary X-ray examination showed a dense shadow which was evidently that of a calculus. The calculus was judged to be near the cortex, probably in one of the calices rather than in the pelvis. A simple cystoscopic examination showed that the bleeding was from the same kidney and that a second, apparently good kidney was present. At operation, because of the apparent position of the stone a pyelotomy was not attempted but an incision was at once made through the cortex of the kidney. At once a large quantity of soft, brain-like malignant papillomatous tissue gushed out. It was at once decided that a nephrectomy was necessary and it was done. With the procedure of to-day a pyelogram would have shown a marked filling defect and distortion of the pelvis, and the surgeon, knowing the true pathology, would have done a nephrectomy and a complete ureterectomy without opening the kidney or ureter and so would, in all probability, have avoided any contamination of the wound with particles of the growth. As it was the patient had a recurrence of the growth with multiple metastases in the bones and died about two years later. The association of calculi with renal neoplasm has been frequently noted.

The methods of the laboratory reveal the presence of pus, blood, casts, and bacteria, determine the specific gravity and sometimes the urea content of the bladder and separate kidney urines. Much of this the general practitioner can do for himself or, lacking time or inclination, may have it done at some laboratory. In the case of a female patient the finding of pus or blood in the urine must be confirmed by a catheter specimen so as to exclude contamination with vaginal secretions. It cannot be too strongly emphasized that even a few pus cells or a few red corpusles are not found in normal urine. Their presence may indicate merely some passing congestion or slight inflammation but all too often they are due to serious organic disease. A too hopeful view of their significance may allow a tuberculosis, a malignant condition, an obstructive lesion or an infectious process to develop beyond the possibility of cure.

The phenolsulphonephthalein test of total excretion for two hours is available to any practitioner who is willing to use it and gives valuable information for diagnosis and prognosis.

The chemical methods of examination of the blood for evidence of retention, especially of urea and creatinine, can only be carried out

in a well equipped laboratory by an expert, but are exceedingly important. For several years they have been in routine use in the Victoria General Hospital in all prostatic cases and in all serious renal cases. By these tests one may form a very accurate idea of the fitness for operation of a prostatic case, other factors being assumed to be satisfactory, may watch an inoperable case become fit for operation under catheter and suprapubic drainage, and in all conditions of severe renal impairment may form a fairly accurate opinion as to the prognosis.

Having thus briefly considered the urological methods of the present it may be well to direct attention to the possibilities of treatment. Occasionally there is some reason to suspect that patients do not receive from their family physicians sufficient assurance of the value of operative procedures. I remember the case of a patient, a woman in a very toxic state from a pyonephrosis of one kidney, shown by the extrusion from the ureter of a wormlike cast of thick pus. Operation was urged, the other kidney having been proved sound. The husband, however, fortified by the advice of a physician who had not even seen the patient refused operation. There seem to be some practitioners who feel that prostatectomy is not worth while, despite the low mortality of the present day two-stage operation and the comfort and health restored to the great majority of patients. This attitude is perhaps partly to be attributed to the experiences of the past. In the past many succumbed to enucleation of the prostate who might have survived if they had received the preliminary care and preparation of to-day. So, also, poor results in cases of nephrectomy might have been avoided to some extent by an earlier perfection of urological methods. To-day a nephrectomy is not justifiable unless the existence of a second kidney capable of sufficient activity is first proven. Otherwise it may happen, as it has in the past, that the better or even the sole kidney will be removed.

In benign hypertrophy of the prostate the prognosis with early operation is very good. The danger lies much more in delay until irreparable impairment of the renal function has taken place than in operation. In malignancy of the prostate operation may occasionally relieve obstruction for a time, in favourable cases, but the implantation of radium and deep X-ray therapy offer some hope of cure. In carcinoma of the bladder operation has usually little chance of success, because of the advanced condition of the disease or its situation at the base of the bladder. Here, again, radium has accomplished much, relieving for a long period in many cases and apparently arresting the disease in some. By the time this appears in print we hope to be able to do much more for these patients in the Victoria General Hospital than in the past, as it is expected that an adequate supply of radium will be available.

In the more benign papillomata of the bladder treatment by the diathermy current applied through the cystoscope is the standard procedure. It enables the patient to continue at his work, and avoids

the danger of wound implantation to which excision is liable. Even quite large growths may be attacked in this way, and, while loath to attempt it by this method, I was able to effect the complete disapperance of a papilloma at least as large as a walnut, by several applications of the current.

Stone in the bladder is dealt with generally by suprapubic cystotomy except in certain centres where the large number of cases enables the surgeon to become expert with the lithotrite. The mere removal of the stone is nearly always insufficient, for there is very commonly some obstruction, due to stricture or enlargement of the prostate, which must be treated as well. Foreign bodies introduced *per urethram* are sometimes found. It was my fortune about a year ago to encounter two cases of hairpin in the bladder. One, recently lost by a young woman, was readily removed by grasping the loop with the cystoscopic forceps. The other, in a girl of six, formed the nucleus of a calculus which had caused much suffering for several months, and I was forced to do a suprapubic cystotomy to remove it.

Unilateral renal tuberculosis demands early operation, which offers good prospect of cure if the condition be regarded as a surgical complication in a tuberculous subject, and the after treatment be directed accordingly. There is here an opportunity for the family physician to outline a regimen and carefully direct the general care of the patient, much as he would in pulmonary tuberculosis. The rapidity with which extensive tuberculous infiltration of the bladder will heal after the removal of the diseased kidney is remarkable. In bilateral renal tuberculosis operation is rarely justifiable except where one kidney is so completely disorganized as to cause severe pain or septic absorption.

In renal tumors early operation may result in cure, where metastases have not already occurred. When the growth is a malignant papilloma of the pelvis it is essential that a complete nephro-ureterectomy be done, to avoid implantation into the wound and the danger of recurrence from fragments implanted in the ureter.

Of those calculi small enough to engage in the ureter the majority will be able to pass through into the bladder, but, in so doing, they may cause much pain and much injury to the ureteral wall. By cystoscopic manipulations, including dilation with bougies and the slitting of a too tight ureteral orifice, their passage may be greatly aided. Those too large to pass should be removed surgically as early as possible.

It would be well for all of us to realize that stricture of the ureter is now a well established clinical entity, the pioneer work of Hunner of Baltimore having been largely corroborated by many eminent urologists. Its causes are numerous, including localization in the ureteral wall of bacteria from distant foci, such as the teeth and tonsils, extension of infection from contiguous structures, tuberculosis, the effects of a previous pyelo-ureteritis, probably often the trauma of calculi. The stricture in turn may predispose to further calculous formation. The

urine may show evidence of infection or may be quite clear or sometimes show a few red corpuscles. The symptoms vary greatly. There may be an unexplained frequency of micturition, a dull aching pain in the loin, sometimes acute and prostrating pain from acute pelvic distension from oedematous blocking at the site of stricture. The diagnosis is not easy. An ordinary ureteral catheter may pass, but one having a wax bulb formed on it will catch or hang at the point of narrowing. The pyelo-ureterogram gives corroborative evidence. In many cases removal of foci of infection and dilatation of the stricture will give complete relief. Others are more resistant. In this connection the profession may be asked to be on the watch for cases of progressive renal impairment and infection with obscure early symptoms in children. Many of these are due to some congenital stricture or valve formation in the urethra leading to progressive dilatation of the ureters and pelves. Pyelitis especially, pyonephrosis, hydronephrosis and stones are found much more frequently in infancy and childhood than has been realized in the past. Even in quite young children the usual urological examination may be carried out, using special instruments, as accurately as in the adult.

In conclusion the general practitioner may be urged to seize the opportunity which is so often his alone, and to see that those urological patients who consult him are thoroughly and promptly investigated, and to direct the after care of the patient with the authority and insight which his intimate relations with the family make possible.

An Irishman was sitting in a station smoking, when a woman came in and sitting beside him remarked: "Sir, if you were a gentleman you would not smoke here." "Mum," he said, "if ye wus a lady, ye'd sit farther away." Pretty soon the woman burst on again: "If you were my husband, I'd give you poison." "Well, Mum," returned the Irishman, as he puffed away at his pipe, "if you wuz me wife, I'd take it."

A Scotchman got a position in a large commercial house in London; a friend meeting him, shortly afterward asked:

"Well, how are you liking England?"

"All right," he replied.

"But how do you like the English?"

"Oh, weel," said the Scot. "I have na' met mony of the English yet. Ye see a' my dealing are wi' the heads o' the departments."

An Enquiry into the Causes of the Zymotic Diseases as they occur in Nova Scotia

SEVERAL years ago a document with the above title was uncovered in an old fyle in the office of the Provincial Secretary and was placed in the hands of the writer. The document is undated, but was evidently written about 1879. The author was the late Dr. J. W. MacDonald, who graduated at Edinburgh in 1861, practised for several years at Londonderry, and afterwards removed to the United States, where, it is said, he became a professor at a medical college. His paper is in the nature of a report upon the sanitary conditions of the province, based upon a personal survey of some thirty-six localities and upon communicated information, collected during the course of a tour, which covered the parts of the province which could be conveniently reached by rail or boat. The tour was made under the auspices of the Nova Scotia Health Society,* and for the purpose of securing data to assist in answering the following questions:

1. Is diphtheria an infectious disease?
2. Can diphtheria arise from bad sanitary conditions such as accumulations of filth?
3. How can its continued prevalence and constant spread be accounted for?
4. What are the causes of typhoid fever as it occurs in this country
5. What means are best calculated to prevent the zymotic diseases?

The interest in Dr. MacDonald's paper centres in the contrast between present day ideas relative to "zymotic" diseases and those which he advanced. He wrote less than half a century ago: "If we accept the germ theory, and everybody does nowadays, we must admit that the germs of disease can be preserved in suitable conditions for weeks or months, and if for months why not for years? If the germs of wheat can remain in a mummy for thousands of years and retain their vitality, who can say that it is impossible for the germs of diphtheria to live a century?" He cites a number of instances in which the germs of diphtheria had seemingly survived in clothing, playthings, etc., for many years and then caused fatal attacks of the disease. In one case, the disease was attributed to handling books which had been in a room with a diphtheria patient twenty years previously. It is likely that Dr. MacDonald's paper was written before the diphtheria bacillus was isolated, so at that time the laboratory was not a factor in the diagnosis

*The writer would greatly appreciate any information about this Society which any readers of the Bulletin may be able to furnish.

of diphtheria, there was no suspicion of carriers as we understand the term, and much stress was laid on the membrane as a diagnostic feature. With our knowledge of the rapidity with which virulence disappears when the germ leaves the body, we are now inclined to attribute infection to association with carriers or persons suffering with an unrecognized mild diphtheria rather than to contact with remotely infected fomites.

A dozen or more outbreaks of diphtheria are discussed which seemed to originate without the exposure of the first victims to infection. These outbreaks are attributed to uncleanliness of the surroundings, especially if bad odours result. A stagnant ditch, slops and waste waters, decomposing fish—to such things are assigned the origin of diphtheria. One of Dr. MacDonald's paragraphs is as follows: "In the county of Lunenburg is a house which stands upon a very dry hill, apparently a most healthy locality. Every member of the family living in this house unexpectedly took diphtheria and four out of five died. There was no conceivable way in which they could have taken the disease by contagion. Through the kitchen wall passed a wooden spout which carried the slops from the sink and allowed them to fall upon several cartloads of mixed straw and moss heaped up against the wall. To this filthy compost the doctors felt convinced the diphtheria owed its origin. Several medical men in large practice have told me that they have frequently found that this method of making a compost produced typhoid and diphtheria."

But our author was evidently not persuaded that filth alone was sufficient to account for infection. "Perhaps the vigorous researches into what is sometimes called microzoums or contagion animatum may ere long make this mystery clear. The history and the characteristics of disease render it very probable that there is a close connection between diseases and these small living organisms which are in the air, the water, the soil and every where around us. * * * May it not be that the diphtheria germ is always in the air but in a harmless state until some filthy spot supplies it with a feeding ground upon which it can further develop and become the potent poison of disease? * * * The germs given off from a person suffering from diphtheria are in course of time oxydised by pure air and rendered harmless but may it not be that the gases arising from a foul drain or heap of filth can supply these germs with new force which restores to them their former deadly power? The day is coming, and is near at hand, when all these questions will be cleared up by the aid of science which, in this and other devious pathways, will lead us as a kindly light amid the encircling gloom". We may feel that "the day" which Dr. MacDonald visioned has come, but science has answered his questions in a way which he did not expect. Further knowledge may lead us to think more as he did, but for the present we must believe that the germ can ordinarily regain lost virulence only in the tissues of the living being, and that the effect of a bad sanitary environment is differently explained.

Dr. MacDonald pleads for the interest of the Legislature, and for

more satisfactory health laws. "The present state of our provincial finances is the only difficulty in the way, but it is a false economy to save a few thousand dollars and lose almost as many thousands of lives, not to speak of an untold amount of disease and suffering which a little judicious outlay may prevent. Even if the funds were raised by taxation, a rate of from 45 to 50 cents on each inhabited house would provide the means to carry out a law which would rid our province of zymotic diseases or at least reduce them to a fraction of their present power".

In discussing typhoid fever, Dr. MacDonald sums up the causation in water contamination and air contamination. As the contamination of water by the discharges of persons suffering from the disease was so generally recognized as a cause, he did not deem it necessary to produce evidence, but he cites several instances in which infection was attributed to the use of water contaminated by the discharges of healthy men or animals. Air contamination might result from effluvia arising from sewers or house drainage or from decomposing animal or vegetable matter. "The decomposition of sawdust in the beds and on the banks of the streams appears to be a fruitful source of typhoid." "The disturbance of chips in an old shipyard has in several instances been followed by typhoid." We, of course have the advantage of a very wonderful half century's addition to human knowledge and have different notions of the cause of typhoid. Such things as the fly, the carrier and ambulant case enter into our philosophy, but the tremendous reduction in the prevalence of typhoid is proof that suspicion of the water supply was fully justified.

Dr. MacDonald referred to several of the earlier advocates of the germ "theory", but makes no mention of Pasteur, Lister or Koch. It may, therefore, be supposed that his paper was written before their work was made known. Our ideas relative to many things have been so revolutionized that one can scarcely realize that so little time has elapsed since Dr. MacDonald made his "enquiry". Surely ours is a marvellous age!

It must not be assumed that the extracts quoted give a fair resume of Dr. MacDonald's paper. It is to be regretted that its length forbids its reproduction in full. Little of its literary charm or evidence of scholarship is revealed in the quotations, nor do they indicate fully its intent—that of creating a practical interest in preventive measures.

A further quotation is given because it contains the opinion of a greatly beloved member of our profession, who is happily still with us, and still carrying on with the energy and enthusiasm characteristic of those who cannot grow old: "Dr. Robinson of Annapolis has observed that in the same family one person may have simple sore throat, the next may have diphtheria in a mild form, and the third may present the malignant type of the disease". Here we have evidence of a realization that the membrane is not a *sine qua non*, and that infection may spread from a mild case.

W. H. HATTIE

Sinus Disease in Daily Practice

Dr. H. W. Schwartz, Halifax, N. S.

(Paper read before Halifax Medical Society)

Ladies and Gentlemen:

I intend speaking to you this evening about purulent disease of the accessory nasal sinuses, one of the most common conditions met with in practice.

In the first place, we will quickly review the anatomy of the parts with which we are concerned. The nostrils are separated from one another by the nasal septum, a structure of which the deformities play so important and far reaching a part in the pathology of the nose. Into each nostril drain three well defined cavities or sinuses, namely, the maxillary antrum, the frontal and sphenoidal and a honeycomb like mass consisting of a varying number of cells—probably 10 to 15—and called the ethmoidal labyrinth.

These wet and dry specimens will freshen your memory pictures of the nasal sinuses, their relative positions, size and shape, and renew your acquaintance with the radiator like nature of the outer wall of the nostril with its turbinate bones designed to provide a large surface area in a small space. The drawings will aid in fixing the picture in our minds, and, I hope, make our talk more easily followed. A reference to them at this point will be in order.

Between the wet and dry preparations and the drawings we now have a picture of the areas under discussion.

Next, we will deal with the Physiology of the nose and the accessory sinuses. The average text book of Physiology never as much as mentions the sinuses and refers only to the nose as an organ of smell. Pleasant and useful as smell is—especially in its relation to the enjoyment of food and thus indirectly as an aid to digestion—yet, in all probability, this is the least important function of a well regulated nose.

The chief purposes are the filtering and the warming and moistening of the air preparatory to its entrance into the lungs. Micro-organisms are practically all filtered off by the time the air reaches the pharynx. Frosty air may enter the nose but the temperature is well up by the time it reaches the larynx. It has been estimated that in 24 hours over a litre of water is supplied by the nose (i. e. the mucous membrane of the nostrils and accessory sinuses) to moisten the air. There are no arrangements in the mouth, pharynx or trachea for the

secretion of any such quantity. This explains the dryness and tendency to catarrh in these regions, and the injury that may result to the bronchi and lungs when the functions of the nose are impaired.

The nasal sinuses empty on inspiration and fill during expiration. By this arrangement cold air never enters the cavities, but that they may play more than the passive role of warm air reservoirs, is certain. The presence in the cavities of ciliated epithelium, of which the chief function in the respiratory passages is to establish a waving sheet of moisture to facilitate the easier absorption of it by the passing air, may mean that they are intended to complete the saturation of the already warmed air. They are further concerned with the growth of the teeth. The size and development of the maxillary sinuses have an intimate relationship of this nature.

The sinuses give the necessary bulk and strength to the framework of the face without adding to its weight. Perhaps the most important function which the air sinuses have in man is that of resonating chambers in relation to speech.

The functions of the nose and its sinuses then may be classed as olfactory, respiratory and vocal; and, in addition, each nostril acts as a drainage way for the lachrymal secretions and as a ventilating shaft to the Eustachian tube.

With this review of the anatomy and physiology we are now in a position to understand the pathology and to appreciate the principle underlying all operative treatment, namely to drain and ventilate.

At this point I will refer to a very common group of symptoms frequently associated with sinus disease, namely, stuffiness and obstruction of the nostrils with or without discharge, a group of symptoms that would make all of us think of adenoids in a child. Adenoids in the adult—that is, giving rise to obstruction—is, I think, very rare. I have on occasion removed adenoids from adults, but not for interference with breathing. Personally I have only operated on one adult for adenoids to provide free breathing. I have had adult patients who had been subjected to more than one operation for adenoids within a year, the physician being unable to conceive of anything except adenoids that could give rise to nasal obstruction.

What then shall we substitute for adenoids when thinking of these symptoms in the adult? A gross septal deformity will explain the great majority of cases of nasal obstruction in adults. A deformity of this kind may be corrected by a sub-mucous resection of the septum.

The septum in relation to sinus diseases will become clearer as we go along. By a purulent sinusitis we will mean an acute or chronic inflammatory condition characterized by the presence of pus and as a rule secondary to, e. g. "a common cold" or influenza.

We may look upon each case of a cold in the head with its sneezing, headache and general feeling of malaise, and watery discharge, which later becomes purulent and finally clears up, as a case of acute sinusitis in a well drained nose.

With this conception, comparable to that of earache due to acute middle ear disease originating in much the same way, we always have, strictly speaking, a mastoiditis. In each instance however, nature, aided possibly by medical treatment, makes a cure, and it is only in the exceptional case that operative treatment is necessary.

As a rule few people consult a physician for an acute cold in the head, which they feel sure will be all better in a day or two, unless it is associated with persistent pain expressed possibly in the form of headache or neuralgia, a condition of affairs arising either from the virulence of the infection or interference with proper drainage or a little of each. The simple type we very seldom see, as home remedies or nature unaided accomplishes a cure.

Suppose a case of what we will classify as of second degree of severity presents itself for relief. What shall we do? Between bed, purging, aspirin or rhinitis tablets, warmth externally and medicated steam inhalations, maybe preceeded by an adrenalin and followed by a mentholated oily spray—relief usually follows. Suppose relief does not follow medical treatment. Here as elsewhere pus under pressure must be given vent. Surgical measures must be resorted to. The antrum of Highmore may have to be explored, the anterior end of the middle turbinate resected, and, if hampered for room to work, the latter may have to be preceeded by a submucous resection of the septum, or even the frontal sinus may have to be opened.

Suppose on the other hand medical treatment has been successful in relieving the immediate distress and a free discharge follows, but, instead of the discharge lessening and ceasing altogether it persists after a fortnight or three weeks, although a tonic and possibly a "coryza" vacine may have been used, are you justified in saying that all will be well when the "warm weather comes" and to advise some watery wash or douche in the meantime? As for douches, they may give a temporary sense of clearness and cleanliness by clearing the nostril of what disagreeable material happens to be there at the monent. They cannot possibly modify the course of the disease in an adjoining cavity, which they cannot enter.

In regard to the fine weather prediction—it will probably be fulfilled in a first offence case. Why do I say that? Because of a common history which goes like this, "I was never troubled very much with colds in the head until several years ago when I had a very severe one with a good deal of headache. I thought I was suffering from a touch of 'flu'. My nose ran for two months. Since then I have had several colds which hung on but seemed to get alright in the summer. The last cold I got seems to hang on the worst yet. During this last summer, you may say, I have never really been free from a head cold."

I am inclined to believe that the mucosa of a cavity, which has been the subject of acute inflammation and is allowed to be bathed in pus for months before it finally recovers, is not in as good condition to deal with subsequent infections, even if they be of a less virulent type.

A sinus defends itself by an increased flow of mucus which entangles the attacking organism and the whole is moved along by the cilia out the ostium into the nostril. Once the mucous defence is broken down the cilia become exposed to the direct action of the toxins. When the activities of the cilia are inhibited—if not paralysed—particularly in a cavity like the antrum with its natural exit near its roof, the pus is retained and only the overflow escapes. It is reasonable to suppose that repeated inflammatory attacks result in increased thickening of the mucosa and that the orifice of a sinus shares in this process and then the lumen becomes narrowed and impeded. So much for the increasing susceptibility of a sinus due to changes within.

The whole may be aggravated by changes from without. The frontal, antrum and anterior ethmoid cells all drain into a gutter like tract called the sinus semilunaris over which lies like a rigid curtain the middle turbinate. In deflections of the septum in this vicinity the parts may become so jammed that in the presence of the swelling, that is part of inflammation, obstruction to drainage results. In acute cases this gives rise to great pain and much distress generally, and, although relieved by medical measures, gives rise to the conditions that make for a delayed recovery, or make for a chronic discharge that is free enough to avoid pain but not free enough to permit of prompt recovery.

It may interest you as to the way a suspected case is investigated. First, of course, comes the patient's own story. Probably the two most common things complained of are, first, catarrh, by which is meant some degree of nasal or post nasal discharge, second, a sense of obstruction. Or, it may be, of an odour either noticed by the patient or by some one else. Or again, it may be dryness and chronic irritation with scabbing in the throat, or, impairing of the voice with coughing up of nasty material—either moist or in the form of crusts—or, perhaps of indigestion or chronic bronchitis. These are about what you would predict in the presence of a nose whose functions are impaired and a purulent discharge running down and drying in the pharynx or about the glottis or passing into the stomach or entering the lower respiratory tract.

More general symptoms such as headache, languor, irritability, loss of memory, inability to concentrate and so forth, are very much what you would expect from the presence of foci of infection within the skull. You may ask, "Why within the skull?" "Would not a focus of infection give somewhat the same general symptoms regardless of its situation, as the distribution of toxins is carried on by the blood stream?" Perhaps they do but may I ask, "Is it common for patients to express themselves in regard to their mental state as, 'feeling so clear in the head,' 'relieved of that sense of depression,' 'as if a load had been removed','' and similar phrases after the removal of a tooth, gall bladder or appendix? I cannot recall a tonsil case to have used such expressions.

Perhaps with some of the complaints mentioned you might have associated sinus disease but never think of its similarity to tuberculosis. A patient who apparently has T. B. as evidenced by an afternoon rise in temperature, night sweats, wasting, and, in spite of the most careful and repeated examination, the finger cannot be placed on the spot nor organism found in the sputum, then the nasal sinuses will bear investigation.

After the history comes palpation. This is of value in relation to the frontal and antrum. Next follows the inspection of the nostrils, which may or may not reveal the presence of pus. After that, transillumination, then exploration, that is, washing through a canula and examining the return for pus, and lastly the X-ray.

The history may be misleading. Palpation may be misinterpreted. Transillumination, x-ray and exploration are all subject to fallacies. So that a diagnosis is made after weighing the evidence, as elsewhere in the body.

The antrum of Highmore is the sinus most commonly subject to purulent disease—probably because gravity plays no part in its normal drainage. Next in order of frequency comes the frontal, then the ethmoid, labyrinth and lastly the rather rare sphenoid.

The antrum may be found diseased at almost any age because this sinus is not only present but well developed at birth. The probability of the others being diseased is not so likely until after puberty.

The cases that have been quoted were selected to illustrate some everyday manifestations of sinus disease, so much so that cases of ethmoid and sphenoid disease have not been mentioned. As few cases of disease are identical, one could go on reading case records which would be both tiresome and without point. Those given at length are quoted because they represent types varying from the very acute to the very chronic and not because of any degree of success that may have followed their treatment, although, here again, I think the impression given is not misleading but gives a fair idea of what is usually accomplished.

(EDITOR'S NOTE: As intimated wet and dry specimens were presented. Also a number of very interesting case histories were reported, illustrating points brought out in the paper which, owing to lack of space, cannot be published.)

The physician had been summoned and found his patient in a more jovial mood than what the telephone call indicated, consequently he turned his eyes inquiringly toward the patient's wife who was standing by. "I don't know what is the matter with him," she volunteered, "but I think he must have got hold of some of that good-natured alcohol."

Three Hemorrhagic Infants

The following cases have two points of interest:

A.—They occurred in my service at the Grace Maternity Hospital all within a year, an abnormally high percentage.

B.—They all responded remarkably to the proper treatment when it was instituted.

Case 1.—Mother primipara, with threatened eclampsia. She was treated by elimination after the Dublin method and never got further than the pre-eclamptic state (epigastric pain, tenderness over liver, flashes of light before eyes, oedema, urine solid with albumin). When the second stage had lasted something over an hour and a half low forceps were applied and the baby extracted (a girl) without much effort. Three days later the baby vomited coffee grounds for the first time. Breast feeding was stopped and boiled water given but vomiting of coffee grounds continued. Melena began to appear in stools. Purpuric spots in skin. Calcium lactate which had been started on first day of vomiting was without effect, and the baby was going rapidly down hill, temp. 102, pale, greyish, dehydrated. On the third day after onset of vomiting when the case looked pretty hopeless 30cc. of mother's blood citrated was injected into longitudinal sinus. Baby vomited coffee grounds twice after transfusion and then stopped. Boiled water retained on day following transfusion. Milk pumped from mother's breast given on second day. Melena cleared up in stools. Baby's color improved, began to lose dehydrated appearance. Four days later baby put to breast and able to suck. Baby steadily improved but purpuric spots took months to clear up. At nine months baby weighed 20 lbs.

Case 2.—Mother multipara, easy normal labor. Boy. Three days following labor baby vomited coffee grounds twice. Was immediately given injection of 30cc. mother's blood into peritoneal cavity and all feeding by mouth stopped. Did not vomit but once after injection, and was put to breast and able to suck on the third day after injection. Left hospital in excellent condition above birth weight.

Case 3—Mother primipara, easy normal labor. Girl. Day following birth baby began to vomit coffee grounds. Following day still vomiting and 60cc. mother's blood injected into peritoneal cavity. This injection had no effect and the day following baby was still vomiting, there were large masses of hemorrhage into the fatty subcutaneous tissues, melena in stools. The next day baby's condition much worse,

temp. 105, nose and gums bleeding, more subcutaneous hemorrhage, more coffee ground vomiting, color ashy-grey. The case looked even more hopeless than No. 1, but it was decided to give more mother's blood intravenously. 35cc. mother's citrated blood injected into longitudinal sinus. Vomiting stopped that night as did nose and gum bleeding. Able to keep boiled water down next day. Day following fed pumped mother's milk. Fourth day thereafter able to suck at mother's breast. Baby began to pick up rapidly and left hospital above birth weight and in good shape.

With all these cases when even water could not be kept down subcutaneous injections of an ounce each of sterile saline were given every three hours into abdominal wall and thighs to make up for the loss of fluids. The babies were well wrapped and surrounded by hot water bottles when the temperature was below 102, but these were removed while the temperature was above that point. The babies were handled as little as possible.

The method of giving the injection was as follows: Twenty-five cc. Record syringe capable of holding 35cc. was used. It was first thoroughly rinsed in a 2% solution of Potassium Citrate in distilled sterile water. Four cc. of the Citrate Solution was then drawn into the syringe and 30-35cc. of the mother's blood drawn into it from the median-basilic vein. The baby's scalp which had been shaved over the anterior fontanille was painted with iodine and the needle pressed fairly in its middle and slightly directed backwards until blood flowed from it. The syringe was then attached and the citrated blood slowly injected.

Mother's blood is compatible with the infant's for some time after birth and tests therefore do not have to be made.

My reason for injecting the blood into the peritoneal cavity in Cases 2 and 3 was that I had read, in the interval between Cases 1 and 2, a paper advertising this method. It worked all right in case 2 but was a complete failure in Case 3 and I would not use it again.

To recapitulate the treatment of this condition:

1. Do not handle baby more than necessary and keep warm, but not too warm.
2. Stop all feeding by mouth and give an ounce of sterile saline every three hours into subcutaneous tissues until vomiting has ceased.
3. Inject 30-35cc. mother's citrated blood into longitudinal sinus.
4. As these babies are weak do not put them at once to breast which they will be unable to suck but give them pumped milk.

It is not essential that the Citrate solution be made up with distilled water; if that is not available, boiled sterile water would do.

The finding of the longitudinal sinus with the needle for transfusion is really extremely easy and not nearly so trying as one would

expect before doing it, however, a needle with a small guard that can be clamped against the scalp when the needle is in the sinus is an advantage since it prevents the point slipping beyond the sinus if the baby moves. To prevent the baby moving have it lying flat on the table with its head slightly over the end and the nurse holding the head firmly with a hand pressed against each side of the face.

H. B. A.

Here are one or two attractive replies to medico-legal questions put during a United States Civil examination for which Los Angeles students sat:—

Q—What is arson?

A—The act of trying to poison a person with arsenic.

Q—What is a morgue?

A—A piece of paper held against property for borrowed money.

Q—What does habeas corpus mean?

A—The red corpuscles in the blood.

Q—If you found a man with a severe cut on the head that was bleeding freely, what would you do?

A—I would put a turnique on his neck.

A Scotch wife nagged and nagged her husband until the poor fellow died. Then she was sorry, very sorry, so she erected a fine stone over his grave on which she had carved the following inscription:

"Rest in peace until I join you."

"Do angels have wings, mummy?"

"Yes, darling."

"Can they fly?"

"Yes, dear."

"Then when is nursie going to fly, 'cause Daddy called her an angel last night?"

"To-morrow, darling."

A colored woman demanded a refund on a pair of hose recently purchased. The floor walker asked:

"Madam, did they not come up to your expectations?"

"Lordy, no," she answered, "Dey hardly come up to my knees."

Infantile Thymic Hyperplasia*

By Norman M. McNeil, M. D.

Instructor in Pediatrics, Jefferson Medical College, Philadelphia.

(Dr. McNeil is a native of Grand Narrows, Cape Breton, and this article is a reprint from *Archives of Pediatrics*, December, 1925).

In view of the fact that Felix Platter first described thymic death in 1614, our present knowledge of thymic hyperplasia, its etiology, pathology and diagnosis, save roentgenologically, is very unsatisfactory, and it is rather with the hope of directing attention to the relative frequency of the condition in the patients of a pediatric clinic, than bringing new light on the subject, that this small series of cases is presented.

The thymus gland, in its normal anterior mediastinal location, is so situated as to cover the base of the heart and great vessels, and to be in intimate anatomic relation with such important nerves as the vagus, phrenic and inferior laryngeal. Its weight in the new-born is about 13 grams. Its caudal extremity reaches the 4th costal cartilage and in its extreme hyperplastic state, it may extend as far as the diaphragm. It is known that it increases in size until puberty, when its average weight approximates 30 grams.

Since the earliest recorded physiological study of the gland by Friedleben, sixty-seven years ago, much has been written on its physiology and experimental pathology by competent investigators. Their findings, however, have been so contradictory as to leave the definite question of its functions in doubt.

It is most probable that it possesses a regulatory or metabolic influence on growth and development, and its inter-relationship with the endocrine system would seem to be borne out by Grotti's observation that thymectomy is followed by thyroid hyperplasia; that it undergoes hyperplasia after thyroidectomy, and that these changes are associated with certain changes in other endocrine structures. It is assumed to influence osseous development through its lymphocytic content. Bloom states that it increases in size in most acute infections, and that, while it is often enlarged in diphtheria, it is atrophied in the course of scarlet fever.

Our concern, however, is chiefly with the fact that thymic hyperplasia, with or without objective symptoms, and in either case

*Read before Philadelphia Pediatric Society, February, 1925.

potentially dangerous to life, is not an uncommon condition in the infant. Peterson and Miller in a recent study of 120 new-born infants, report its incidence from 40 to 50 per cent. Blackfan and Little in a series of 60 infants, with no symptoms referable to the thymus, found a hyperplasia in 48 per cent.

The most constant and striking symptom in thymic hyperplasia is dyspnea, which may be permanent or intermittent. The stridor is more often inspiratory, though it may be expiratory, or both. It may vary in degree from a gurgling, or a crowing sound associated with the respiratory effort, to severe paroxysms of choking which may terminate fatally.

The cause of the dyspnea is variously attributed to the mere mechanical obstruction by the enlarged gland; to its intimate relation with, and pressure upon, the heart, great vessels, and respiratory nerves already referred to; to some abnormal or hyperfunctional activity of the gland, exerting an influence on the respiratory centres; or to a combination of these causes.

In a few cases the enlarged gland may be palpated in the episternal notch. Dulness on percussion, extending beyond one inch to the left of the left sternal line, or one-half inch to the right of the right sternal line, suggests a hyperplasia. Ingenious and complicated methods of outlining the gland by auscultation have been described; the margin of error, however, in these diagnostic procedures is so great, that it is felt too great dependence should not be placed on them, particularly in consideration of the possibly grave consequences of error. The roentgenogram, with competent interpretation, represents our only positive method of diagnosis. Though the technique of interpretation is beyond the scope of this paper, it may be noted in passing that exposures should be made at the end of expiration and that crying and respiratory excursion cause fluctuation in the size of the gland. It may also be mentioned that an anteroposterior thickening of the gland, which may be conceived to occasionally occur, would not necessarily show a widened thymic shadow.

In the differential diagnosis the following conditions must be ruled out: laryngeal spasm, asthma, foreign bodies, enlarged lymph nodes, adenoids, polyps, pertussis, retropharyngeal abscess, injuries to the trachea, edema of the glottis, and defects in the cartilaginous framework of the larynx. Thymic hyperplasia, per se, must not be confused with the disease entity status thymicolymphaticus, in which there is usually a thymic hyperplasia associated with peculiarities of anatomical configuration and a more or less generalized lymphoid hyperplasia.

The following cases, from the out-patient service of Dr. E. E. Graham, do not represent a special study of thymi, but a small group selected from the routine work of the clinic, which are fairly representative in symptomatology and which were brought to the clinic for a variety of symptoms usually attributed to other causes than the

thymus, and which responded promptly to roentgen therapy under the direction of Dr. W. F. Manges.

Case 1. A. C. White male, age two months. Normal labor. Breast fed. Chief complaint—"cold in the head, present since birth." Condition on admission suggested luetic rhinitis. Wassermann negative. Roentgenogram showed "considerable enlargement of thymic shadow, especially on the left."

Case 2. R. McK. Colored male, age one month. Normal labor. Breast fed. Referred from the maternity department because of marked interference with breathiug. Wassermann negative. Roentgenogram showed a "widened thymic shadow."

Case 3. M. deR. White female, age two months. Born following a long, difficult, instrumental delivery. When first seen at two months she was suffering from an extreme degree of dyspnea which made nursing almost impossible. There was a tumor in the right sternomastoid which was presumably the remains of a hematoma. Roentgenogram showed "marked enlargement of both lobes of the thymus and a paralysis of the right diaphragm."

Case 4. I. G. White male, age 10 months. Breast fed. Chief complaint—"cold in head since birth." Condition on examination suggested luetic rhinitis. Wassermann negative. Roentgenogram showed "persistent thymic enlargement."

Case 5. J. E. White male, age one month. Born following a short but difficult instrumental labor. Chief complaint—"a peculiar snoring sound which varied in degree and was so marked at times as to resemble the snoring of an adult."

It may be noted that all the above cases were brought to the clinic because of some respiratory difficulty. Following the roentgenological diagnosis, they were referred to that department for treatment. In each case a marked abatement of the respiratory difficulty was noted following the initial treatment. Subsequent treatments to the numerical total of three to four therapeutic exposures were given at monthly intervals, the number of treatments being gauged by the degree of improvement in symptoms.

It must be noted here that Liss' interesting study showed a spontaneous retrogression of the thymic shadow during the first, and in some cases extending into the second year of life, a fact which would seem to lessen the urgency for treatment. The possibility of a sudden fatal termination in these cases however, particularly in view of the fact that the symptoms increase in severity during the course of respiratory infections, with a consequent added risk to life, leaves little choice in the selection of a therapeutic procedure which not only relieves the gross symptoms, but appears free from danger and unfavorable after-effects.

The recent report by Hardy of a case of fatally terminating bronchopneumonia, and several cases of severe convulsions following radium treatment of thymic hyperplasia make that procedure one to be employed with extreme caution, and by contrast would seem to enhance the value of roentgen therapy.

CONCLUSIONS.

1. Thymic hyherplasia occurs in a large (40 to 50) percentage of new-born infants.

2. It represents a potential danger to life, particularly during the course of acute respiratory infections.

3. Any abnormal respiratory symptom in the new-born, or in early infancy, should suggest a roentgenogram to determine the possible existence of a hyperplastic thymus.

4. Hyperplastic thymi are known to undergo retrogression following therapeutic exposure to the roentgen ray, and without any known unfavorable sequelae.

5. All hyperplastic thymi in infants, whether or not accompanied by symptoms, should be given the benefit of roentgen therapy.

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It was a busy day in the butcher shop. The butcher yelled to the boy who was helping him: "Hurry up, George! Cut off Mrs. Murphy's leg, weigh Mrs. Jones' ribs, wrap up Mrs. Smith's liver and slice Mrs. Small's tongue."

Pastor—"So God has sent you two more little brothers, Dolly."
Dolly—"Yes, and He knows where the money's coming from to keep them, I heard Daddy say so."

On Getting an Eyeful.

Last season's styles appealed to me,
With stockings showing to the knee.
This year there's still more on display,
The *knee plus ultra*, one might say.

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

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

VOL. V. MARCH 1926 No. 3

Fighting Death

AT the annual banquet of the medical students a short time ago, one of the clinical professors at Dalhousie University spoke on the importance of optimism in the treatment of every patient. The doctor must have the most lively faith, hope and perseverance, and he must inspire the patient with the same elements. Together they must "fight Death". In this slogan is not only good advice for the students, but matter, too, which many of us who have been long in harness, might study and practise to our own and the patient's benefit.

"To fight Death" you will say is rhetoric, and not medicine. It is not a phrase heard in the laboratories or the lecture room. Perhaps seldom or never in the clinics; though here is where it belongs. We have been stuffing our students with so many sciences, that when they come to apply them; in other words, when they come to practise medicine, they are liable to forget that human units are not fixed standardized entities like the Ford car, but a strange combination of body and spirit, with almost infinite shadings of characteristics.

If we are to fight Death, then, with even a measure of success, we must train and coax every physical and psychical resource of the patient into an efficient fighting unit. No one questions that our profession was never so effective as at the present time. Hygiene has become a reasonably practical science and is clearing the way for other departments of preventive medicine. The old and the new order have a striking exemplification in the health measures adopted in the building

of the Panama Canal. The canal zone became the graveyard of those who, in the days when the laws of hygiene and sanitation were little known, and their practise ignored, essayed the big undertaking. Our profession virtually built the canal, because it was able to send Gorgas, a very great man, to put into effect modern hygiene and sanitation. He did a marvelous thing. He changed a pestilential tropical country into a health resort.

In the realm of curative medicine, our resources have multiplied enormously. Our numerical strength has kept pace with every scientific advance. Our medical courses have been lengthened so as to cover a big per cent of the students' life outlook. So that we seem to have most of the things at hand with which to "fight Death".

The speaker at the banquet, however, was not thinking of these things. He was thinking of the psychology of the sick room. In his mind were two pictures. One, the faltering, uncertain medical pessimist, whose face is an open book whereon the patient reads his inevitable doom. The other is the serene, deeply hopeful type, which refuses to be downed. He recognizes, as does the former, that things are extremely bad; the evidence of the laboratory, the X-ray and the clinical manifestations are all against him, but the patient has still psychical resources left, and he is going to draw on them from their very depths. He brings earnest hope to his patient, and inspires him with the thought that together they are fighting for victory.

The family physician of a quarter of a century or more back, recognized more than we the importance in the sick room of cheerfulness and hope, as opposed to gloom and doubt. We have heard physicians claim that patients were tided across to their crises in pneumonia as much, or more, by encouragement and psychic urge than by the drugs administered. There are few cases so bad that have no ray of hope. Most of us can quote experiences where we gave a hopeless prognosis, only to find that the patient got well despite our death sentence; either in our own hands or under the care of some irregular, who had as his whole stock in trade, the only thing we lacked, or at least failed to apply. Hope is positive, doubt, negative; and the old philosophers when a choice had to be made, regarded the former as the better mental state.

G. H. M.

Official Notice.

THE attention of the members of the Medical Society of Nova Scotia is called to the fact that the Annual Meeting will this year be held in Halifax, July 7th and 8th. In order that the scientific programme may be completed at an early date, it is essential that the Titles of papers be received by May 1st next.

Papers and case reports should be condensed so as not to occupy more than fifteen minutes so that time will permit of adequate discussion. Members are reminded that there will likely be considerable business discussion at this meeting.

(Sgd.) E. V. Hogan,
President.

Mayor Addresses Physicians.

"A public meeting at the Town Hall, January 28, comprising, among others, about 1,500 physicians of the city, was addressed by Mayor Walker, Dr. Louis I. Harris, Health Commissioner, and Dr. Wendell C. Phillips, President-Elect of the American Medical Association. The addresses concerned the health of the city, its gratuitous medical service through private and allied hospitals, and the proposed national home for aged and incapacitated physicians."

The above refers to New York City. How about such a meeting in the cities and towns of Nova Scotia, say about two weeks after the civic elections. Such a meeting in Halifax would be at least interesting.

Halifax Branch, Medical Society of Nova Scotia

A regular meeting of the Society was held in the Clinic Theatre of the Victoria General Hospital on the evening of January 27th, 1926, at which there were 31 members present.

After the transaction of routine business, the programme arranged for the evening was proceeded with.

Dr. A. G. Nicholas exhibited a specimen in which a linear cut in the oesophagus 11 inches long had been produced by the patient swallowing a piece of bone. The cut was at the level of the cricoid cartilage and an abscess had formed behind it extending into the mediastinum. Dr. Nicholls described a number of causes of laceration of the oesophagus.

Dr. J. G. MacDougall presented an interesting case of extra-pleural Thoracoplasty. The patient, a young woman, had chronic tuberculosis of the right lung with cavitation at the apex and profuse purulent sputum. There were also flares of temperature. Artificial pneumothorax was considered inexpedient. The first stage of the operation was done six weeks ago, the lower six ribs except the twelfth being removed. The second stage was performed two weeks ago, the 5th, 4th, 3rd, 2nd and one inch of the first being removed. The last is particularly necessary in order to ensure apical collapse. The technique of the operation was described in detail. Since operation, there have been no febrile flares and the sputum has greatly lessened being now chiefly mucoid. Convalescence has been uninterrupted so far.

The speaker stressed certain essential conditions viz:—the case must be a chronic one; must be resistant to tuberculous processes; the disease inactive, and the other lung in good condition. X-Rays of this case were demonstrated by Dr. S. R. Johnston.

Dr. K. A. MacKenzie presented two cases of "auricular flutter." The first case, a man aged 68, was admitted to hospital apparently in extremis, with breathlessness, orthopnoea and general avasarca. Pulse 150 and regular. Patient given Tr. Digitalis, dr. 1½, T. I. D. On the fourth day, the pulse dropped to 60, the patient became comfortable, and many of the distressing symptoms disappeared.

Dr. MacKenzie showed several tracings, and explained the difference between flutter and fibrillation. In the latter, the auricles do not contract, whereas in the former, they do contract. The ventricular beats are half the rate of the auricular.

Case 2, a man aged 54 with marked arrhythmia. The condition looked like fibrillation; but tracings showed it to be really "flutter."

Dr. MacKenzie also exhibited a case which after exhaustive examination, has been diagnased as splenic anemia. It was proposed to transfuse the patient and then perform a splenectomy.

Dr. F. G. Mack presented a man aged 37 who on addmission to hospital in April 1924, was suffering from urinary incontinence, headache, and staggering. Knee jerks were exaggerated and pupils reacted feebly. Rhomberg's sign present. The patient gave a history of a chancre two years previously. Wasserman reaction was negative in the blood, but positive in the spinal fluid. Under treatment with diarsenol considerable improvement took place.

The patient returned to the hospital in January 1925, complaining of frequency and urgency, and weakness of the legs. Knee jerks were increased. There was no Rhomberg present. Wasserman as before.

At the present time, the patient has incontinence, stiffness of the legs, sluggish reaction of the eyes to light, exaggerated knee jerks and Babinski in the right foot. The interesting point about this case is, that the chief complaints are referred to the bladder. Dr. Mack pointed out that four tests are essential in the examination of the spinal fluid:—Cell count, globulin, wasserman and colloidol gold. Discussion of the cases was taken part in by Drs. Carney and V. O. Mader.

A regular meeting of the Society was held on the evening of February 10th, 1926 and took the form of a joint medical and dental meeting. Owing to the extremely inclement weather, the attendance was not as large as had been hoped for, there being 23 present.

Dr. W. W. Woodbury gave a scholarly address on "Anomolies of the Teeth and Associated Parts." He first sketched the history of the formation of Dental schools, and then took up the subject of Orthodental methods. He stated that malformed cases once they are corrected usually remain so. They rarely tend to relapse. Teeth retain their position not on account of being solidly set in bone; but as a result of metabolic action, muscular action, circulation, nerve action, etc. Malformation is a sign of poor physical condition.

An interesting series of diagrams was shown illustrating the changes which have taken place in the formation of the teeth and jaws of modern man as compared with the ancient Briton. In the latter, the incisors meet edge to edge, while in the former, they overlap. No contracted palates are found in the ancient skulls, whereas in modern man a very large percentage show contraction.

The so-called "adenoid face" is considered to be due to defect in the mechanism affecting the growth of the whole organism, more fundamental than the mere presence of adenoids. Contributing causes to be considered are defective nutrition, errors in dietary, endocrine deficiency. Heredity is not now regarded as the chief factor in malformations; but we should not be too ready to accept this view.

Dr. J. S. Bagnall then read an interesting paper dealing with "Systemic Infections due to Dental Disease." He divided these into two classes:—1. In which infection gains entrance directly into the system either by the alimentary tract or by the circulation; 2. Where infection is from closed-off areas. The latter are shown by X-Ray only. There may be residential areas enclosed in bone. Also impacted teeth. Caries in the mother has been demonstrated by charts to affect a child's growth. No demonstrable blood change has been found in cases of dental foci. A series of X-Ray pictures should always be taken to definitely determine the presence of trouble about a tooth root. One exposure is not enough, owing to the possibility of error.

All crowned teeth are not to be condemned, because a gold crown frequently covers a vital tooth. They do sometimes provide a growing place for the bacilli of disease.

Discussion of the papers was taken part in by Drs. Morrison, K. A. MacKenzie, McLarren, Schwartz, Thomson, Hennigar and Weatherbe.

"TRANQUILITY."—It has been proposed that the national home for aged and incapacited physicians shall be "home" in the fullest sense of the word and that it shall be called "Tranquility". The first unit, founded four years ago in Caneada, N. Y., has been successful. There have been hundreds of cases that could not be accommodated. It has been necessary to appeal to the public to secure funds to build a home of national size with smaller units throughout the country to meet sectional needs. The project was laid before some of the ablest physicians and before a number of prominent persons outside the medical profession, and their unanimous belief was that the public would support a campaign to raise funds. The campaign was recently opened with headquarters in the Times Building, Forty-Second Street and Broadway, New York City, to which office subscriptions should be sent. Several million dollars will be required. The home is not to be in any sense luxurious. It will be a plain, substantial institution, well furnished, to meet the average wants of the average man. The inmates will be encouraged to employ their time; a well appointed laboratory is contemplated wherein those whose faculties permit may still pursue their studies with the hope that medicine may benefit by their investigations; it is also contemplated that arrangements shall be made for physicians who, failing ill, may need a haven in which to win back their health. Those who subscribe $5,000 will be designated as Benefactors; those who subscribe $2,500 will be designated as Donors; $1,000, Patrons; $500, Life Members, and $100, Sustaining Members. None of the officers or directors of the home are paid as such nor will they participate in the funds subscribed.
(A. M. A. Journal).

OBITUARY

The death occurred in New Glasgow, on February 20th, of Mrs. Hannah McCaffrey, who had been in failing health for several months. She was a sister of Dr. Daniel MacIntosh of Pugwash. Another brother, Mr. A. S. MacIntosh, druggist in Oxford, died on January 30th.

The death occurred on December 25th, of Dr. Thomas Walker of Saint John, N. B. He was 86 years of age and had been prominent both as a physician and a citizen since his graduation from the University of Edinburgh in 1863. He was well-known to many of the profession in Nova Scotia, and many have partaken of his hospitality.

The death at Annapolis Royal, on March 7th, 1926, of Mrs. J. M. Owen, came as a great shock to many persons in Nova Scotia. Her husband has been Judge of Probate for Annapolis County for many years. Her father was the late Dr. James C. Farish of Yarmouth. Dr. James was a brother, if we are not mistaken, of the late Dr. Henry Farish, father of Dr. G. W. T. Farish, now in practice in Yarmouth. Mrs. Owen was an intellectual and cultured lady beloved by all who had the pleasure of knowing her.

European Tour.

Under the title of Inter-State Post Graduate Assemblies of American Physicians in Europe in 1926, a clinic tour has been arranged, starting April 28th and returning July 5th, 1926. Dr. Charles H. Mayo is the Chief Executive; Dr. William J. Mayo, President of Clinics; Dr. George W. Crile, Chairman of Programme Committee. Dr. C. F. Martin of Montreal and Dr. Alexander Primrose of Toronto, are the Canadian Representatives on the Committee on Foreign Relation.

Clinics will be held in Rome, Florence, Pisa, Bologna, Padua, Milan, Berne, Zurich, Munich, Vienna, Prague, Berlin, Amsterdam, The Hague, Utretcht, Leyden, Brussels.

The cost of the trip will be from $830.00 to $1450.00, according to the class and number of clinics visited.

Babies are the coupons on the bonds of matrimony.

PERSONALS

BORN—To Dr. and Mrs. C. A. Donkin of Bridgewater, a daughter.

Dr. V. H. T. Parker of Stellarton was a recent visitor to Boston.

BORN—To Dr. and Mrs. S. R. Johnson of Halifax, on March 7th, a son.

Dr. M. E. Armstrong, is Chairman of the School Board of Bridgetown.

Dr. W. D. Forrest is starting his 19th year as Health Officer of the City of Halifax.

Dr. D. J. Hartigan of New Waterford, spent a week in Boston early this month.

Dr. and Mrs. J. S. Chisholm of Mahone, recently returned from a short visit to New York.

Dr. M. R. Elliot of Wolfville, has recently returned from New York where he has been doing special work in Pediatrics.

A war veteran was recently in the Halifax Police Court, charged with assult on Dr. Donovan, Superintendent of Camp Hill Hospital.

Dr. J. A. Milne is at present looking after the practice of Dr. Zwicker of Chester, who is not yet able to resume his duties.

Dr. L. W. Johnson, Sydney Mines, received a most enthusiastic reception on his return home, following the recent adjournment of the House.

Acadia University proposes several new buildings and an increase of its endowment. For this purposes $1,500,000 is to be raised by June of this year. The bulk of the amount is even now in sight. $100,000 will be devoted to a new Biology building.

The profession will be glad to learn that Dr. Evan Kennedy, who was severely injured last fall, has recovered sufficiently to resume his practice.

Dr. F. E. Gullison who has been surgeon for the United States Government at the Port of Yarmouth for the past three years, has resigned. Dr. H. T. DeWolfe is his successor.

Dr. C. S. Hennigar of Liverpool, spent several days recently in Chester in attendance upon his father who, it is pleasing to note, is now convalescent after a severe attack of pneumonia.

Dr. R. G. McLellan of Lunenburg, was ill during the month of February, but has now renewed his practice. Dr. Jack Acker of Halifax, assisted Dr. Forbes during Dr. McLellan's illness.

Miss Anna Miller, daughter of Dr. A. W. Miller of New Waterford, was a patient in St. Martha's Hospital, Antigonish, for several weeks. She was successfully operated on and has fully recovered.

Irma Kennedy, daughter of Dr. W. J. Kennedy of Musquodoboit Harbor, while coasting down the school hill, fell and struck her head. She was unconsious for several hours but is now making a good recovery.

On February 25th, Dr. Horace Rindress of North Sydney, was married to Neta, daughter of A. G. and Mrs. Kirk, Antigonish. Dr. and Mrs. Rindress are taking their honeymoon trip to Boston and New York.

Dr. Franklyn B. Royer, formerly Director of the Massachussetts-Halifax Health Commission, has recently been appointed Medical Director of the National Committee for the Prevention of Blindness in the United States.

Mrs. Lewis S. Payzant recently celebrated her 93rd birthday, at the home of her son, Dr. H. A. Payzant of Dartmouth. Mrs. Payzant was a daughter of the late Squire John King of Lower Onslow, and a sister of E. D. King, K. C. Halifax and W. P. King of Truro.

The medical students of Dalhousie University held a very successful banquet at the Halifax Hotel February 16th. The banquet was characterized by speeches dealing very largely with the ideals which should inspire medical students and medical practitioners. Dr. Rehfuss, M. P. P., gave one of the addresses advocating the Golden Rule of Idealism over and above Commercialism and petty jealousies. Dr. G. H. Murphy, Dr. Churchill, Dr. Atlee and Dr. Nichols were other speakers at the meeting.

Dr. W. F. Read of Digby, after spending some six weeks in Florida, returned to his home March 2nd, and has resumed practice. Mrs. Read remained for a time longer with her brother, residing in Cocoanut Grove, Florida. Dr. Read spent some days on his return, in visiting New York hospitals.

Since September 1908, interest at 4% has been deducted from the annual allowance to the Payzant Memorial Hospital, Windsor, the original grant being $14,000.00. On January 29th, 1926, this proviso in the original Order-in-Council was rescinded to the great satisfaction of the Hospital Board.

The many friends of Dr. Fraser Harris, will be glad to know that he is very fully engaged in literary work. Writing not only in medical, but in literary and scientific magazines. The Contemporary Review has one of his last articles, "Childish Traits in Adults". Dr. Harris has also made a very large collection of superstitions, or mannerisms or customs. These will propably form material for a very interesting book.

The Evening News of New Glasgow, has the following note:—"*The McLure of the East River*—In your last issue I notice a paragraph "Nice Tribute to Doctor." I take my hat off to Dr. T. W. MacLean, Scotsburn, we have another of same calibre on East River, Dr. H. D. Chisholm, Springville. He turns out night or day in rain or snow and on snowshoes when necessary to help the sick. Kindness is stamped on his genial countenance and his pay is his last thought. God bless our Doctor."

Dr. J. A. M. Hemmeon of Wolfville and Miss Ethel Hemmeon, sailed by the S. S. Chignecto March 12th for a six weeks trip to Demerara. Dr. J. G. McDougall left March 10th for the West Indies via New York. Dr. S. J. McLennan of Halifax, proposes to take this trip sometime this month. Mrs. McDougall and Mrs. Walker returned the last of February from Trinidad, spending about six weeks on the trip. Dr. E. O. McDonald of Sydney, also sailed by the Chignecto for this West Indies trip.

Dr. J. G. McDougall of Halifax, has an article in the March Journal of the C. M. A. entitled,—"Arteriotomy for Embolus Obstructing the Circulation in an Extremity Illustrated by a Successful Case." The Embolus in the case reported was in the femoral artery, and was seven-eights of an inch long, weighing twenty-seven grains.

"Toxaemias of Pregnancy" is the title of a paper by Dr. E. K. McLellan also appearing with March issue of the Journal.

Dr. M. T. Sullivan of Glace Bay has reported in the C. M. A. Journal of March "An obscure Case of Acute Intestinal Obstruction, due to presence in Mesentery of Small Intestine of a Fibrous Polyp-undergoing Calcareous Degeneration."

McKay—Hennessy.

Rev. Douglas Wiswell officiated at the marriage, in Christ Church Cathedral, Montreal, on March 2, of Muriel A., daughter of Mr. and Mrs. Thomas W. Hennessy, of Truro, and Dr. Joseph Wm. McKay, a son of the late Dr. John H. and Mrs. McKay, Truro. The news is of special interest here, Miss Hennessy, who is a very charming girl, being a sister of Mrs. H. MacArthur Wood, of Halifax, whom she has frequently visited. She was formerly a student and a most popular student at the Halifax Ladies' College, has been for the past eight years a member of the secretarial staff of the Royal Bank of Canada in Truro. The felicitations from Halifax will be many and cordial.

The February issue of The Canadian Medical Association Journal contains the paper read by Dr. A. R. Campbell of Yarmouth, at the last annual meeting of the Nova Scotia Medical Society,—"Gassy Indigestion" as related to gall bladder disease.

Dr. M. G. Burris of Dartmouth, gives a Case report of abortion of one twin, the other going to full term. This would have been good material for the Bulletin.

Dr. A. C. Jost of Halifax, contributes a biography of Jacques Bourgeois, Chirugien 1621-1701, which greatly supplements the brief mention made of him by the late Dr. D. A. Campbell in his "Pioneers of Medicine in Nova Scotia" republished in the June 1925 issue of The Bulletin.

Medical Bonspeil.

The Manitoba Medical Bulletin reports that on February 16th, 1926, sixteen rinks of medical men began a Bonspeil at the Granite Rink, Winnipeg at 8.30 A. M. The winning rink was, Doctors Gardner, Leishman, Black and Jones, skip. The Bulletin adds,—"Many doctor's households were minus a broom that day, and by nightfall many Doctors had aching backs."

THE CANADIAN MEDICAL ASSOCIATION

President—J. F. Kidd, Ottawa.
President-Elect—David Low, Regina. Annual Meeting, Regina, 1925.
Vice-Presidents ex-officio—Presidents of Affiliated Associations.
Honorary Treasurer—A. T. Bazin, 836 University Street, Montreal.
General Secretary—T. C. Routley, 184 College Street, Toronto.

THE COUNCIL

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

EXECUTIVE COMMITTEE

W. G. Reilly, Montreal, *Chairman.*
J. F. Kidd, Ottawa.
David Low, Regina.
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C. F. Martin, Montreal.
S. E. Moore, Regina.
J. S. McEachern, Calgary.
M. MacLaren, St. John, N. B.
F. N. G. Starr, Toronto.
S. L. Walker, Halifax.

SPECIAL COMMITTEES

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

MEDICAL SOCIETY OF NOVA SCOTIA

ANNUAL MEETING, JULY, 1926, AT HALIFAX

OFFICERS FOR 1925-1926.

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

EXECUTIVE

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

Eastern Counties.
Dr. J. J. Cameron, Antigonish.

Colchester-Hants.
Dr. C. H. Morris, Windsor.
Dr. E. D. McLean, Truro.

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

Lunenburg-Queens.
Dr. R. G. McLellan, Lunenburg.

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

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

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

COMMITTEES

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

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

Arrangements.
Halifax Medical Society.

Editorial Board—C. M. A. Journal.
Dr. W. H. Hattie.
Dr. G. H. Murphy.
Dr. J. G. McDougall.
Dr. K. A. McKenzie.
Dr. E. V. Hogan.

Workmen's Compensation Board.
Dr. G. H. Murphy.
Dr. E. V. Hogan.
Dr. M. G. Burris.

Members of C. M. A. Council.

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

Nominated to Education Committee C. M. A.
Dr. K. A. McKenzie, Halifax, N. S.

Nominated to Legislative Committee C. M. A.
Dr. J. G. McDougall, Halifax. Dr. W. H. Hattie, Halifax.

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

CAPE BRETON

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

EXECUTIVE

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

COLCHESTER-HANTS

Officers 1924-25

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

Executive Committee

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

Nominated to Provincial Executive

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

CUMBERLAND COUNTY

Officers

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

EASTERN COUNTIES

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

Executive Committee

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

MEDICAL SOCIETY OF NOVA SCOTIA

DIRECTORY AFFILIATED BRANCHES

LUNENBURG-QUEENS

Officers for 1923-24

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

Executive

The above Officers with:

Dr. A. E. G. Forbes, Lunenburg. Dr. F. A. Davis, Bridgewater.

Annual Meeting is held on the second Tuesday in June of each year, and other Meetings on the second Tuesday of August and January, the time and place of the wo latter Meetings to be decided by the Executive.

PICTOU COUNTY

Officers for 1924-25

Priesident.....Dr. Clarence Miller, New Glasgow
Vece-President.....Dr. M. R. Young, Pictou.
Secretary-Treasurer.....Dr. John Bell, New Glasgow.

Members of Executive and nominated to the Provincial Executive:—
Dr. H. H. McKay, New Glasgow and Dr. G. A. Dunn, Pictou.
Benvie, S. C. McKenzie, G. A. Dunn, C. W. Stramburg, F. B. Day.

Meetings:—First Tuesday in January April, July and October. Annual Meeting in July.

VALLEY MEDICAL SOCIETY

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

Representatives on Executive of Medical Society of Nova Scotia:—
Dr. M. R. Elliott, Wolfville. Dr. W. F. Read, Digby.
Dr. F. S. Messenger, Middleton.

WESTERN NOVA SCOTIA MEDICAL SOCIETY

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

Nominated to the Executive of the Medical Society of Nova Scotia.
Dr. A. R. Campbell, of Yarmouth.

HALIFAX MEDICAL SOCIETY

1925 Officers 1926

President.....Dr. F. R. Little
1st Vice-President.....Dr. P. Weatherbe
2nd Vice-President.....Dr. S. R. Johnston
3rd Vice-President.....Dr. V. L. Miller
Secretary-Treasurer.....Dr. W.L. Muir

Executive

The above Officers with
Dr. H. W. Schwartz
Dr. G. W. Grant

PROGRAMME FOR 1925–1926

NOV. 4th. Opening Meeting - - - - - - - - Carleton Hotel
President's Address

NOV. 18th. Nova Scotia Hospital.
Clinical Evening

DEC. 2nd. Victoria General Hospital.
Clinical Surgical

DEC. 16th. "Paralytic Deformities, especially in Childhood."
Dr. J. Appleton Nutter
Orthopaedic Surgeon to the Montreal General Hospital.

JAN. 13th. "Purulent Disease of the Accessory Nasal Sinuses."
Dr. H. W. Schwartz

JAN. 27th. Victoria General Hospital.
Clinical Medical

FEB. 10th. Dental Symposium—"Focal Infection, Deformities, etc., etc."
Drs. W. W. Woodbury and J. S. Bagnall

FEB. 24th. "X-Ray Diagnosis of Bone Conditions."
Dr. S. R. Johnston

MAR. 10th. Subjects to be Announced.
Dr. John Stewart
Dr. Murdoch Chisholm

MAR. 24th. "The Surgery of Putmonary Tuberculosis."
Dr. J. H. Allingham
Saint John, N. B.

APR. 14th. "Recent Advances in the Physiology of Gastric Secretion."
Dr. Boris Babkin
Professor of Physiology, Dalhousie University.

APR. 28th. Annual Meeting.
Election of Officers, Etc., Etc.

A Country Doctor Defined.

If you can set a fractured femur with a piece of string and a flat-iron, and get as good results as the mechanical engineering staff of a city hospital at 10 per cent. of their fee;

If you can drive through ten miles of mud to ease the little child of a dead beat;

If you can do a podalic version on the kitchen table of a farm house with husband holding legs and grandma giving chloroform;

If you can diagnose tonsilitis from diphtheria with a laboratory forty-eight hours away;

If you can pull the three-pronged fishhook molar of the 250-pound hired man;

If you can maintain your equilibrium when the lordly specialist sneeringly refers to the general practitioner;

If you can change tires at 4 below at 4 a. m.;

If you can hold the chap with lumbago from taking back rubs for kidney trouble from the chiroprac;

Then, my boy, you are a Country Doctor.—*H. W. Davis, in the Kansas Medical Journal.*

If a chiropractor can, by manipulation, move a dislocated vertebra so that the pressure on a nerve can be relieved and paralysis cured, he can by the same process dislocate a vertebra and cause a paralyzed condition.
