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## Hospital Growth

The July issue of the Nova Scotia Medical Bulletin is featuring the opening of the new Colechester Hospital. Elsewhere in this edition is an historical review of hospital and medical care in Colechester County up to the year 1954. In the past twenty years this will be the third hospital to serve the area. The structure of 1950 was an addition to the existing hospital built in 1925. The bed capacity increased from 43 beds to 105 beds. The new hospital is a complete new unit with a capacity of 218 beds. But the opening of new hospitals in Nova Scotia is becoming quite a common event. In the past ten years new hospitals or additions to old ones, has surpassed hospital construction for the preceding twenty-five years.

It is becoming apparent in many cases that the planning of the 'new hospital' was not big enough. That is, the thrill of anticipated adequate beds and facilities is soon dampened when a few years after the new building is functioning, these facilities again become overstrained and overworked. The public interest in, and demand for health service, seems insatiable, and its appetite is being constantly stimulated by the progress of medical research, social reforms and agencies, and by the press, TV, and radio. Where it will all end is just as exciting a thought as landing a man on the moon, and no doubt will cost equally as much. For in attaining the healthful status it wants, society may gobble up its economic stability.

The new hospital with its capacity of 218 beds is big in many ways. The outpatient department is much larger, with five examining rooms and two minor operating rooms, compared to the present two small examining rooms. The X-ray department will have four examining rooms, three with flourescopy, and with improved dressing room facilities for patients. The Laboratory space will certainly be adequate and a welcome release from the cramped quarters which have turned out an amazing volume of work. The Operating Room will have three major rooms and one minor room, with well planned facilities for anaesthesia and recovery. The Obstetrical floor provides three labour rooms and two case rooms and a capacity of 37 beds. Our present Physiotherapy department consists of one room and, at present, no physiotherapist. The new department will be much larger and better equipped. This is just a summary of some of the striking improvements in facilities. In a separate article in this issue, Mr. E. O. Hodge, the hospital administrator, gives a more detailed description of the building.

Only fifteen years have elapsed since the construction of the extension to the old hospital. For the past eight years this building has become increasingly inadequate. All departments have been overcrowded and work has been carried on with inconvenience to the patient and to those providing patient care. Many factors are involved in this

increasing need for better and larger facilities to treat the sick.

Increase in population in the area is one factor, but apparently not a very important one. In the last census there has been a total increase of only about two thousand people.

More people are using hospitals and their facilities, laboratory, X-ray, physiotherapy and outpatient department services. And these people are being referred to the hospitals by the doctors in the community. Therefore, the doctors are becoming more and more test conscious, or they are striving harder to make accurate diagnosis. In the X-ray department alone the increase has been from 25,000 radiological units in 1958 to 45,000 units in 1964. In the new hospital it is expected that before too long a second radiologist will be employed. Laboratory services have increased similarly at a tremendous rate, from a relatively small output of work in 1959 with one full and one part-time technician, to 120,000 units of work in 1964 with a full time pathologist and twelve technicians. The new laboratory will be required to handle work from other areas and soon a second pathologist or bacteriologist will be required. At present we have no physiotherapist, but there is no doubt that when one is employed she will be kept very busy and an orderly to help her will be needed. It appears that all one has to do is to establish a service and extensive use is made of it.

Certainly a great factor in stimulating people to seek hospital help has been the advent of free hospitalization, and the increasing number of people subscribing to prepaid medical plans and insurance programs.

The increase in traffic accidents, and the accidents occurring in the new industries in the area make demands on hospital facilities.

A brief review of the cost of all this is certainly impressive. The payroll of the hospital in 1964 was \$460,000, the anticipated yearly payroll in the new hospital will be approximately \$750,000. The new hospital budget for the year 1965, not including the new hospital expenses, was set at \$800,000.

The opinion of hospital administration is that within the next 5 to 10 years, another one hundred beds will be needed in this area. One can foresee and predict that as new specialists move in, more equipment and facilities will be needed. Some day research projects and grants for such, must be made available to hospitals outside the Halifax area in order to make full use of all medical brains in the province. We must hope that, as man's diseases and injuries are prevented or relieved, he will continue to use a sound mind in his healthy body to create a healthy and happy world to live in. □

T.C.C.S.

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## Nova Scotia Hearing and Speech Clinic

In 1963 the Hearing and Speech Clinic at 1318 Robie Street, Halifax, Nova Scotia, officially opened. The Medical Director of the Clinic is Dr. Arthur G. Shane. The Audiologist, Speech Pathologist and Administrator is Dr. Adam J. Sortini, formerly the Director of the Speech and Hearing Clinic at the Children's Hospital in Boston. Other members of the staff include speech therapists, social worker, consulting paediatrician, two consulting otologists, nurse, secretarial staff - and a psychologist will be added to the staff in the near future.

The Clinic is the only clinic of its kind in the Atlantic Provinces and a major goal of the clinic is the diagnosis of hearing problems at as early an age as possible through the use of electro dermal audiometry. Children under one year of age have been tested and fitted with hearing aids when

indicated. Extensive diagnostic equipment is also available for the testing of the hearing of adults and specific recommendations for hearing aids are made, when medical aid is excluded.

In 1963, 596 speech therapy visits were made, whereas in 1964, 1426 visits were made, an increase of 139%. The youngest patient seen for evaluation was eleven weeks of age; the oldest, 87 years of age.

The overall function of the clinic is the diagnosis of speech and hearing problems in children and adults, the recommending of hearing aids (for children and adults) and the providing of speech and hearing therapy, whenever possible. Appointments are made on clinic or private patient basis, but by medical referral only.

Requests for information and for appointments should be directed to the Administrator. □

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# Colchester Hospital 1965

## An Interior Description

E. O. HODGE<sup>1</sup>

Truro, N. S.

The New Colchester Hospital is expected to receive its first patients during the early part of September of this year and the facilities and services will far surpass any existing in the present hospital.

The main entrance faces Willow Street and the whole structure forms the shape of a "Y". From the main entrance, our patients and visitors will enter the foyer and general waiting area. To the left, our Ladies' Auxiliary will be operating their gift shop, and on the right is the information wicket at the rear of which is the telephone switchboard and the canteen operated by the Canadian National Institute for the Blind.

On the opposite of this main corridor to the hospital is the Admitting Office with its waiting room and private offices for taking patient information. Adjoining the Admitting Office is the Social Service Department.

The visitor to our hospital will pass the Admitting Office and upon turning left will enter the North Wing which houses on the left, or facing the front of the building, in this sequence; Business Office, Administrator, Secretary, Assistant Administrator and Board Room.

Opposite these rooms are the Records Room, Doctors' Charting Room, Director of Nurses, Secretary, Assistant Director of Nurses, Pastor's Room, Doctors' Lounge and Public Toilets. The covered passage to the present hospital leads off this corridor.

From the main entrance to the right, or South Wing, we enter the Radiological Department and the Department of Public Health Clinic is located at the far end of this front part of the wing.

This is a double width wing and the back portion at the joint of the "Y" has the Ambulance Entrance which leads directly to the Out Patient and Emergency Department. There are two Operating Rooms, five examining Rooms, four Recovery Beds and two observation beds in this department. At the far end of this part of the wing is the Pharmacy.

The remaining Wing on the ground floor, the East Wing, is taken up by kitchens, food preparation areas, refrigerators, dishwashing area, Cafeteria and Dining Rooms.

In the centre area are four elevator shafts, - three elevators are installed and provision is made for the fourth to be installed when required.

Taking the elevator to the second floor, our visitor will see the Post Partum section in the North Wing. In this area we have 5 Private Rooms, 12 Semi-Private beds and 20 Standard Ward beds, - these rooms have only four beds each.

As is the case in all patients' rooms in the hospital, they have piped oxygen, private toilets, hand washbasins and bedpan flushing devices. Selected rooms have piped suction and air. Each nursing unit has an examining room, soiled and clean utility rooms, linen rooms, Nurses' stations complete with a small drug room. All patients' rooms have an Audio-Visual Nurses' Call System. For the up-patient on each wing, we have a Solarium which will be equipped with Television, Radio and a small library of books and magazines.

The South Wing front portion is taken up by the Physiotherapy Department. The waiting area, office and storage makes the entrance to a large treatment room in which are installed the whirlpool baths, treatment plinths, etc. Another large exercise room is also part of this department.

The rear portion of the South wing is still of double width, contains the Laboratories. At first glance our visitor may think this is a large department for the size of the hospital, but when we explain this hospital is to serve the region with three or four other smaller hospitals referring specimens in for examination, the need for the size becomes apparent.

In this department Urinalysis, Haematology, Pathology, Bio-Chemistry, Bacteriology, Serology and various other examinations will be performed.

The East Wing of this floor is wholly taken up with the advent of the infant and the first few days of his or her existence on this planet. Nurseries are divided into three categories; the normal infant, the suspect, or infant with a suspicion of a

<sup>1</sup>Administrator, Colchester County Hospital.



communicable disease, and the prematurely born, who must be housed in an incubator.

The far eastern portion of this wing is occupied by the Labour Rooms, Instrument Storage, and most important to the prospective mother, the Case Rooms. We have two with one Labour Room set up to act as emergency delivery.

Ascending one more floor to the third, the visitor finds himself on the Surgical Floor, the South Wing being for Female patients and the Males occupy the North Wing. There are 67 surgical beds. These wings are equipped by all the services as described on the second floor patients' area.

The East Wing of the third floor contains the Recovery Room, seven beds; Urology Room, X-Ray Dark Room, Doctors' Dressing Room, Nurses' Dressing Room, Anaesthetic Induction Room, Instrument sterilizing and storage rooms, three major operating rooms, one minor operating room and scrub up areas.

The fourth floor and the last one for patients to be completed in this building programme has Medicine, Long stay, Intensive Care and Pediatrics.

The centre portion, South Wing and a part of the North Wing, has 44 beds and will provide care for the Medical and Long Stay patients. The remaining portion of the North Wing is designed for the care of patients requiring intensive nursing services. This area is laid out in bays, each of the eighteen containing one bed on the outside walls, with three Nurses' stations, each of which will serve six patients. Utility and other service rooms are built through the centre of this unit.

The East Wing is devoted to the care of the Pediatric patient. There are 41 beds in this section, each room having observation windows from the corridors. We wonder what the nurses' life

is going to be like when the children begin to understand the function of the Nurses' Audio-Visual Call system. Conversations should be most interesting.

A playroom is incorporated in this unit and will be outfitted and maintained by the Gyro Club of Truro. The Ladies' Auxiliary of the Hospital is interested in providing furnishings for part of this essential part of the hospital.

A part of the fifth floor has been built but is not at the present time to be finished. This was necessary in order that the sixth floor could be completed to house the air conditioning units, ventilating fans and elevator penthouses.

In conclusion, we have built a hospital of two hundred and eighteen beds with services of a sufficient size to provide for another hundred beds when required. This will be accomplished by completing the building of the fifth floor.

The Basement is usually of not too much interest to persons other than those working in the hospital. However, besides the usual storerooms, rest rooms, heat exchange room, electrical switch room, automatic telephone switchboard machine room, morgue and autopsy and central sterilizing, we have a large and modern auditorium complete with public address system. We hope the future of this room will well justify its construction by enabling joint meetings of medical and nursing staffs, all hospital staffs off duty and for the lighter but necessary social life of a hospital in a smaller populated centre.

We would be quite remiss in a description of our new hospital if we did not mention those public spirited citizens who, through their generosity, have enabled us to provide equipment, furniture and supplies to adequately set up the hospital for the only goal we know - Patient Care. □

# Standard Bicarbonate

## An Easily Interpreted Measurement of Acid-Base Disorders

C. P. HANDFORTH, M.B., M.C.<sup>1</sup> Path, AND S. G. MacKENZIE, M.D.

Truro, N. S.

### Definition

Standard bicarbonate is the bicarbonate content of plasma which has been separated from whole blood equilibrated at 37°C. with carbon dioxide at a tension of 40 mms. of mercury and with oxygen for full saturation of the hemoglobin.

### Introduction

As therapeutic medicine advances some diseases and their complications are controlled, and others such as biochemical disorders become relatively more important as threats to life. Among the severe biochemical disorders, alterations in acid-base balance have been most difficult to measure and understand. Fortunately this situation is now changing as a result of the work of Dr. Paul Astrup and his associates in Copenhagen, Denmark.<sup>(1)</sup>

The purpose of this article is to explain how Astrup's standard bicarbonate measurement can be used in general hospital practice. The advantage of this measurement is that it is not affected by alterations in pulmonary ventilation, so it can be used as an accurate indication of the presence and severity of non-respiratory (metabolic) acid-base disorders.

### The Physiology and Measurement of Acid-Base Balance

The hydrogen ion concentration, (pH) of the blood represents a balance between the production and excretion of acid. Acid is produced by oxidation of food in cells, and is mostly in the form of carbonic acid, which is dissolved carbon dioxide. Also, oxidation produces a smaller quantity of other acids, such as lactic acid and phosphoric acid. Under abnormal circumstances, such as anoxia, the proportion of these non-volatile acids may be increased. As acid diffuses out of the cells into the blood it is buffered so effectively that there is

very little change in the blood pH. However, the buffers in the blood have a limited capacity for absorbing acid, and the final regulation of the blood pH depends upon adequate excretion of acid by the lungs and kidneys.

The rates of production and excretion of acid are inconvenient to measure in clinical practice, so investigations of acid-base disorders usually depend on measurements of changes in the blood. Alterations in the bicarbonate content of the plasma are most frequently measured, because there are technical difficulties in determining the blood pH.

The bicarbonate content of the plasma is more difficult to determine than might be expected. Most technical methods measure the total figure for bicarbonate and dissolved carbon dioxide, so an appropriate correction has to be made. In the past, attempts were made to standardize the amount of dissolved carbon dioxide by exposing the plasma to gas mixtures which had a carbon dioxide content similar to that of alveolar air. Astrup has pointed out that this procedure is unsatisfactory, and that the equilibration must be performed with whole blood rather than plasma. The reason for this is that carbon dioxide is buffered mainly by hemoglobin in the red blood cells. As carbon dioxide enters the blood and diffuses into the red cells, an equivalent amount of bicarbonate diffuses out from the red cells into the plasma ("chloride shift" mechanism). In other words, alterations in the amount of dissolved carbon dioxide produce corresponding changes in the plasma bicarbonate content. These changes cannot be reversed after the plasma and red cells have been separated, so the older measurements were liable to produce confusing results. When the bicarbonate content of the plasma is measured under the standard conditions defined by Astrup, it is not affected by respiratory variations in the amount of dissolved carbon dioxide. As a result the standard bicarbonate values change only with non-respiratory, or metabolic, acid-base disorders.

<sup>1</sup>Pathologist, Colchester County Hospital.

## Clinical Applications

Older measurements such as "alkali reserve" and "carbon dioxide combining power" were difficult to interpret because they altered in a confusing way with both respiratory and metabolic disorders. For example, an increased carbon dioxide combining power could be due to metabolic alkalosis or respiratory acidosis.

By contrast, Astrup's standard bicarbonate measurement is very simple to interpret. The normal range is 21 to 25 mEq/L. Values over 25 mEq/L. indicate that there is a metabolic alkalosis, and values below 21 mEq/L. indicate a metabolic acidosis. The variation from the normal range is proportional to the severity of the disorder. For example, a patient with acidosis due to chronic renal failure might have a standard bicarbonate of 10 mEq/L., and in alkalosis due to loss of gastric juice the standard bicarbonate might rise above 50 mEq/L. as in the patient described below.

Common clinical disorders which affect the standard bicarbonate are shown in the accompanying table. Usually when an abnormal value is found there is little difficulty in determining its cause and prescribing appropriate treatment. Metabolic acidosis can be corrected by intravenous bicarbonate solution, and metabolic alkalosis caused by loss of gastric juice responds well to intravenous 0.9% NaCl solution providing the patient's kidneys are healthy. In this type of alkalosis it is important to provide the body with adequate amounts of sodium chloride, and to avoid giving only glucose and water intravenously.

COMMON NON-RESPIRATORY (METABOLIC) DISTURBANCES OF ACID-BASE BALANCE

	Standard Bicarbonate LOW (acidosis)	Standard Bicarbonate HIGH (alkalosis)
Therapy	administration of ammonium salts	administration of bicarbonate
Abnormal losses	loss of bicarbonate in diarrhoea or a pancreatic fistula	loss of acid gastric juice by vomiting or gastric suction
Abnormal metabolism	diabetic ketosis hypoxia (see text)	
renal disorders	acute or chronic renal failure	

The only unfamiliar condition mentioned in the table is metabolic acidosis caused by hypoxia. This is an important state to recognize because it may produce unexplained post-operative collapse and death. The clinical picture consists of hypotension, rapid pulse, air hunger, mental confusion, and loss of consciousness.(2) If this is not recognized as being due to acidosis it may be misdiagnosed as irreversible shock. However, if

a standard bicarbonate measurement is performed and metabolic acidosis is diagnosed, it is possible to produce rapid and complete recovery by intravenous bicarbonate therapy.

## Summary

Astrup's standard bicarbonate test is an easily interpreted measurement of acid-base disorders. The normal range is 21 to 25 mEq/L. Values higher than this are found in metabolic alkalosis, and lower values occur in metabolic acidosis. The standard bicarbonate is not affected by respiratory changes, and this is its advantage over previous tests such as the carbon dioxide combining power.

Clinically, it is advisable to request standard bicarbonate measurements when acid-base disorders are suspected, also whenever there is any unexplained deterioration of a patient's condition.

## Case Report

A previously healthy man, age 21, was admitted to hospital with multiple injuries resulting from an automobile accident. There were fractures of the pelvis and of the left rib cage. In addition, the left dome of the diaphragm was ruptured, and the stomach and spleen (which also was ruptured) had become displaced into the left thoracic cavity. The stomach was distended with gas and displaced the mediastinum towards the right. In addition to hemorrhagic shock, the chest injuries produced severe respiratory distress. The stomach was aspirated continuously in an attempt to reduce the size of its intra-thoracic portion.

One week after admission, the patient's condition was steadily deteriorating and serum chemical analyses showed the following results:

constituent	result	normal range
sodium	126	135 to 155 mEq/L.
potassium	2.4	3.5 to 5.6
chloride	72	100 to 110
standard bicarbonate	52	21 to 25

This demonstrated that there was severe metabolic alkalosis accompanied by very low sodium and potassium levels. This chemical pattern is typical of the disturbance which follows loss of gastric juice. When this was recognized the patient was treated with intravenous 0.9% sodium chloride solution. He improved rapidly, and a few days later a successful operation was performed to remove the ruptured spleen and repair the diaphragm.

This patient's recovery depended on a confident biochemical diagnosis of metabolic alkalosis. Clinically this was not as obvious as it appears in retrospect, because the gastric aspiration

continued on page 167



# Growth of the Medical Profession in Truro\*

D. S. McCURDY M.D.<sup>1</sup>

Truro, N. S.

In five and a half years we shall be in the year 1960—the 200th anniversary of the settlement of Truro by the British. We are well acquainted with our beautiful town, its institutions, its homes and probably most of us know our fifteen medical men who carry on Medicine and Surgery in its advanced form in the home or in our well organized hospital. To go from this to the early days of Medicine in Truro is a 200 year backward glance.

In 1760 we read of Janet Fisher—the 17 year old bride of Matthew Archibald—landing at the Board Landing Bridge. All the women and men were down to see her as she stepped from the boat in her Boston finery. She died in 1843 at the age of 93 leaving: 12 children, 100 grandchildren, 250 great-grand children and 23 great-great grand children. A total of 385—of whom 323 were living. I give this to show that with families like this there must have been some medical attendance necessary.

At that time much of the practice must have been of the "Herb Doctor" type as antisepsis, germs, sterilization, anaesthetics and all our new drugs and methods were unknown.

A "Medical Book" published about 280 years ago in England and much used in parts of Nova Scotia has contents of interest in this day as it dealt with the art of healing with herbs and plants under the guidance of the once honoured mysterious science of Astrology—the stars and heavenly bodies. Such a book may have been used in early Truro, but the first trained medical man we have record of in Truro was Dr. John Harris—1778.

The year 1905 saw the following advances in medicine: *Treponema pallidum* (causative organism of syphilis) was discovered. The term Hormone was first used. A method for counting red blood cells was devised. Auscultation of arterial sounds was employed in measuring blood pressure.

In the "McCulloch Book" written by Rev. Dr. Wm. McCulloch, Minister of what is now First United Church, Truro, for half a century, there is an account of his father, the Rev. Thos. McCulloch in the early 1800's, who not only preached and taught in Pietou, but having had a brief medical

course at Glasgow, Scotland, travelled by horse or on foot to Colechester County and even to Hants County doing Medical work. As this was only a side-line of work for him he never accepted payment.

Following the first Dr. Harris were various men, some trained some half-trained, some having served an apprenticeship only with a regular doctor. Not until 1853 was there any organized medical work. In that year the Nova Scotia Medical Society was formed with Dr. (Hon.) Wm. Gregor—a one time physician in Truro but then of Halifax,—as its first president. Dr. Bent of Truro was present representing Truro among the forty-five medical men assembled.

In 1883 the Colechester Medical Society was formed with Dr. Robinson Cox of Upper Stewiacke president and Dr. Wm. S. Muir of Truro Secretary. Later in 1889 this society having lapsed was revived with Dr. H. V. Kent as secretary—a position he held until 1935.

Between 1850-1900 the most important advance in medicine was made by the discovery of germs and antisepsis. Dr. John Stewart of Pietou and Halifax—a pupil of the discoverer of these germs and antisepsis, Lord Lister—advanced the introduction of this principle in Nova Scotia.

Years later in our Colechester County Hospital when Dr. Stewart retired, I remember his calling the Truro doctors together and there in the operating room handing over, one by one, his operating instruments to us. He would handle each one thoughtfully as he passed it over, giving some detail of its use or history and parting with it as an old friend.

We all recall the early days of surgery in Truro when emergency operations were performed at home by visiting men as Dr. Stewart; and it was only after Dr. D. L. McKinnon opened the Ainslee Hospital in 1917 that the bulk of surgery was gradually assumed by the Truro doctors.

As we mentioned, Dr. Harris was the first recorded medical man in Truro—educated at Princeton, N. J., coming to Nova Scotia with the little group which settled in Pietou, members of the

\*Reprinted with permission from the Colechester Historical Society Reports 1954-57.

<sup>1</sup>Deceased. We are indebted to Dr. McCurdy's widow for permission to republish this paper.

Philadelphia Co., of which Dr. Harris was attorney and so had much to do with the settlement of Pictou. He was the first magistrate of that district, and after coming to Truro was clerk of the Peace. He also represented the County in the Nova Scotia parliament 1779-1785. As part of his magisterial work he celebrated marriages, and a Mrs. Nancy Soby reports that she saw him marry a Mr. Davidson of Upper Stewiacke with a Miss Downing of Brookfield, and for aught she knew he did it as well as any parson could do.

Dr. Harris died 1802 of apoplexy—falling from his horse.

We read from an account "The Slave in Canada" which says "A bill of sale may be found in the Registry of Pictou making over Dr. John Harris of Truro, as security for £40 one negro man named Sambo, also one brown mare and colt. Slavery was quite common then.

I have here a candlestick, given to me by the late Mrs. Florence Hallett of Brookside (who was a collector of candles) which she stated once belonged to Dr. Harris.

Dr. Daniel Eaton came to Colchester in 1789 from U.S.A. and was cousin of Dr. Page in later years.

Dr. John Murray Upham followed Dr. Eaton, coming as a Loyalist from U.S.A. and having obtained a limited education in medicine. Dr. Page later wrote of him "His reputation as a physician was good—socially and professionally he was very popular."

If I may quote from our Historian F. H. Paterson's book—"Mary Dickson" re Dr. Upham:

"He came as an attractive bright young man, bringing to a yet raw countryside the refinements and social graces of a city. He came, too, with healing power when at a time there was urgent and widespread need for a surgeon. Now, with our knowledge of modern medicine we know that often it would have been better had he not been called but the stricken ill of that time did not think so."

He became friendly with the Chas. Dickson family—shipbuilder and merchant of Onslow and married his daughter Mary. They lived on Prince Street, probably in the house now used as offices by Dr. Ross and Dr. McKean next to the Post Office.

From the court records we know that his time was one of financial tribulations "often he was sued with the horror of imprisonment even by his brother-in-law S. G. W. Archibald, who at one time had been engaged to his wife Mary Dickson. To us this seems strange family relations, but in those days it was the will of God that debtors be sued and pursued.

Upham, during part of his years in Truro, was the only surgeon; and as I turn the pages of the old court house records of debt and miseries, I think

of the long hours in the saddle on roads of mire and snow, the midnight calls to the candle-lit cabins—wary he returns home to find the sheriff at his door. No wonder that he again went into the army and from Truro, leaving his wife—the former Mary Dickson—in Truro. As previously mentioned, Mary Dickson had been engaged to S. G. W. Archibald but he on one of his court duties in Wolfville called on Mary's attractive sister who was attending Acadia. She in turn begged Mr. Archibald to take her home to Onslow, so on his horse, both rode to home and soon afterward she instead of Mary was married to S. G. W. Archibald.

Dr. D. B. Lynds of North River, having studied with Dr. Head of Halifax came to Truro early in 1800. For a time there wasn't any physician nearer than Amherst on the North and Halifax on South and Pictou on the East. He travelled at times, all through this country. He was an expert phlebotomist (blood cutting) and heroic in ridding the patients of their pesky fangs—although not always getting the right tooth! Chloroform or ether were unknown to him and he had no faith in 'new fangled notions.' He died in 1871 in his 90th year and as Dr. Page writes "He probably did as little harm during his long life and practice as any physician that ever lived" and that is high praise. He made no pretensions to skill as a surgeon and some of his attempts at bone setting would indicate that his own estimate of his proficiency was about correct.

Through the kindness of Mrs. S. A. Fulton, several documents are in my hands. You see the cylinder of tin in which they are contained. These were found in her attic and must have come from Dr. Fulton's office.

In 1804 Dr. Lynds contracted to study pharmacy and medicine with Dr. Head of Halifax. Agreement is for four years—the last year to be taken up with medical work. During this time he shall not absent himself nor divulge Dr. Head's secrets. Dr. Head to provide for Dr. Lynd's board and lodging. £10 per year for the purpose of getting clothes, and at the end of the term to dismiss him with an entire new suit of clothes fitting for his situation.

Later in 1811 Dr. Lynds received a diploma from the University of Pennsylvania, and there are also certificates from his various classes stating that he showed diligence, integrity and industry, not marks, distinctions or passes as at the present time.

On going to Pennsylvania, Dr. Lynds' recommendations are interesting:

"The bearer of this Dr. Lynds is a worthy young Man and of a very worthy Family. He was baptized by the Rev. Theodore S. Harding. He has been engaged in this Town in the practice of Physies and Surgery, with Dr. Head (a valuable Gentleman) about four years. Dr. Lynds is highly esteemed by Dr. Head, and every Medical Gentleman of this Town, on the account of

his good conduct and great proficiency which he has made in his studies and practice. Since he left Dr. Head he has practiced at Onslow in this Province, about one year, to the great satisfaction of the inhabitants there. He leaves this Place, with a Design to attend the Lectures at Philadelphia. During his stay in Halifax, he has diligent attended with the Baptist Church here, and since his removal from this Place to Onslow (his native Place) he has constantly attended with the Baptist Church there. Ever since he made a profession of Religion, he has manifested great love to the Baptized Cause of Jesus Christ, and the followers of the Lamb. We hope the Lovers of Jesus will receive this our esteemed Br. and Friend with all Christian freedom, and friendship, and do him all the good they can, and remember not to forget to entertain strangers. Many have had reason to say it was well for them that ever they visited the States of America, and so can one of the subscribers say in particular. We hope that it will be the language of our Br. also. By showing kindness to our friend it will be very gratifying to us, and we believe pleasing to the Lord."

Halifax October 3rd., 1810.

(Signed) John Burton, Pastor of the Baptized Church of Jesus Christ of Halifax.

(Signed) Theodore Seth Harding, Pastor of the Baptist Church in Horton.

In 1815 a letter re smallpox—Jenner 1796 England.

HALIFAX, 8th. March, 1815

SIR:

His Excellency the LIEUTENANT-GOVERNOR, has been informed that the Small Pox has made its appearance in several parts of the Province, and as there probably may be persons in the Townships of Truro and Onslow who from poverty, and never having been vaccinated, may be exposed to danger from the spreading of the contagion: His Excellency is extremely desirous to prevent such calamity, and has commanded me to request that you will immediately vaccinate such poor persons within the said Townships as are unable to reward you for your services, and forward a list of their names to me; you will at the same time transmit a certificate from two of the Justices of the Peace of the County of Halifax that proof has been made before them, that the persons names in such list, have been vaccinated by you, and are from poverty unable to pay you for such service: His Excellency directs that you shall then be paid, for each and every person so vaccinated and certified, the sum of 2s 6d. and hopes that you will be satisfied with such compensation, as the funds placed at His Excellency's disposal will not admit of a larger allowance. If you decline accepting of these terms, you will please to signify the same to me, without delay, for His Excellency's information. The vaccine matter can be obtained upon application to Dr. W. B. Almon, in Halifax.

I am, with much respect,  
humble servant,

(Signed) Henry H. Cogswell.

To Dr. David Lynds, Truro.

"Exhibit E" shows a map by Surveyor General Morris of Halifax showing a tract of land and purchased by Dr. Lynds near the Stewiacke River—(spelled Souiaic.)

*Dr. Wm. Gregor:* Born in Scotland, educated at Edinburgh, came to Nova Scotia in 1819 and practiced in Truro five years. He was a friend of Mr. Archibald, Speaker of the House of Assembly, and was persuaded by him to go to Halifax where he became a prominent figure in medicine and political circles. In 1855 he was elected the first President of the Nova Scotia Medical Society. He was a large, fine looking man, of good address, of literary tastes and a born artist. Dr. Gregor was well-informed in all branches of medicine, a good

physician and a qualified surgeon. He was a Liberal in politics, a friend of Joseph Howe and a member of the Legislature.

*Dr. Charles Head:* A son of Dr. Head of Halifax, came to Truro in 1825. Ten years later he moved to Halifax. In Truro he married the widow of John, son of the late Sir S. G. W. Archibald.

*Dr. Edward Corrett:* Came to Truro about 1835 and built the house later owned by Sherriff Crowe which in later years was torn down to make room for the present Catholic Church on Prince Street.

*Dr. Robert F. Crowe:* Born at Debert in 1805, educated at the University of Pennsylvania. He practiced in Truro only a short time but he became very popular. He died in Londonderry at the age of 39. Dr. Crowe had some striking eccentricities. For instance—he had his coffin made and brought to the house some time before he died. Some time before he died he decided that he wished to die in his native village, so he moved from Truro following his coffin which was conveyed in another carriage. Dr. Crowe owned the property now consisting of the houses of Mrs. S. W. McCullough and Dr. D. S. McCurdy. Two houses stood here, and it was this property that Dr. Samuel Muir later purchased and from then until the present day there has continued to be a doctor's office here—Dr. Samuel Muir, Dr. Dave Muir, Dr. Will Muir, Dr. Yorston's home, Dr. Walter Muir and Dr. D. S. McCurdy.

*Dr. Waddell:* Born in Truro in 1810, educated in Edinburgh, was a Scotch Irishman or Irish Scotchman, and any other country might have been proud to claim him.

*Dr. Samuel Muir* came to Nova Scotia in pursuit of his diploma which had been stolen. Dr. Muir came to River John where he found his man and his diploma. It was then a common practice for a diploma to be stolen and taken to the colonies where the holder would set up a practice of medicine. He did not intend to make his home here but on seeing everyone driving his own carriage he got the impression that all the people were wealthy and concluded that this would be a good country to live in. He lived to learn that the possession of such property did not mean so much here as it did in the old country. He first settled at West River, Pietou Co., but when Dr. Crowe's health in Truro failed he came to Truro and took over his house and practice. This practice soon enlarged and he travelled all over the county and beyond it, which in days before cars and railroads called for strength and endurance. He was a man of varied and expensive readings. He was full of anecdotes and had a keen appreciation of wit and fun. In his social relations he was exceedingly genial and was never happier than when enjoying an evening's chat with educated men. He was quick to recognize and acknowledge ability in others. He was the "medical father" so to speak,

of many of the best practitioners in the Province. Dr. Muir enjoyed the confidence of his patients to an almost unlimited degree. He died in 1875 age 64 survived by his widow and five children. Two of his sons later practiced in Truro. Dr. David H. and Dr. Will S. Muir. They were prominent in their profession and in high standing with the Provincial Medical Fraternity. Both were men who made themselves felt in the community and social life of Truro. Dr. "Dave" was mayor of Truro 1886-1891. As stated earlier, Dr. Samuel Muir purchased his home from Dr. Crowe which stood on the present property of Mrs. S. W. McCollough\*. In this house, Dr. Muir lived and brought up his family. The other house stood where Dr. D. S. McCurdy now lives. Between these houses a road was opened up known as Muir's Lane, later changed in name to Arlington Place. The original house on Mrs. McCullough's land was moved across the street and become the present home of Mrs. Ira Thompson. The other house, now Dr. McCurdy's residence had a front on it which is still the main portion of the house. Later, the old house was removed to Robie Street where it became the home of a Mr. Kempt and an ell was added in its place, thus completing the present house. Another house built by Dr. Samuel Muir on the McCullough property was moved back and is now the home of Mrs. Graham, Arlington Place. Dr. Dave Muir built his beautiful brick house (now the residence of Mrs. S. W. McCullough and soon to be the site of a new Federal Building). The business-like doctor also erected houses on Arlington Place and Muir Street making him one of the largest house owners in Truro. The contract prices for some of these houses was so small that if you saw the figure in Ripley's you could "believe it or not". I remember that my father, a building contractor, used to tell of his going to Boston and bringing back the oak panelling for Dr. Muir's house.

*Dr. Will Muir:* practiced from about 1880 to 1902 when his untimely death cut short a brilliant and beloved career. His death gave rise to the original Hospital Trust Fund, which finally in 1926 resulted in our present Colechester County Hospital. On the door of the operating room may be seen the name of "Dr. Will Muir". Dr. Will Muir was one of the best loved physicians of our county. His large home, 640 Prince Street was always open to the public. The V.O.N., the Red Cross etc. held meetings in an otherwise unused room. One room upstairs was spoken of as the "Shubenacadie Room". In this room he kept drinking water, which, on account of the poor town water of that day, was brought from Shubenacadie. Some of us well recall his funeral. As the cortege passed down Prince Street we saw his favourite horse

drawing the empty carriage. Dr. Muir was secretary of the Nova Scotia Medical Society for 18 years 1887-1901.

*Dr. A. C. Page:* Born in Truro, educated at Harvard and graduating in 1856, he came to Truro. His property on Church Street is now included in the Elm Apartments. In 1875 he was elected President of the Nova Scotia Medical Society and later a member of the Provincial Medical Board. In 1883 he was elected the first President of the Colchester Medical Society.

*Dr. J. H. McKay:* was a well known Truro Physician and a contemporary of Dr. W. L. Muir. His office was on Prince Street between Outram and Havelock streets. Besides medical work he became the owner of considerable real estate on Inglis Street. Through the County he was known for his fine horses and with his associates in Truro he was an ardent sportsman and curler. At the Natal Day races in 1882 he had a horse "Maude Mae" entered in the races. Apparently horses of that day were given a handicap.

*Dr. McKay's son Joe* followed him in practising in Truro but in 1925 he went to Montreal where he is today one of the leading X-ray specialists of the city.

*Dr. F. S. Yorston,* a Truro young man, began his practice in a Queen Street office and in 1890 built an office on Church Street adjoining the Royal Bank of Canada. In later years he purchased the fine residential property of Dr. Dave Muir—Corner Prince Street and Arlington Place. Dr. Yorston, at the time of his premature death, had become one of the leading and most popular doctors of the Town.

In 1931 the Truro News in an issue celebrating its forty years in Truro states that in 1890 *Dr. H. V. Kent* was just commencing his career as a Truro doctor, making his first rounds in company with Dr. W. S. Muir who, on one occasion made the remark to a friend that "Dr. Kent will make a good doctor". Many of us will remember how this came true. Dr. Kent was one of the group who practiced in the transition days between horse and buggy and automobile. There lived many stories, of difficult travel by day and by night to all sections of the county. Dr. Kent was especially interested in chest conditions and carried the interest of organizing a T.B. League for years. His sudden death in 1940 was but a few months short of his completion of 50 years of practice.

*Dr. F. F. Eaton.* While in Truro celebrated his 50 years of active practice, at which time a banquet was held for him by his fellow practitioners in the Scotia Hotel where suitable addresses and presentations were made. His office and home were on the site of the present Royal Theatre although later he purchased and lived in the fine property of Mr. Hugh MacKenzie, Queen Street, now occupied by Dr. Douglas Brannan.

\*Replaced in 1957 by Truro's new post office.

*Dr. W. R. Dunbar.* In addition to his medical practice he was active in church also in politics both in town and province. For years he was mayor of Truro and in 1926 when our hospital was built he as mayor was active in securing considerable financial assistance from the town. Dr. Dunbar was from Pictou County but came to Truro from Shubenacadie.

*Dr. S. L. Walker.* Son of A. J. Walker, Truro, began to practice in Truro about 1890. He built and occupied the house and office recently remodelled and known now as the Mitchell Building. Dr. Walker was a skillful organizer of work and the T.B. League and the N. S. Medical Society owe much to his original effort. Following his career in the first world war, he was engaged to organize the N. S. Medical Men and their new Medical Bulletin. The official N. S. Medical Society's journal, was started by Dr. Walker.

Many of us remember the tragic death of *Dr. R. D. Bentley*, shot by a maniac on a summer day as he was preparing to go to his summer cottage at Folly Lake. He lived in the residence of Mrs. J. B. Diekie, now the home of Dr. J. B. Reid, Prince Street. Dr. Bentley came to Truro from Wallace.

It is not so long since we saw *Dr. S. A. Fulton* and his red sleigh on our streets. After graduation he practised with Dr. Halliday at Shubenacadie then came to Truro with and succeeded Dr. McKay in his Prince St. office. A Graduate and Gold Medalist of Dalhousie he enjoyed a large practice in Truro until his sudden death in 1934. A tribute in the Truro News of June 6, 1934 says in part:

*"Kind, sympathetic, he had won their grace  
His storehouse oft he shared for needy tots."*

*Dr. E. D. McLean.* 1854-1929: Coming here from Shubenacadie, he practised until the First War in 1914 when he entered the C.A.M.C. Following the war, he again carried on his Medical work although in poor health. He was a friend to all, a great horseman, and many a social group enjoyed his company.

We all recall *Dr. J. W. T. Patton* as a General Practitioner and later as an E.E.N.T. specialist on the corner of Queen and Logan Streets until his death about 1951. He was a great reader and the possessor of one of the best Medical libraries in Nova Scotia

*Dr. Lyl Cock* practised in Truro as a general practitioner for a number of years preceding the First World War. Going overseas with the C.A.M.C. he rose to the rank of Lieutenant Colonel and returning following the war, he remained in Halifax.

*Dr. Walter Muir*, son of Dr. W. L. Muir, also carried on a medical practice from his late father's residence, 640 Prince Street. Joining the C.A.M.C. during the First World War in 1914, he served overseas and on returning to Canada, settled in

Halifax where he became anaesthetist at the Victoria General Hospital and other hospitals. He is still living in Halifax, although retired from active practice.

The history of attempts to organize a Hospital service for Truro has been highly published during the past years. Private homes became hospitals for a time and the operations were done by visiting surgeons.

About 1909, Miss Rebecca Cameron, R.N., opened a hospital on Park Street, now the home of Mrs. Alfred Johnson. In 1914, Miss Cameron closed this hospital and opened a hospital on West Prince Street, being the home of the late Israel Longworth. This she continued to operate until 1916, when Dr. D. L. McKinnon took over the building and renamed it "Ainslie Hospital" and here he introduced surgery by our local doctors which has gradually replaced the visiting surgeons' work.

Previous to 1917, practically all medical work in Truro was carried on in the Doctors' offices or in the home. Gradually, following the opening of a hospital, cases went to this institution, first the surgery, the emergency medical cases requiring nursing and then by 1945, the majority of sick went to the hospital. This change was influenced by more equipment having been made available for diagnosis and treatment, the training of graduate doctors more in the way of hospitals, rather than homes and also to the fact that nursing help and housekeepers became very difficult to secure.

This hospital system changed the life of doctors too. From 1920 when medical men spent much time travelling summer and winter, night and day, remaining with obstetrical cases for hours or all day, the hospital relieved them of much of this as cases came to the hospital and were there attended with a great saving of time and travel, and also modern advances in treatment were made possible. So, today (1954) we are at the time when we have a new medical personnel in our town, a new hospital and the story from here on will be left for another. □

#### Standard Bicarbonate continued from page 162

was intended to remove gas rather than acid juice from the stomach. An elevated carbon dioxide combining power might have been misinterpreted as showing the effect of respiratory acidosis due to the chest injuries, but the standard bicarbonate left no doubt that there was metabolic alkalosis.

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# Polaroid Radiography

H. R. L. MARTENSTYN, M.B.<sup>1</sup>; and R. D. BENTLEY, R.T.

Truro, N. S.

Many advances have been made in the field of radiology since the discovery of X-Rays by William Conrad Roentgen almost seventy years ago. These have resulted in greatly reducing the exposure to radiation of the patients, technicians and radiologists. The application of electronic principles on the other hand has greatly increased the information available to the physician - sometimes by a factor of three thousand over conventional methods. All this has greatly widened the horizons of radiology to limits never dreamed of a few years ago.

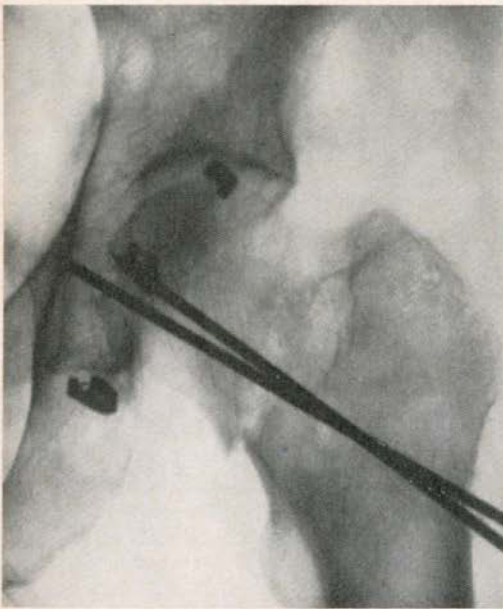
Possibly one of the less spectacular but extremely practical developments has been the application of the Polaroid principle to radiography. At its present stage of development, the principal value of polaroid radiography is in operating room procedures. A positive radiograph can be obtained with conventional X-ray apparatus, a polaroid film pack in a special cassette and a com-

pact processor that can be used just outside the operating room door, in about half a minute from the time of exposure. No dark room is necessary as the film pack can be loaded in daylight and all the developing chemicals are contained in a pod on the film pack itself. The principle involved in the developing is the extraction of the final print under constant pressure by two rollers. This only takes ten seconds.

The most obvious advantage in polaroid radiography is the enormous saving of time in operating room procedures involving the use of X-rays. This becomes increasingly important because of the larger numbers of older patients admitted to hospitals with fractured hips, etc. In addition to the advantage to the patients, there is a tremendous saving of time of the Surgeon, Anaesthetist, Radiologist, technicians and nurses. In our hospital, by the use of polaroid radiography and two portable X-ray machines, the average time for hip pinning procedure has been halved. At the same time the quality of the print has been adequate with direct visualization, doing away with the need for a view box in the operating room.

In addition to its application in orthopedic work in the operating room, polaroid radiography has also been used in operative cholangiography, pneumoencephalography, hysterosalpingography and for catheter localization in catheterization studies and in arteriography. In the latter instance, the need for fluoroscopy has been largely done away with in the correct placing of catheters. One other important advantage in polaroid radiography is that compared to regular X-ray film, only a fraction of the radiation is required to produce a print. This is a very important factor, especially in operating room work where there is very little protection offered from scattered radiation.

Polaroid radiography, however, is not suitable for routine X-ray studies. The paper print lacks the degree of definition of regular film. At the present time only one size of print is available, i.e. 10 inch by 12 inch and the cost of the print is 5 to 6 times that of regular film. These disadvantages however, do not depreciate its value as an important development in radiography.



A.P. view of hip taken during hip-pinning using Polaroid Film.

<sup>1</sup>Radiologist, Colechester County Hospital, Truro.

# Perinatal Mortality 1964

H. R. McKEAN, M.D.<sup>1</sup>

Truro, N. S.

## INTRODUCTION

This report is an account of an investigation conducted by the tissue committee of Colchester County Hospital. The purpose of this investigation was to determine whether the perinatal mortality rate could be reduced by better application of our present knowledge. The term perinatal mortality is used to include still-births and neonatal deaths up to the age of one week. Infants weighing between 400 and 1000 grams (approximately 1 to 2½ lbs) are classified as "pre-viable" without any further subdivision of the causes of death. Foetuses weighing less than 400 grams are not included in this investigation.

## RESULTS

During 1964, there were 819 live births, 15 still-births, and 10 neo-natal deaths in Colchester County Hospital. Autopsies were performed on 15 of the 25 infants who died or were born dead during that year. The numbers of infants dying from various causes are shown in the accompanying table. Prematurity is not shown as a cause of death, but it is noteworthy that 19 of these 25 infants were born prematurely and weighed less than 5 lbs. Definitions of the diagnostic cate-

gories and discussions of individual case histories are given in the paragraphs below.

### 1. Ante Partum Death, with Maceration Only

This group consists of stillborn infants known to have died before the onset of labour. Maceration is the only outstanding feature at autopsy. The object of performing an autopsy is to exclude other causes of fetal death, such as asphyxia and malformations.

There were 3 infants in this category, and all were born prematurely. One had an unusually small placenta, one mother had toxemia of pregnancy, and no predisposing cause was established for the third.

### 2. Ante Partum Asphyxia

This group consists of stillborn infants in whom there is evidence of intra-uterine anoxia, such as intrathoracic petechial haemorrhages and inhalation of amniotic contents, also clinical evidence that fetal death occurred before the onset of labour.

There was only one infant in this category. This death was associated with post-maturity.

	Stillbirths			Neonatal Deaths			Total		
	Under 2½ lbs	2½-5	Over 5 lbs	Under 2½ lbs	2½-5	Over 5 lbs	Under 2½ lbs	2½-5	Over 5 lbs
Antepartum Death with Maceration only		3						3	
Antepartum Asphyxia			1						1
Intrapartum Asphyxia		4	1		1			5	1
Malformations		1				2		1	2
Birth Trauma									
Pulmonary Syndrome						1			1
Infections		1						1	
Hemolytic Disease									
Haemorrhagic Disease						1			1
Pre-Viability	4			2			6		
Intraventricular Haemorrhage					1			1	
Miscellaneous					2			2	
Total						—	6	13	6

<sup>1</sup>Chairman, Tissue Committee, Colchester County Hospital.

### 3. Intra-Partum Asphyxia

Infants dying either during labour or shortly after birth, and showing signs of anoxia as described above.

Of the six infants in this category, three died as a result of premature separation of the placenta (abruptio placenta). One died when there was prolapse of the cord and arm resulting from malpresentation and premature labour after only 7 months gestation. The remaining two infants were born prematurely, one was the first born of twins.

### 4. Malformation

Three infants had lethal malformations as follows:

- (a) anencephaly with adrenal hypoplasia;
- (b) achondroplasia with deformity of the rib cage interfering with respirations at birth;
- (c) polycystic kidneys, and a tricuspid valve malformation resembling Ebstein's anomaly.

### 5. Birth Trauma

This is defined as intra-cranial haemorrhage due to tears of the meninges or great vein of Galen, or similar mechanical damage elsewhere in the body.

No deaths were attributed to this cause during 1964.

### 6. Pulmonary Syndrome of the Newborn

This is a syndrome associated with neo-natal death during the first week of life, and is characterised by secondary pulmonary collapse (resorption atelectasis) with one or more of the following:

- (a) hyaline membrane;
- (b) intra-alveolar haemorrhage;
- (c) pulmonary edema.

Also, there is a recognized clinical association with prematurity and with Caesarean section. The immediate cause of this condition is obscure, but it appears to be related to the lack of a surface-tension-reducing agent in the infants lungs.

Only one infant was considered as belonging to this category. This infant had pulmonary haemorrhage and died six hours after birth.

### 7. Infections

There was one still-birth attributed to congenital syphilis. The mother's V.D.R.L. was positive to a titre of 1:40 and the infant was macerated and edematous. This is the outstanding example of a preventable death in this series. There had been no ante-natal observation of this patient in Truro, and she was visiting this area when she went into premature labour. The importance of this case in this series is to illustrate

that routine antenatal serological tests for syphilis are still mandatory.

### 8. Hemolytic disease of the Newborn

During 1964 there were no perinatal infant deaths due to hemolytic disease. This is a tribute to the effectiveness of routine antenatal Rh blood group and antibody tests, and to the subsequent management of infants developing hemolytic anaemia and jaundice. We are indebted to the medical staff of the Halifax Children's Hospital for their acceptance and care of infants requiring exchange blood transfusions.

### 9. Haemorrhagic Disease of the Newborn

One full term infant died two days after birth. At autopsy there were haemorrhages in several different sites, and it was suggested that the cause of death was haemorrhagic disease, probably due to Vitamin K deficiency. This death is theoretically preventable as the administration of Vitamin K might have corrected a haemorrhagic tendency. However, death occurred suddenly with no preceding manifestations of this disease.

### 10. Pre-Viability

Six infants were pre-viable (weight less than 1000 grams). Two of the mothers had hydramnios. No preventable factors could be demonstrated in this group of infants.

### 11. Intra-Ventricular Haemorrhage

This condition occurs in live-born premature infants, probably because of anoxia due to poor pulmonary function. Pathologically, the ventricular system of the brain is filled with clotted blood. The source of this haemorrhage is congested veins in the floor of one or both lateral ventricles.

One example of this was observed in 1964. The infant weighed only 2 lbs. 12 ozs. and died 5 hours after birth.

### 12. Miscellaneous

Two premature infants had inadequate respirations at birth and were difficult to resuscitate. One died 12 hours after a breech delivery and was not autopsied. The other was the second born of twins and died after 3 days. Autopsy showed signs of anoxia and cerebral edema.

It is considered that both these infants may have had cerebral depression as a result of anoxia during delivery. In addition, both mothers were given barbiturates and one was given morphia. These drugs may have contributed to the cerebral depression, and to this extent there is a theoretical preventable factor in the infants' deaths.

continued on page 178



# Congenital Duplication of the Gall Bladder

## Review of the Literature and a Presentation of a Case.

H. R. L. MARTENSTYN, M.B., B.S., and S. G. MACKENZIE, M.D., F.R.C.S. (C)

Truro, N. S.

The presence of a double gall bladder has been long recognized. Babylonian cuneiform characters record as an omen of victory the presence of a double gall bladder in a sacrificial animal. Pliny, the Elder, in 31 B.C. mentions finding a double gall bladder in an animal sacrificed at Augustus' Victory at Actium.

In more recent times, E. A. Boyden published studies he carried out on gall bladder physiology and anatomy. He found an incidence of one in four thousand cases of double gall bladder in man. This was based on two cases discovered in 9,221 autopsies and three cases found on 9,970 oral cholecystograms. He also reported a higher incidence of double gall bladders in animals. Based on a study of 10,000 domestic animals, he gave the following incidence.

cats 1 in 8 cases  
calves 1 in 28 cases  
sheep 1 in 85 cases  
pigs 1 in 198 cases

A review of the English literature shows 101 cases of gall bladder duplication have been reported in man. An additional proved case is presented, with a brief review of the embryology and classification of gall bladder duplication.

The biliary tract develops as a diverticulum from the foregut into the ventral mesentery at approximately the fourth week of foetal development. The gall bladder itself develops as a bud of solid cells on the ventral side of the diverticulum and is at one stage bilobed. In the normal course of events, these paired buds fuse and develop a central cavity to form a normal gall bladder. At times, the buds fail to fuse resulting in a double gall bladder. The other possibility is that having fused, cavitation of the gall bladder is incomplete, leaving a central septum.

Gross in 1936 classified the anomaly on the basis of anatomic structure. He distinguished two groups:

(1) **BILOBED GALL BLADDER** (*Vesica Fellea divisa*) - in which there was only one cystic duct draining both gall bladders. This is considered to be very rare in man. Two types - a V shaped gall bladder and the septate type - come under this group.

(2) **True Double Gall Bladder** (*Vesica fellea duplex*) - in which there are two cystic ducts which may or may not unite to form a common cystic duct. When the two cystic ducts persist, they may drain into a single or separate common ducts.

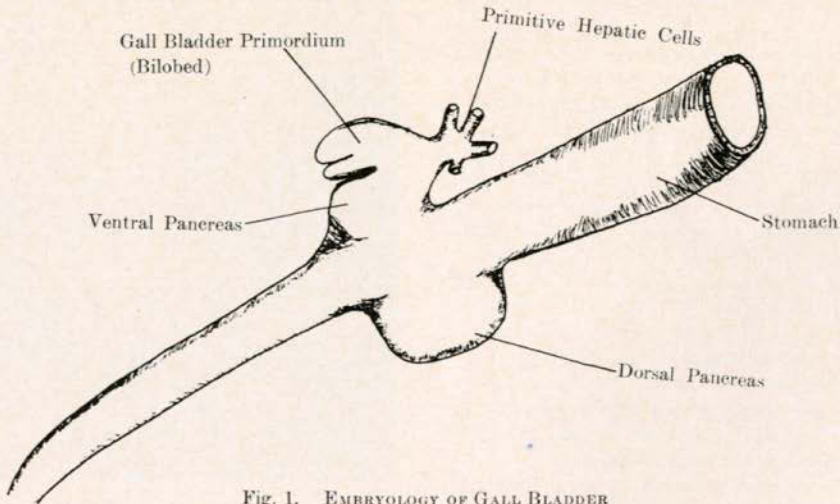


Fig. 1. EMBRYOLOGY OF GALL BLADDER

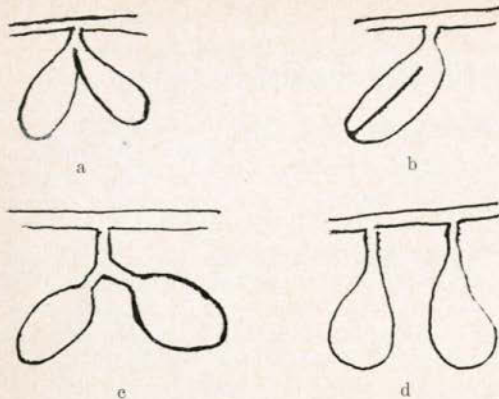


Fig. 2. TYPES OF DOUBLE GALL BLADDER.  
 a, b. Bilobed Gall Bladder  
 c, d. True Double Gall Bladder

Gall bladder duplication as such, probably produces no particular symptoms, if both organs function normally. Some authors, however, believe the anomaly to be accompanied by a greater tendency to stone formation and inflammation. At times only one gall bladder is effected, but more commonly pathology is found in both gall bladders. When only one gall bladder is diseased and the other is visualized, a mistaken diagnosis of a normal gall bladder may be made. This presents a real diagnostic problem.

The diagnosis of gall bladder duplication in the cases reported in the literature, was made pre-operatively, in 35% of cases, either by oral or intravenous cholecystogram. The remaining cases were either found at surgery or autopsy. The presence of two cystic ducts, however, was rarely diagnosed pre-operatively. Segal and Ingegno reported one case each. The proximity of the ducts, the size of the ducts and the lack of contrast makes recognition a difficult task. However, with careful technique and the use of tomography, more cases may be demonstrated.

The demonstration of a double gall bladder itself may be self evident on a routine cholecystogram. At times the presence of two columns of gall stones separated by a space has made some authors (Nichols 1926) make the correct diagnosis. In the differential diagnosis, a kinked or 'Phrygian Cap' gall bladder should be ruled out. Multiple spot films taken at different angles of rotation of the patient, invariably makes the differentiation. Congenital diverticula of the gall bladder are very rare - Mayo clinic study found only three cases in their series. The differentiation is not too difficult with an adequate examination.

The importance of recognizing the anomaly is threefold:

(1) If the diagnosis of a double gall bladder is made pre-operatively, the surgeon will be alerted to the possibility of two cystic ducts, and more important, the possibility of two common ducts. These structures will then not be mistaken for vessels.

(2) Millbourn reported one case in Sweden, where the patient had two cholecystectomies as only one of the double gall bladder had been removed at the first operation, with pathology left in the second gall bladder.

(3) Because of the overlap of the gall bladders, recognition of small calculi becomes more difficult and they may be missed. This is illustrated in the case presented.

### Case Presentation

Mrs. M. J., 45 years old, complained of epigastric distress and fatty food intolerance of several years duration. Repeated oral cholecystograms showed a well visualized double gall bladder with no definite evidence of calculi. Because of persisting discomfort and right upper quadrant tenderness, another oral cholecystogram was done. On this examination, only one gall bladder was visualized and multiple small radiolucent calculi were noted. At surgery, the external appearance of the gall bladder was that of one large gall bladder containing calculi. The surgical specimen, however, on careful examination proved to be a double gall bladder with two cystic ducts. One of the cystic ducts was obstructed by a calculus.



Fig. 3. CHOLECYSTOGRAM



a



b

Fig. 4. EXCISED GALL BLADDER

a. Section showing septum

b. Unopened specimen

c. Radiograph after injecting opaque dye



c

### Summary

Congenital duplication of the gall bladder is a fairly rare occurrence in man. Including the case presented, 102 cases have been reported in the English literature. The importance of its recognition, embryology and anatomic classification has been briefly reviewed. □

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- Man. P. 38



## Dalhousie Notes

### VI. THE 1965 GRADUATING CLASS

C. B. STEWART, M.D.\*

On Thursday morning - May 13, 1965, 53 Dalhousie Medical students received the degree of M.D. and completed their formal training to enter the Practice of Medicine. An analysis of this group brings out several points of interest for members of the Medical Society of Nova Scotia.

When discussion turns to the career choices of recent graduates, one usually hears the statement that "no one is going into General Practice anymore". Of this group, twenty-three are going into General Practice; eight are discharging their commitment to the Armed Services where they will be doing restricted types of General Practice; two are entering hospital employment; and only twenty (fewer than forty percent of the Class) are undertaking postgraduate training.

Nineteen of these graduates are non-Canadian and two Canadians are from outside the Atlantic area. This is a reflection of insufficient qualified applicants to the Medical School from among residents in the Atlantic area five years ago. Under normal circumstances, no more than five students from outside the Atlantic area would have been accepted into this class.

Already the shortage of qualified applicants to Dalhousie from among residents of the Atlantic area has been over-corrected. Selection for sixty-eight posts available in the fall of 1965 will shortly be made from well over this number of applicants. It is indeed fortunate that the entering class of Medical students can be increased to ninety-six upon the opening of the new Sir Charles Tupper Medical building.

Following are the names and present addresses of these new doctors to whom we wish every success:

- ACKER, John Christopher**, Fredericton, N. B.  
**ANDERSON, Kenneth**, Come-By-Chance, Nfld.  
**BARNES, Adam George**, Cottage Hospital, Channel, Nfld.  
**BEAZLEY, Ronald William**, 94 King Street, Dartmouth, N. S.  
**BERENS, Sanford Victor**, Dept. of Radiology, Downstate Medical Center, Clarkson Avenue, Brooklyn, N.Y.  
**BLAIR, Robert Douglass Gordon**, Saint John's General Hospital, St. John's, Nfld.  
**BORDEN, Lester**, Leslie, 64 Marcus Ave., New Hyde Park, N.Y.  
**BROWN, Charles Arthur**, 6026 Cedar Street, Halifax, N.S.  
**BUGDEN, Claude**, Old Pelican Cottage Hospital, Trinity Bay, Nfld.  
**BURKE, Francis Adolphus**, 181 Elm Avenue, Charlottetown, P.E.I.  
**BURNS, Gerald Ross**, 1173 South Park Street, Halifax, N. S.  
**CAMPBELL, Clarence Murdock**, Officer's Mess, Camp Gagetown, N.B.  
**CRAIG, Ronald Thomas**, Beaverbrook Ave., Saint John, N.B.  
**DARBASIE, Merle Cecile**, 19 Gordon Street, Curepe, Trinidad, W.I.  
**DOUGLAS, George David**, 219 Crichton Ave., Dartmouth, N.S.  
**GAUM, Winston Elliott**, Montreal Children's Hospital, Montreal, P.Q.  
**GELDART, Vance LeRoy**, South Lynnfield, Mass.

\*Dean of Medicine, Dalhousie University.

- GILLIS, Francis** Gerard, Base Hospital, R.C.A.F. Stn., Trenton, Ont.
- HAMMERLING, Judith** Dorothy, 6777 Quinpool Road, Halifax, N.S.
- HANSEN, Neils** Henry, Canadian Forces Hospital, H.M.C.S. Stadacona, Halifax, N.S.
- HARRIS, Lawrence** Kenneth, Albany Medical Center Hospital, Albany, N.Y.
- HAWK, Hubert** Edmund, 5648 Victoria Road, Halifax, N.S.
- HOGAN, Martin** William, Placentia Cottage Hospital, Placentia, Nfld.
- JEFFERSON, John** Chalmers, R.C.A.M.C. Edmonton, Alberta.
- KINLEY, Richard** Hummer, 6051 Welsford Street, Halifax, N.S.
- LANTZ, Joseph** Brodie, 65 Goodwill Avenue, Charlottetown, P.E.I.
- LEA, Robert** Henry, Simmon's Medical Clinic, Saint John, N.B.
- LOEBENBERG, Ralph**, 5855 Spring Garden Road, Halifax, N.S.
- MACKENZIE, Colin** Albert, Butte County Hospital, Oroville, California.
- MACKENZIE, Kenneth** Spurgeon, Queen Charlotte City, B.C.
- McNEILL, Laurie** Keith, Fredericton Medical Clinic, Fredericton, N.B.
- MAHARAJ, Deodath** Thacoopersad, Neil's Harbour, N.S.
- MAHARAJ, Gunness** Ramnanan, C/o Dr. Charles R. Maharaj, Benito, Manitoba.
- MARTIN, John** Craig, 22300 Euclid Avenue, Cleveland 17, Ohio.
- MEASHAM, Anthony** Raymond, 2 Waltdale Drive, Woodlawn, Dartmouth, N.S.
- MOCKLER, Gordon** Raymond, 20 Glen View Avenue, Glen Falls, N.S.
- PARIAGH, Kishor**, 2 George St., Sangre Grande, Trinidad, W.I.
- PRICE, Carmen** Scott, Old Perlican Hospital, Trinity Bay, Nfld.
- RAZACK, Abdool**, New Waterford, Nova Scotia.
- ROBB, Kenneth** Ian, R.C.A.M.C., Vancouver, B.C.
- ROSENBERG, Edwin** Michael, Department of Psychiatry, Victoria General Hospital, Halifax, N.S.
- ROSS, Robert** Alexander, Grenfell Mission Hospital, Happy Valley, Labrador.
- SCHWARTZBERG, Stuart** Gerald, 1 Weight Court, Great Neck, N.Y. (U.S.A.F. Kadema Air Force Base, Ryukyu Islands).
- SHAW, Mervin** Glenn, R.C.A.M.C., Camp Gagetown, N.B.
- SHORTT, James** Dawson, C/o Banting Institute of Research, University of Toronto, Toronto, Ontario.
- SIM, Franklin** Hindson, Mayo Clinic, Rochester, Minn.
- TEICH, Morton** Max, 1090 New York Avenue, Huntington Station, N.Y.
- TRUEMAN, Douglas** Hugh MacMillan, H.M.C.S. Cornwallis, Cornwallis, N.S.
- TZE, Wah** Jun, Children's Hospital, Halifax, N.S.
- VALLET, Herbert** Lawrence, 228 East Hudson Street, Long Beach, Long Island, New York.
- WOOLFREY, Ivan** Roy, Botwood Cottage Hospital, Botwood, Nfld.
- YOUNG, Michael** Kwing-Kwing, C/o Richard K. Young, 137 Isabelle St., Apartment 408, Toronto 5, Ontario.

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## Drug Resistance in Pulmonary Tuberculosis\*

*Analysis of the degree of bacillary resistance to the three commonly used drugs in tuberculosis therapy points up the clinical significance of even a low degree of resistance and the importance of susceptibility tests capable of detecting resistance, however slight.*

An attempt has been made to determine whether bacteriologic, roentgenographic, or clinical deterioration occurs in patients with tubercle bacilli of low degrees of resistance to drugs in use as well as in patients with highly resistant bacilli.

The analysis was carried out retrospectively. All patients with pulmonary tuberculosis whose names were brought to the notice of the research laboratory from 1952 through 1957 were included, provided there was definite evidence of resistance to at least one of the standard drugs, there had been at least three months' treatment with standard drugs, and the bacteriologic, roentgenographic or clinical information was available.

A separate analysis was made for each of the three standard drugs—streptomycin, PAS, and isoniazid.

For each patient the degree of drug resistance was classified as high, variable, or low. Seventy patients who had 187 treatment courses were analyzed.

In 91 per cent of the treatment courses, the pretreatment roentgenogram showed far-advanced disease. In 71 per cent, the disease was considered chronic; in 22 per cent, chronic with acute spread; and in 3 per cent, acute. The mean duration of treatment per course was 8.23 months. Only treatment given while the patient was in the hospital has been considered.

For treatment courses including streptomycin and PAS, the duration of treatment at risk of change was somewhat greater in patients with organisms of a high degree of resistance than in those whose bacilli remained at a low degree of resistance; that is, those in the high resistance group had a longer period of treatment during which deterioration could occur. With isoniazid, the longest duration at risk was in the combined low-degree groups.

### Deterioration Incidence

Bacteriologic deterioration was demonstrated in 12 of 16 patients with a high degree of resistance to streptomycin, in 5 of the 6 patients with organisms of a variable degree of resistance, and in all 7 patients at risk whose organisms were of a low degree of resistance. The incidence of deterioration by at least one criterion (bacteriologic, roentgenographic, or clinical) was 68 per cent in the high-degree group, 60 per cent in the variable group, and 82 per cent in the low.

Of the 19 patients at risk with a high degree of resistance to PAS, bacteriologic deterioration was demonstrated in 16. The numbers at risk in the variable and low-degree groups were small, the incidence of deterioration being 3 of 3 and 2 of 2, respectively. The incidence of deterioration by at least one criterion was 68 per cent in the high-degree group, 83 per cent in the variable group, and 75 per cent in the low-degree group.

Of the 36 patients at risk with organism of a high degree of isoniazid resistance, 29 showed bacteriologic deterioration, compared with 2 of 4 in the variable group, and 13 of 16 in the low-degree group. Twenty-three of the 66 patients in the high-degree group deteriorated clinically, 3 of 8 in the variable group, and 7 of 22 in the low-degree group. The incidence of deterioration by at least one criterion was 70 per cent in the high-degree group, 50 per cent in the variable group, and 64 per cent in the low-degree group. The incidence of *improvement* when the organisms were resistant to all of the drugs was 41 per cent, 50, and 29 for the three groups.

The incidence of deterioration was therefore at least as high in patients with organisms of a low degree of resistance to any of the three drugs as in those with highly-resistant bacilli.

Sheila M. Stewart, Ph.D., and J. W. Crofton, M.D. The American Review of Respiratory Diseases, June, 1964

\*Reprinted from the Abstracts of the National Tuberculosis Association, January, 1965.

Printed through cooperation Nova Scotia Tuberculosis Association.

Improvement occurred in a number of patients when their bacilli were still susceptible to at least one of the drugs and in some patients even when their bacilli were resistant to all the drugs in use. The improvement was more frequently shown by clinical criteria than by roentgenograph.

If bacilli of a low degree of resistance are of less clinical significance than those of a high resistance, it might be expected that deterioration associated with organisms of a low degree of resistance would occur later. However, in 10 of the 34 courses analyzed, deterioration occurred before the detection of resistance to streptomycin; in 8 of 23, deterioration occurred before the demonstration of resistance to PAS; and in 10 of the 63 courses which included treatment with isoniazid, deterioration occurred before resistance to that drug.

In 7 patients treated with drugs in adequate combinations, organisms were shown to be of a low degree of resistance to at least one drug and fully susceptible or of a low degree of resistance to at least one other before the start of treatment. Failure under treatment showed that the low degrees of resistance recorded before treatment were

clearly of clinical significance. Two of these patients were primarily infected with bacilli resistant to one of the standard drugs.

#### Choice of Test Important

The evidence from the present analysis shows that organisms which are only slightly less susceptible to streptomycin, PAS, or isoniazid than normal strains are as important clinically as those which are highly resistant. Deterioration during treatment frequently occurred in patients harboring bacilli of a low degree of resistance. It is therefore of primary importance that any tests used for the detection of drug resistance should detect these organisms with low degrees of resistance.

The main problem in assessing the efficiency of a susceptibility test is that there are many strains of bacilli in which resistance will be detected by virtually any method of testing. But there are others in which resistance is not detected if unsatisfactory tests are used.

Even a slight decrease in drug susceptibility in strains of tubercle bacilli is of clinical significance.

## THE DOCTOR AND THE BOAT

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## FORTY YEAR AGO

From the Nova Scotia Medical Bulletin  
July, 1925<sup>1</sup>

During the year which has elapsed sufficient progress has been made in the study of Scarlet Fever to justify the opinion that the serum treatment of the disease is being placed on a firm basis. There are now being made a number of preparations similar to those used in the control of Diphtheria, namely, an Antitoxin, a Toxin Antitoxin and Immunity Test. From the results met with in practice, it would appear that varying values are placed on these. The Antitoxin has been very favourably received, and is thought to have added very greatly to our methods of disease control. Concerning the other preparations, there appears to be a well marked difference of opinion, the majority of practitioners apparently not being convinced that the results up to the present obtained are meeting the expectations.

<sup>1</sup>From the Report of the Public Health Committee for 1924-1925. Presented to the Annual Meeting of the Society held at Bridgewater on July 1st and 2nd, 1925.

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Perinatal Mortality continued from page 170

### CONCLUSIONS:

During 1964, there were 25 perinatal deaths at Colchester County Hospital, out of a total of 834 deliveries. In four of these deaths there are factors concerned which are theoretically preventable. The death from congenital syphilis could have been prevented if the mother had sought antenatal care. The death from haemorrhagic disease might have been prevented by Vitamin K administration, though the toxic effects of Vitamin K in the newborn suggests that it should not be administered routinely. Two premature infants with cerebral depression might have survived if barbituates and morphia had not been given to their mothers shortly before delivery, though this is uncertain because in addition there is evidence of intra-partum anoxia.

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## The Coronary Muse

BY WATSON KIRKCONNELL

### 2. Sed. Index

The Index of Sedimentation  
Brings sorrow or joy to the nation:  
If it goes up too high,  
You get ready to die,  
But if low, you have sure restoration.

On this course, I am told I would par it,  
Did not the "Sed. Index" still mar it;  
For the day I shall roam  
From this hospital home  
Will depend upon stern Mrs. Starratt.  
W.K.

### 3. The 25th Day


Barnacle Bill had a heart attack -  
To the hospital he's gone.  
Limp as an oyster he lay, alack,  
Cautiously breathing, on side or back,  
For fear that his ticker some more might crack,  
While the weeks crawled slowly on.

Barnacle Bill was a patient cuss,  
As the nurses will testify.  
He wasn't the feller to raise a fuss  
Though the days were long and the nights were wuss  
And he felt as low as a mote of pus  
In a mouldy tomcat's eye.

Barnacle Bill is happy at last  
As they loosen him from his log;  
For the doctor has spoken; the die is cast;  
He may sit in a chair, as straight as a mast,  
From three o'clock to the full half-past.  
He's the merriest sort of dog.

Barnacle Bill had his lesson learned  
As he lay in his barnacle state:  
That age is a legacy gently earned  
By leisure cherished and stress well spurned,  
That the candle at both ends must not be burned;  
The wise in their day will wait.





## Personal Interest Notes

We have delayed publication of this issue of the *Bulletin* a few days to bring up to the minute news of the C.M.A. Meeting in Halifax last month. This is reported below.

Editor

Halifax doctors - and their wives - as co-hosts with N.B., P.E.I. and Newfoundland, relax, conscious of a job well done after the strenuous days and nights of the CMA Annual Meeting during the week June 14-18. The atmosphere was not like that when members of a county medical society in rural Nova Scotia arrived at a small hotel for a dinner meeting, only to find that, and through some slip-up, the dining room was in use. The proprietor offered the use of a large bedroom, where dinner was served, after each doctor had carried a chair up three flights of stairs. Things were a bit crowded but the surgeon who was guest speaker looked relaxed enough as he delivered his address while lolling on the bed. (*Maclean's Magazine*).

Despite a chilly welcome from the elements, the week generally was delightfully sunny and the entertainment committees' many activities had glorious settings. The Bluenose Cruises were very popular; Ashburn Golf Course was seldom empty and the Atlantic Lobster Carnival in Pier 23, thronged by more than a thousand people, in the gala setting of lighted ships of the U.S. Navy and the Bluenose, looked down on by the still inviolate

Man in the Moon will long be remembered.

Live colour television daily, excellent addresses by distinguished visitors, and daily hours of long work by Council, in an atmosphere, far less hazy with smoke than formerly, and good exhibits made memorable the 98th meeting during which Dr. Robert O. Jones was installed as President at an impressive ceremony.

The Dalhousie Alumni Reception brought together graduates from near and far. We were glad to see Dr. and Mrs. Hugh Schwartz and were proud of Nova Scotia's new Senior Members, Dr. H. Bengé Atlee and Dr. G. A. Barss.

Dr. Maureen Roberts was invested by Dr. Bernice Wylie, Vancouver, retiring President, with the Arnheim Medal, symbolic of the Presidency of the FEDERATION OF MEDICAL WOMEN OF CANADA, at the Annual General Meeting of the CMA. June 14 was "FEDERATION DAY", and after a talk by Dr. Roberts on Easter Island, "which she later gave to the CMA", the Annual meeting was held with about 36 in attendance, followed by a luncheon. In the afternoon, a drive to Peggy's Cove and Chester was followed by an informal evening spent at the home of Dr. Alice Kitz where slides of the Medical Women's International Association were shown. The meeting of the Association was held last year in Norway. The slides had been taken by Drs. Henrietta Banting, Helen Hunter and Dr.

Maria Rostosca who were part of the Canadian delegation. Dr. Banting is co-chairman of the committee to plan for next year's meeting in Rochester, N. Y. when Canada will be co-hostess with the U.S.A. to the International Association.

Graduation time for many is just over. Throughout the Province, from the various colleges and High Schools doctors' sons and daughters have been gaining various honours and awards. To them all we extend our congratulations. Especially do we take cognizance of the fourteen members of the graduating class of Dalhousie University who are either son or daughter of physicians.

1. **Dr. John Acker**, now Resident at Fredericton, son of Dr. J. C. Acker.
2. **Dr. Sanford Berens**, son of Dr. Abraham Berens, Brooklyn, U.S.A.
3. **Dr. Gerald Burns**, Resident in Surgery, Halifax, son of the late Dr. G. R. Burns.
4. **Dr. Winston E. Gaum**, Resident, Paediatrics, Montreal, son of Dr. A. R. Gaum, Sydney.
5. **Dr. Judith Hammerling**, daughter of Drs. Anne and James Hammerling, Halifax.
6. **Dr. Lawrence K. Harris**, son of Dr. I. R. Harris, Jersey City, U.S.A.
7. **Dr. Brodie Lantz**, son of Dr. I. P. Lantz, Keppoch, P.E.I.
8. **Dr. Richard H. Kinley**, Resident, Surgery, V.G., Halifax, son of the late Dr. C. E. Kinley.
9. **Dr. Kenneth MacKenzie**, son of Dr. J. W. MacKenzie, Queen Charlotte Islands.
10. **Dr. Edwin Rosenberg**, son of Dr. Bernard Rosenberg, '37, Resident, Psychiatry, V.G.H.
11. **Dr. Robert A. Ross**, Truro, son of the late Dr. R. F. Ross, Grenfell Hospital, Happy Valley, Labrador.

12. **Dr. James D. Short**, son of Dr. C. D. Short, Lachine, P.Q. Banting Research, Inst. Toronto.
13. **Dr. Morton T. Teich**, son of Dr. Samuel Teich, Huntington Station, N. Y. Paediatrics.
14. **Dr. Michael Young**, son of Dr. C. C. Young, Kowloon, Hong Kong, P.G. in England.

Congratulations to **Dr. D. J. Tinning**, specialist in Internal Medicine in Halifax on winning a special award of merit for his traditional painting, "High Altitude" depicting a scene in Labrador. This is the second time in seven years exhibiting that Dr. Tinning has won an award. Other prize winners in the annual Canadian Medical Association Art Exhibit, shown during the CMA Convention at the N. S. Technical College were, **Dr. E. B. Johnson**, Halifax, **Dr. G. M. Saunders**, Amherst, and **Dr. Garth Vaughn**, Windsor. Congratulations to them all.

#### ANTIGONISH-GUYSBOROUGH

**Dr. J. J. MacDonald** received a silver medal for his entry "Large Queen's Issue 1868" and another silver medal for his exhibit of Registered Covers of Canada, while **Dr. Rolf Sers** won a bronze medal for his Latvian exhibit of stamps at the National Convention of the Royal Philatelic Society of Canada. **Dr. A. W. Gyorfi** of the Sydney Stamp Club, received a silver medal for his exhibit of the Canadian two cent surcharges of 1897-1908. **Drs. Donald** and **Gyorfi** were also presented with engraved trays for having the best exhibit for their respective clubs. These trays are put up for competition and awarded by the Society's President, **Dr. G. M. Geldert** of Ottawa.

Later in May **Dr. and Mrs. Sers** took a holiday in New York **Dr. C. A. Herbin**, Arichat, attended the meeting of Coin Collectors in Halifax in May.

Friends of **Dr. G. R. Deveau** of Arichat are glad that he is recovering from his recent fall. He has been practising in Arichat since 1919, and at present is continuing an office practice.

On National Hospital Day, **Dr. J. J. Carroll**, senior physician at St. Martha's Hospital, Antigonish unveiled a picture of the late **Dr. J. L. MacIsaac** who died in 1940, who, in the days before antibiotics and new techniques in medicine and surgery, had done so much to build up the present excellent reputation of St. Martha's by his skill in surgery and an extra-sensory skill in diagnostic ability. **Dr. MacIsaac** was born in Dunmore, Antigonish Co. He taught school and worked as a lineman in British Columbia in order to finance his university education at St. Francis Xavier and Dalhousie. In 1925, he entered politics and was MLA for Antigonish Co. at the time of his death.

**Dr. T. W. Gorman** brought greetings from the Medical Society of Nova Scotia and **Dr. Robert Greening** welcomed those present on behalf of the medical staff of St. Martha's.

#### CAPE BRETON

Dalhousie is not the only medical school where doctor's children graduate in Medicine. At McGill's Convocation on May 28, **Dr. Vita Land**, daughter of **Dr. H. David Land** of Sydney, following in the footsteps of nine male members of her family, father, uncles and cousin, tied for highest aggregate standing in fourth year medicine, won the Wood Gold Medal for the best clinical examination of the final year, won by her uncle in 1930, as well as the J. Francis Williams Scholarship in Medicine and Clinical Medicine and the Montreal Children's Hospital Cushing Memorial Prize. Congratulations to her and her family.

**Dr. John A. Chadwick** from Antigonish also received his MDCM from McGill.

**Dr. James Lawley** was presented with a 50-year jewel at a large gathering of Masonic brethren representative of the various lodges in the district gathered at Tyrian Youth Temple, Glace Bay. **Dr. D. R. MacLean** of Sydney Mines was also presented with a 50 year jewel from the local Brier Lodge, I.O.O.F. Due to illness **Dr. MacLean** was unable to attend the meeting, but a special deputation visited him to bestow the jewel.

**Dr. and Mrs. M. B. Shaik** were recently honoured by members of the medical and nursing staff of the Harbour View Hospital, Sydney Mines, at the Columbian Home. They were presented with two Cape Breton scenes on behalf of the nurses.

**Dr. Lloyd R. Meech**, chief of the Medical Staff of North Sydney's Saint Elizabeth Hospital was honoured by a gift at a banquet held in his honour at a meeting of the medical staff in recognition of the 50th anniversary of his graduation from Dalhousie's Medical School.

**Dr. A. W. Gyorfi**, (see above), was guest speaker at the regular meeting of the Cape Breton Academy of the Canadian Society of Laboratory Technologists which was held at St. Rita's Hospital. **Dr. Gyorfi** spoke on new techniques in Histology.

#### CUMBERLAND

**Dr. and Mrs. Rham Boodoosingh** were honoured at the River Hebert High School when over 200 guests were present to WELCOME them to the community. They were presented with a purse of money. **Dr. Boodoosingh** graduated from Dalhousie.

#### HALIFAX

**Dr. Donald M. MacRae**, professor of Ophthalmology at Dalhousie and head of the Department of Ophthalmology at the Victoria General Hospital was

elected president of the 270 member, 25 year old organization of the Canadian Ophthalmological Society at its annual meeting in Vancouver in May.

**Dr. Anthony R. Measham** has opened an office at the Dartmouth Medical Centre for the practice of General Medicine and Obstetrics.

**Dr. D. M. Aitken, M.D., Dal.** 1956, has been appointed Assistant Secretary of the Canadian Medical Association to be effective July 1/65.

**Dr. Douglas L. Roy** as of July 1 becomes a full time member of the staff of DALHOUSIE UNIVERSITY and of the active staff of the Children's Hospital on a geographic fulltime basis and will be restricting his practice entirely to paediatric cardiology.

**Sister Catherine Gerard**, who is well known to every doctor who has had anything to do with the Halifax Infirmary since 1928, is retiring as Administrator of the Halifax Infirmary, and has been appointed as Hospital Consultant for the Congregation of the Sisters of Charity, to the five hospitals conducted in Canada by that Order. Sister Catharine Gerard has had wide experience in hospital administration. She is a life member of the Registered Nurses Association of Nova Scotia. Last year she was specially honoured by her appointment to the first Board of Regents of the American College of Hospital Administrators of which she is a Fellow. We congratulate her and are glad that her accumulated experience will still be available to Nova Scotia.

It has been reported to us that **Dr. N. H. Gosse** is disposing of his Dormobile (camper). It is hoped that it does not mean that he is giving up his Salmon Fishing Trips in Newfoundland. Rather not!

#### ADDITION:

In a recent issue of the Bulletin we recorded that **Dr. Macdonald** had spoken at three of the Cape Breton Branch meetings of the

Canadian Arthritis and Rheumatism Society. Actually he spoke also at the Annual meeting in Glace Bay on April 28 of this year.

#### CORRECTION:

**Dr. and Mrs. Paul Minc** of Freeport, Digby Co., who were reported as having moved to Dartmouth, are actually settled in Sault St. Marie, Ont. Previous to their departure they were tendered a farewell party by the Hospital Ladies Aid.

AN ORGANIZATIONAL MEETING was held in the Nova Scotian Hotel on Saturday, June 12, 1965 at 4:00 p.m. for the formation of a "Section of Obstetricians and Gynecologists of the Medical Society of Nova Scotia."

The following specialists attended this organizational meeting and are members of this new Section: Drs. Kenneth Grant, Irving Perlin, George Flight, Donald Smith, Carl Tupper, Stewart Robinson, James Corston, Jean Lawson all of Halifax, N.S.; Kenneth MacLennan, Sydney, N. S.; Patrick Gardiner, North Sydney, N. S.; John Greening, Antigonish, N. S.; and George Burton, Yarmouth, N. S. The following specialists did not attend this organizational meeting but had made previous application and were elected members of this new Section: Drs. Dennis Johnson, Dartmouth, N. S.; Murray Davis, Ethel Pereira, M. G. Tompkins, Jr., Halifax, N. S.; and Dr. D. Moore, Truro, N. S.

For the year 1965-1966 the following officers were elected: Chairman - Dr. Donald Smith; Vice Chairman - Dr. John Greening and Secretary Treasurer - Dr. Jean Lawson.

#### BIRTHS

To **Dr. and Mrs. D. S. Brennan** of Bear River, a son, Mark Robert, on May 10, 1965 at the Digby General Hospital.

To **Dr. and Mrs. Claude Bugden**, a daughter, on May 24, 1965 at the Halifax Infirmary.

To **Dr. and Mrs. Donald Nicholson**, (née June Meagher), a daughter, Donna Jane, at Radcliffe Infirmary, Oxford, England on June 8, 1965.

To **Dr. and Mrs. K. Ian Robb**, (née Elizabeth Smith, RN), a daughter, Margaret Jean, on May 18, 1965, at the Grace Maternity Hospital, Halifax, N. S.

To **Dr. and Mrs. M. G. Shaw**, a daughter, Sharon Elizabeth, on May 24, 1965 at the Grace Maternity Hospital, Halifax, N. S.

To **Dr. and Mrs. Joseph LeBlanc**, Yarmouth a daughter on May 31, 1965.

To **Dr. and Mrs. J. R. Greening**, Antigonish, a daughter, Kelly.

#### OBITUARIES

A Halifax born medical missionary, who pioneered work in Korea, died recently at the age of 97 years in Toronto. **Dr. Robert Grierson** was one of six Nova Scotians who in 1898 went to Korea where for 40 years he worked under the auspices of the Presbyterian, later the United Church of Canada. He built a hospital in Sunjin, North Korea in 1910, which was destroyed in the Korean War. He returned to Canada in 1934 and continued medical and church work for several years. In 1958, he was honoured by receiving a scroll by the General Assembly of the Presbyterian Church in Korea, where his name will long be remembered for his years of dedicated service. To his wife and children we extend our sympathy.

**Dr. Ronald Evan Pugh**, 47 years old, died suddenly following a heart attack on May 18. A physician and surgeon, a graduate of Dalhousie in 1941, he had served in the New Ross area since August. He was born in Heart's Content, Newfoundland, and had lived in Cape Breton for 23 years. A son is in medicine at Dalhousie. Our sympathy is extended to his wife and children.

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## PRACTICE AVAILABLE

A General Practice, due to a physician leaving, will be available in the town of Pictou in September 1965.

For information contact

Dr. C. B. Smith or  
Dr. J. F. Young, Pictou, N. S.

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