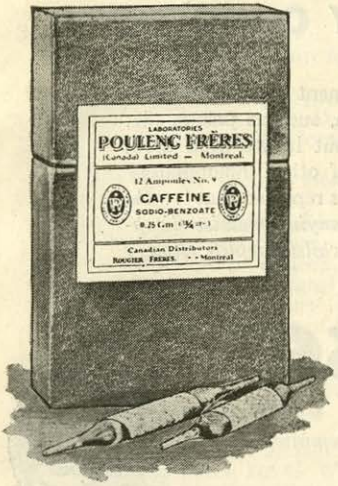

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CONTENTS

Pre-Sacral Sympathectomy for Pelvic Pain in the Female

A Report on 54 Cases.

W. G. COLWELL, M.D.,C.M.
Assistant Attending Gynaecologist at the Victoria General Hospital,
Halifax, N. S.

THE treatment of pelvic pain in the female is one of the most important problems with which the gynaecologist or the surgeon has to deal. The procedures for its relief are varied, and have met with varied success.

In Pre-Sacral Sympathectomy we have at our disposal a means, by which in a certain percentage of selected cases, this troublesome problem may be overcome.

The operation was first performed in 1925 by Cotte[1], a French surgeon, who, in a series of cases, resected the superior hypogastric plexus, which he called the pre-sacral nerve, with apparently lasting results. In 1929 he gave the name plexalgia to the condition for which he performed this operation.

The first work in English on the resection operation, was published by Fontaine and Herrmann[2], in 1932. They reported a series of twenty-two cases with excellent results. Their series comprised three groups, first, a group in which there was no demonstrable lesion, second, slight pathology in the pelvis, third, definite pathology, such as carcinoma, etc.

Kindel[3] reported a series of thirty-nine cases, two of which died post operatively, and four of which were not traced. Of the remainder, an excellent result was obtained in 14, very good in 4, good in 6, fair in 4, and in 5 no result.

Counseler and Craig[4] reported 14 cases, 9 of which were complete cures, 2 with 95%, and 3 with 75% success.

Atlee[5] reported 20 cases with very satisfactory results in 6, partial results in 8, and failures in 6.

The operation of Pre-Sacral Sympathectomy is not a difficult one, and is undertaken in the following way: The abdomen is opened to the right or the left of the mid line, the upper end of the incision being about one inch above the umbilicus, and extending downward midway to the symphysis or lower. With the patient in the Trendelenburg position, the intestines are packed away with tape pads, and the promontory of the sacrum clearly exposed. The posterior layer of the parietal peritoneum is picked up to one side of the promontory and incised from above the bifurcation of the aorta downwards into the pelvis for three to four inches. The pre-sacral nerve tissues lie between the iliac vessels and slightly to the left side. With a blunt dissector the tissues are stripped away from under the peritoneum on each side. On the right side the ureter can easily be seen and on the left side the dissection should bring the left iliac vessels into view. The pre-sacral nerve tissues now lie in the tissue dissected free. This freed tissue is picked up with Allis forceps and the dissection carried on above and below for a distance of about

two, to two and one half inches. Care must be taken in the dissection not to injure small veins which are often present posteriorly over the promontory, and especially to avoid the inferior mesenteric vein, which usually comes off above the bifurcation of the aorta, but which may come off lower down and be liable to be injured during dissection. Having separated out the nerve tissues, a piece about one-half to three-quarters of an inch long is removed, cutting between clamps or not as you wish. In the majority of instances this procedure is practically bloodless, what oozing there is, being easily controlled by gauze pressure

Occasionally one opens into this area and finds it very vascular. One case in particular I recall being almost varicose in nature requiring much care in the dissection. The posterior peritoneum is closed by a plain number one continuous catgut suture. It is our practice to send the piece of tissue removed to the laboratory, for confirmation of the presence of nerve tissue. Only one failure to find nerve tissue has occurred and that in an early case.

The earliest result seen from this operation, is the appearance of vaginal bleeding on the second or third day, which is slight and lasts but a short time. Several observers report this to occur in most of their cases, but it has occurred in but a few of ours. The bleeding is like menstruation and by some is thought to be a period. Others, believe it to be the result of the intense congestion in the pelvis consequent to the section of the nerve.

The series of cases to be reported herewith, total 54, about, 36 of which, we have definite information. All of the cases are six months or more over the operation.

In reporting the cases, they have been divided into various groups or classes, according to, first, Symptoms, second, Operative procedures, third, The condition of the pelvis at operation.

The results are given, as to symptoms, and as to operative undertaking. Some have had a pre-sacral resection, others a pre-sacral resection and other pelvic work. Twenty of the cases had a routine appendectomy as well as a sympathectomy.

Table 1 shows the cases classified as to symptoms complained of, and the number of each.

Symptoms	No. of Cases.
Dysmenorrhoea only	4
Pain in one or other lower abdominal quadrant	15
Pain in one or other lower abdominal quadrant and dysmenorrhoea	17
Pain in both lower abdominal quadrants	9
Pain in both lower abdominal quadrants and dysmenorrhoea	5
Backache	1
Carcinoma of the cervix with lower abdominal pain	3
	54

Table 2 shows what was found at operation.

(a) Normal pelves	30
(b) Pelvic Inflammatory disease (old)	14
(c) Other pelvic pathology including carcinoma	10
	54

Table 3 shows the types and number of operations done in the various instances.

Pre-sacral sympathectomy only	20
Pre-sacral sympathectomy and appendectomy	20
Pre-sacral sympathectomy and Ventro-Fixation	3
Pre-sacral sympathectomy and other pelvic operations	11
	54

The results obtained in the 36 cases which have been traced are given in the following tables.

According to Operative Procedures

	Complete Relief	Partial (50-Relief 95%)	Failure
Pre-sacral sympathectomy only	5	3	4
Pre-sacral sympathectomy and routine appendectomy	5	3	5
Pre-sacral sympathectomy and Ventro-Fixation	1	2	1
Pre-sacral sympathectomy and other pelvic operations	0	5	3
	11	12	13

According to Symptoms

Dysmenorrhoea only	2	0	1
Pain in one or other lower quadrant	1	4	2
Pain in one or other lower quadrant and dysmenorrhoea	4	5	4
Pain in both lower quadrants	3	2	3
Pain in both lower quadrants and dysmenorrhoea	1	0	0
Backache	0	1	0
Carcinoma of the cervix with pain in the lower abdomen	0	0	3
	11	12	13

Summary.

Fifty-four cases in the Gynaecological service of the Victoria General Hospital, have had the operation of Pre-Sacral Sympathectomy performed upon them for the relief of pelvic pain.

Of these 54, the present condition of 36 cases is known from six months upwards following their operation.

Of the 36, 11 have obtained complete relief from symptoms complained of; 12 have obtained partial relief, i.e., from 50% upwards to complete relief; and in 13 cases no relief was obtained. The patients who obtained partial relief were satisfied with the results of the operation.

There were no complications of any consequence in the 54 cases done. No deaths occurred, nor was any prolonged stay in hospital necessary.

From these 36 traced cases it would seem then, that this treatment has a definite place in gynaecology. It is not a difficult operation to perform, and in 23 of our cases was certainly justified from the results shown.

I am indebted to Dr. H. B. Atlee, the Head of the Department, for his permission to use his previously reported cases, and for the great majority of the cases now reported, particularly in regard to results.

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Better Milk Aim of V. O. N. in Kentville.

The establishment of a central milk distributing plant with milk to be secured only from herds certified free from bovine tuberculosis, and better care of the milk after it is delivered to the homes, were the recommendations of an interim report adopted at a monthly meeting of the Victorian Order of Nurses held in Kentville during November.

The committee has been for some weeks considering the possibilities of improving the milk supply for the town, a question that for some time was very much to the front in Kentville.

The committee bringing in the report which was given unanimous endorsation was made up of J. Fred Hockey, chairman; B. S. Bishop, M.D., Mrs. C. L. Baker and Dr. C. J. W. Beckwith.

It was pointed out that a further report is to be submitted based on an investigation that is being carried on at the present time by Dr. B. S. Bishop, medical health officer.

Clinical Observations of Breast Tumors

C. E. KINLEY, M.D.

A RESUMÉ of the more recent interpretation of the term "Chronic Mastitis" is perhaps the best method to introduce this subject. Few terms in surgery have come in for such severe and so much criticism. There are those surgeons who look upon all painful and nodular breasts as being the seat of a chronic inflammatory process, and until recently many pathologists, the histological evidence for this belief being based on the presence of an infiltration of the tissue with lymphocytes. To the lymphocytes is now ascribed the function of involution.

I believe we may now take as accepted the modern view of hormonal influence on breast activity and if such is correct it explains many phases of so-called Chronic Mastitis and also gives a clearer view into the associated problems of breast tumors, both simple and malignant.

We are all very familiar with the marked changes which occur in the breast during puberty, pregnancy, lactation and the menopause. We do not, however, often pause to consider the histological changes in the breast associated with menstruation where there is a striking change under the influence of the ovarian hormone, namely of a hyperplasia during the premenstrual phase, of desquamation and absorption during menstruation and of involution during the post-menstrual phase. A woman menstruates 300 to 400 times during her life so that the influence becomes a very important one. Were these changes to go on in a perfectly orderly manner the process of hyperplasia and involution balancing in a physiological way we would have no such term as Chronic Mastitis. Unfortunately such is not the case and we find many evidences of aberrant physiology in this organ, which is the scene of such constant epithelial and connective tissue unrest.

In a recent series of my breast cases some very striking facts were brought to my notice by Dr. Smith. They have a very direct bearing on ones conception of mastopathia and the development of simple and malignant tumors.

Case I. Woman, aged 46 yrs.

Presented with a lump in the breast 3 cm. in diameter, rounded, firm, and freely moveable. The breast otherwise felt normal. No regional glands were palpable. X-ray of lungs was negative. This patient received preoperative X-ray and four weeks later was operated upon. The operation consisted of a simple mastectomy and the breast then given to the pathologist in the operating room who sectioned the lump. This proved to be a very thick walled cyst containing a serous fluid with no intracystic projections. The remainder of the breast showed nothing on cutting. The operation stopped at this stage. Subsequent histological sections of the cyst area showed a simple cyst but sections however taken from an area in the breast by Dr. Smith, which clinically was not even significant, revealed an early scirrhous carcinoma of the breast. This report of course necessitated a complete radical dissection which was done and subsequent pathological study of the glands revealed no evidence of metastases. The outlook for the patient is thus excellent.

Is it not very evident however that had a simple removal of the palpable tumor been done or worse a biopsy of the tumor, this patient would have carried on with both surgeon and patient ignorant of the true condition of affairs?

The mastectomy was done in the first instance realizing that a study of the entire breast was necessary and that a multiplicity of changes may take place and that a palpable nodule does not necessarily mean the seat of the severest pathological hyperplasia or neoplasia.

A study of numerous sections histologically of the breast was very illuminating. There were evidences of cystic change, fibroadenomatous change, papillomatous change and finally actual neoplastic change i.e. evidence of both hyperplasia and involution and tumour growth, both benign and malignant.

It teaches a lesson in a striking manner that simple biopsy or removal of a single cyst or bit of breast for diagnosis does not present the patient with a verdict of "not guilty."

I can also quote in this regard another case of a woman 28 yrs. who developed a lump in the breast several months following child birth and the lump removed for pathological section. Although the sections revealed a simple cystic hyperplasia the breast was removed as suspicious, no pathological examination however of the entire breast was made. Several months later the patient showed evidence of metastases in the skin and liver. I do not believe a radical operation here would have changed matters much but it does bear out my contention in Case I.

Case III. Girl, aged 21 yrs.

Complained of pain in the breasts, headache and scanty menses. Examined during the menses the breasts were tender and firm but no definite nodules were palpable.

The treatment in this case consisted of Estrogen 50 Rat units, hypodermically for 3 days before the period was due. This was followed by a marked improvement in all the symptoms and was carried on for 4 months with quite striking results. Unfortunately I then lost trace of this patient.

It does show however that relief in early cases may be expected by the use of ovarian extract or better the estrous-producing hormone.

The point here however seems to me that no palpable tumor was present. In the presence of a palpable lump particularly in an older patient I do not believe the above treatment justifiable. If one is consistent in the estimate of histological change, when a palpable nodule is present changes have progressed beyond the therapy of ovarian stimulation as we know it at present and more stringent rules must apply.

I think the previously quoted cases must show some real relation between the hyperplasia-involution cycle, simple tumors and those of a malignant nature. The curious thing to me is that Cheatle and Cutler in their book claim no relationship between Mazoplasia, which is characterized by hyperplasia of the peri-duct connective tissue, round cell infiltration epithelial hyperplasia and the formation of new ducts and acini, but no cyst formation, and cancer though it may have to fibroadenoma, while a later phase, or as they say a different disease, namely Schimmelbusch's disease, a special type of desquamative epithelial hyperplasia with the formation of common cysts of the breast, is accepted by them as sometimes developing into neoplasia, both benign and more often malignant.

I think as a simple surgeon giving advice that a contrary attitude should be adopted as regarding it all as part and parcel of the same process and that the change, especially the cystic variety, is precancerous. Such is a much safer course until proved otherwise. This attitude is supported by the multiplicity of histological changes apparent in Case I.

Case IV. Woman, aged 40 yrs.

Presented with a painless breast tumor 1 cm. in diameter in the right lower quadrant of the right breast. It was freely moveable and firm. No evidence of glandular metastasis. It was a rounded symmetrical enlargement. I feel confident most of us would have said "This is a simple tumor." This was my impression. She was prepared for a radical operation. On operation the breast was first removed and Dr. Smith showed conclusively on cutting into it that it was a scirrhous carcinoma. Radical operation was then completed. The histological report was that of a very dense scirrhous carcinoma. A few minute glands were detected and one of these showed a very cellular carcinomatous infiltration. A thorough X-ray follow up was done. This case shows conclusively the fallacy of recognizing a tumor of the breast by palpation, and the uncertainty of diagnosis of gland involvement.

The prognosis here is poor. A small densely fibrous tumor with early cellular metastases. Although the X-ray of the lungs is negative I am not hopeful of a good prognosis.

In contrast to this case the following is a nice lesson.

Case V. Woman, aged 46 yrs.

Presented with a large tumor of the left breast, firm, rounded, slightly tender, not fixed to the skin or pectoral fascia. She was examined by a physician who told her that her case was hopeless. A cancer and a bad type and that operation was of no value. There was however no clinical evidence of metastases and X-ray of the lungs was negative and the abdomen was negative. She had a radical operation. The tumor was a very cellular medullary encephaloid carcinoma with practically no stroma. The glands searched carefully showed no sign of metastases. It is now two years since operation and no evidence of return can be found. In such a cellular tumor an overlooked metastatic focus should now probably have become evident. Here, from examination of the breast a hopeless carcinoma has an apparently good outlook.

In choosing these few cases from a group for presentation I have selected perhaps those in which outstanding change is most evident. However, I think from clinical and pathological findings of the entire group, which I should be pleased to demonstrate in association with Dr. Smith, the following conclusions or, should I say, opinions may be drawn:

1. Every lump in the breast should be thoroughly investigated histologically.

2. Biopsy of a portion of a tumor or of a section of the organ and particularly by frozen section is not conclusive enough to warrant routine usage. My own experience of frozen sections in the past 12 yrs. of hospital work has been most disappointing.

3. The cellular activity of a tumor is not necessarily a direct guide to prognosis, for two reasons, firstly, the tumor may vary greatly in its gross and histological structure, and secondly, this has no direct bearing on metastas-

es. A small dense scirrhous tumor may have metastatic deposits in the axillary glands while a large bulky encephaloid carcinoma may be still localized.

4. The safest procedure in a patient over 35 yrs. with a palpable lump in the breast or with a serosanguineous discharge from the nipple with or without a palpable tumor is mastectomy and careful study of the entire breast.

5. To return to the term chronic mastitis, which from histological and clinical research is thoroughly proven now to be a misnomer, would it not be better to correlate our conception of breast changes due to hormonal influence with those of a similar nature occurring in the uterus, thyroid and prostate? And substitute the more and understandable terms mastopathia for cases without cystic change and cystic hyperplasia for the others.

Finally may I thank my friend and colleague Dr. Smith for his kind assistance in this study.

Workmen's Compensation Act.

Since the last edition of the BULLETIN the Provincial Government has appointed a Commission to inquire into the Workmen's Compensation Act. J. A. Hanway, K.C., of Amherst is Chairman of the Commission, and the other members are J. H. Cunningham of Bear River and Dr. W. D. Forrest of Halifax. When it was known that this Commission was appointed the members of the Workmen's Compensation Committee of the Medical Society of Nova Scotia held several meetings in Halifax and discussed some of the grievances which have been brought to our attention in the past few years. Dr. J. G. B. Lynch of Sydney, the Chairman of the Committee, was away; accordingly, Dr. H. K. MacDonald of Halifax headed up the Committee and had with him Dr. M. G. Burris of Dartmouth, Dr. J. V. Graham and Dr. J. R. Corston of Halifax, and the Secretary. On November 27th our Committee interviewed the Commission and put before them several matters which we did not feel were just. The first item was the thirty-day clause; secondly, it was suggested that a revision of fees should be made in Nova Scotia as a review of the fee schedules in other Provinces almost invariably showed that the Nova Scotia fees were appreciably lower, and the last item discussed was the importance of including one of the industrial diseases, silicosis, in the list for compensation. Dr. W. A. Hewat of Lunenburg came in to this meeting and presented several difficulties he had had in determining whether or not cases were eligible for compensation. Dr. Hewat suggested that a medical referee who could travel to different parts of the Province would be a help in this respect. The Commission gave our Committee a very friendly hearing, and have made an appointment to meet them again the first week in January.

In the meantime, the Secretary has communicated with all the local Societies asking them to send in to him in writing any grievances or opinions they may have on the workings of the Act. The Workmen's Compensation Committee would also like to hear from any individual throughout the Province who has any suggestion to offer. This is an opportunity for the profession as a whole to express to the Commission through our Committee any grievances they might have. The meeting in January will be the last session.

The Prostatic Problem

FRANK G. MACK.

A SURVEY of urological literature of the past five years reveals that an unusual amount of attention has been given to various aspects of the problem presented by the several types of prostatic obstructions. This is chiefly manifest in the very large number of articles, appearing in the general and special journals, on methods of transurethral resection of the obstruction at the bladder neck. These methods are developments and refinements of the long established punch operations on the bladder neck such as those of Young and Caulk and have been made possible by the perfection of modern cystoscopic apparatus and the development of the high frequency cutting current.

Pioneers in resection such as McCarthy, of New York, were very conservative in their statement of indications for the method and sharply limited its use to certain types of cases. Before long enthusiasts, some of whom had very little cystoscopic experience, began to employ resection indiscriminately in all types of prostatic obstruction even in the largest trilobar hypertrophies. There were many undesirable and unfortunate results, as might be expected, for even in the hands of experienced cystoscopists the mortality in the first fifty cases has been much higher than in the second fifty. Many cases of incontinence due to cutting too far forward so as to damage the external sphincter were reported and the sales of incontinence clamps are said to have rapidly and suddenly increased. Even recognized experts began to extend the method to the larger types of prostatic hypertrophy. In 1933 at the Mayo Clinic 98% of prostatic patients operated upon were treated by a resection process in which the prostatic tissue is coagulated by a needle electrode and then punched out. Lowsley writing in 1933 was amazed at the large number of resections being done in the United States, one "ambitious person" having even reported the performance of over 900 resections in three or four years, and could "draw only one conclusion and that is that there are hundreds being operated on who do not need the operation at all."

There seems now to be occurring that phenomenon so well known in the history of medicine—the swing of the pendulum in the opposite direction. The opinion of the majority of outstanding urologists would appear to be that resection is an extremely valuable procedure which should be used only in the lesser obstructions such as the following:—

Median bar (formerly called atrophy of the prostate and contracture of the bladder neck).
The smaller median lobes.
The smaller bilobar and trilobar hypertrophies.
Carcinoma of the prostate with obstruction.

It is considered justifiable to employ resection in the large hypertrophies in patients whose general condition is so poor as to make prostatectomy too great a risk.

The chief advantages of resection over prostatectomy are the comparative freedom from shock and the shortening of the stay in hospital. As experience accumulated it was often found necessary to keep patients in for fairly long periods and sometimes, where the bladder was grossly infected and there was much renal impairment, a preliminary suprapubic cystotomy for drainage was necessary.

A striking example of the value of prolonged suprapubic drainage was seen recently in a man of seventy who had such a serious myocardial condition that the medical consultants considered him unfit for any surgical procedure. After much discussion a suprapubic cystotomy was done and after a stormy convalesence the patient was sent home with a suprapubic tube in place. He was advised to return in three months if better. His health gradually improved and he led quite an active life and returned after three months looking and feeling very well. The cardiac condition was found still to be such as to make a major procedure unsafe but he stood the operation of resection very well and after three weeks returned home emptying the bladder very satisfactorily.

Resection is by no means free from danger but in the hands of the experienced instrumenteur the risks are minimized. Severe haemorrhage, either primary or secondary, may occur; perforation and gangrene of the bladder have been reported; sepsis and pyelonephritis must be guarded against constantly by aseptic methods, the free administration of water, the use of urinary antiseptics and irrigation of the bladder through the indwelling catheter and after its removal. Considerable discomfort on micturition and a marked pyuria are frequently present for some time after resection. Usually the residual urine rapidly decreases in amount until the bladder is emptied completely. Recently I have been employing ammonium mandelate in the hope of lessening the amount of pyuria but it has been used for too short a time to permit an estimate of its value. This potent urinary antiseptic must be used with caution, because of its tendency to impair kidney function, in these patients many of whom suffer from serious renal impairment.

During the past three and a half years I have employed resection for the relief of retention in a number of cases of carcinoma of the prostate with great relief resulting so that these patients have been able to empty the bladder well until they succumbed to metastases elsewhere.

Some unsatisfactory results after resection, as well as after prostatectomy have been due to lack of proper care and supervision after the patient has returned to his home. Large sounds (26 or 28 Fr.) should be passed occasionally to prevent adhesions and contracture at the site of operation. The urine should be kept acid by medication and diet and where much infection remains lavage of the bladder is most important. A determination of the amount of residual urine from time to time will show the effectiveness of the operation and if much residual urine persists further treatment will be called for. Unfortunately the patient may fail to report promptly to his family physician or he may be so far from him that these measures cannot be carried out with regularity.

Suprapubic prostatectomy by the two stage method must still be considered as the better treatment in the larger hypertrophies when the patient is or can be made a good subject for operation. It must not be forgotten that without adequate preparation in a patient with seriously damaged kidneys and myocardium even the preliminary cystotomy may prove rapidly fatal. In those patients who are good risks the mortality of the two stage operation should not

be high but in the "derelicts" of large cities and in toxic neglected cases the mortality rate will necessarily be lamentably high. Even in the worst types careful preliminary catheter drainage, the free administration of fluids, digitalis in selected cases and where acute retention has occurred, the institution of gradual decompression may convert a very poor risk into a moderately safe one.

Within the past two or three years there has appeared on the horizon fresh hope of relief for prostatics from researches in hormone therapy. European workers and those of the Cleveland Clinic have reported marked symptomatic relief but curiously enough not much apparent decrease in the size of the gland. The hormones used are not yet fully isolated or purified and are derived from the testicle. It is far too early to hold out much hope to the public but as research continues it may be expected that the early use of these products will be very valuable and may perhaps prevent further development of beginning hypertrophy.

In conclusion I would urge that patients be advised to come as early as possible for treatment before serious renal damage has occurred and when, perhaps, the relatively minor operation of resection may be quite sufficient.

Results of the survey re a conjoint fee of $15.00 for membership in the Medical Society of Nova Scotia and the Canadian Medical Association, for the year 1937.

To date 277 physicians in the Province have expressed willingness to pay a fee of $15.00 for conjoint membership in the Medical Society of Nova Scotia and the Canadian Medical Association for the coming year. As it was decided by the Executive that 250 would be sufficient to warrant us entering into the agreement, the matter is now assured. In the past the Canadian Medical Association have collected annual fees in late November, whereas we have always made collections in February. We are now in correspondence with Dr. Routley regarding this matter. When a suitable time is agreed upon, bank drafts for $15.00 will be issued from this office to those who have subscribed, and when the draft is paid $8.00 will be forwarded from here to the office of the Canadian Medical Association. Kindly be prompt in honouring your drafts as this office is now responsible to the Canadian Medical Association for the collection of their fees in Nova Scotia. Those who have objected to bank drafts will be sent accounts.

H. G. GRANT, M.D., Secretary.

The Peregrinations of a Doctor and His "Missus"

By THE "MISSUS".

"ALL visitors ashore! All visitors ashore!" The gong sounded a warning, up went the gang plank and we were off to parts unknown.

The world cruise had sounded fascinating and we wondered just what the next four months would hold in store for us.

We left New York on a fine sunny morning, so we were unprepared for the terrific storm we met a few days out. As we tossed about we wondered if it might have been wiser to have learned the art of staying home, but "true sailors never say die," and our first glimpse of Madeira made us forget our troubles. We arrived in the evening and went off by tender to Funchal, the capital. There was a moon. It shone on the cobble stone streets and showed us flowers blooming everywhere, even in the gutter. There was also a casino high up on a hill, and a bullock carroe to take us there, a strange conveyance rather like an old fashioned wooden sleigh with a top. A native boy ran in front with a greasy rag which occasionally he threw under the runners. The casino was a trifle dull so we were able to tear ourselves away to prepare for a ride up the mountain in the funicular railway next morning. We stopped first to see the wine cellars where we were given all kinds of Madeira wine to sample, then off we went to the hotel on the mountainside from where we had a superb view. We made the return trip in a toboggan sled. It went at a tremendous speed over the cobblestones, and at every turn we felt we might dash into the stone walls on either side, but this did not spoil our enjoyment however, and we were ready for our lunch when we reached Reid's Palace Hotel, from the veranda of which we had a lovely view of the water and surrounding hills. Madeira is a very quaint place and we were sorry to leave it. Our last glimpse was of the natives following the ship in small boats holding up their embroideries, shouting, "Missus, how mooch you pay?"

On we went to Gibraltar. We remember it a trifle coldly. We saw the rock resembling a huge crouching lion in the distance. We landed, and found it gloomy and formidable. We enjoyed seeing the Moorish castle, by far the most interesting building there, but as we trudged through the galleries cut in the rock, from the "windows" of which we had a clear view of Spain, we felt we could find something we liked better, not being of a military turn of mind.

Barcelona, which we visited next, we enjoyed very much. Driving along its spacious boulevards with their beautiful trees, and large modern buildings we discovered there were no square corners in Barcelona, all round ones. We saw a lovely cathedral, and the palace filled with treasures, many of Moorish design, and beautiful paintings. The Spanish people are extremely fond of music and the opera house is a most elaborate building. We went to the bull ring. Bull fighting is still popular in Barcelona, and one look at the enormous fierce looking bulls made us appreciate why there is a hospital in connection with the arena in case of serious accident to the toreadors.

From Barcelona we went to Monte Carlo. The approach is very lovely, but we were a little disappointed not to see the Mediterrannean blue, it remained grey and cold. It was not the season at Monte and at the Casino, instead of beautiful women and smart looking men, there were only a handful of people gambling with a few francs. The Salle Prive was closed. The flag flying at the Palace told us that the Prince of Monaco was in residence. The following morning we drove to Nice over the grand Cornishe and back over the old road. It is one of the loveliest drives in the world and we thoroughly enjoyed the magnificent scenery. In spite of the cold weather the promenade des Anglaise at Nice was crowded with people and it looked much gayer than Monte.

Naples, our next stop, had greatly improved since our last visit, clean streets, no beggars, tariffs in the taxies and the hotels, but we missed the street singers. We drove to Pompeii and poked about the ruins. It was amazing to see the beautiful blue mosaics so well preserved—the ruts in the roadway made by the Roman chariot wheels, and many of the foundations of the houses mentioned in Bulwar Lytton's "Last Days of Pompeii". The following day we drove up to Amalfi. The tiny fishing villages dotted along the mountainside were very picturesque. We met a most unusual procession, which we discovered was a funeral. A bright green hearse was supported on the heads of two men, their faces, except their eyes, completely covered by green masks, behind walked the altar boys with lighted tapers, waving incense as they chanted. We stopped at the Cappacinni monastery for lunch, high up on the mountainside. We just had time to see the old chapel, the monks' cells, (now very comfortable bedrooms,) and the peaceful courtyard before driving to Sorrento. Here we found many quaint houses, pretty gardens, and shops filled with Italian lace and pottery. Back we went by the lower road to Naples.

On board again we sailed for Athens. To see Athens alone is justification for the trip to Greece. The Acropolis is crowned by the majestic Parthenon, the most perfectly proportioned building of all time. We saw its beautiful marble pillars silhouetted against a clear blue sky—a sight we shall never forget; nowhere in the world can one view scenes where so much drama of history has been enrolled as from Athenas Hill—here Persian, Roman, Barbarian, Crusader and Turk have lived their day; here is the ruin of the temple Aesculapius, the first organized hospital. In and around Athens archaelogists are busy delving in the earth in search of temples and statues that once adorned the market place heart of Athens of the golden age. We drove back to the ship through the refugee quarters, and saw the rocky mountains where the Medes and Persians fought their stormy battles, and we caught a glimpse of the Armenian refugees with their remarkable embroideries, the sale of which gives them a living.

Palestine, our next stop, stands at the crossroads of Africa and Asia, and has served as a battle ground for foreign hosts for countless years. It has a fascination for the entire world, for it is still the land of the Bible. We disembarked at Haifa and drove over to Tiberius, that strange city below sea level. The country offers a fascinating picture of scenes identical with the life of the scriptures. The Sea of Galilee appeared calm and still, Bethlehem a quiet little village, and at Nazareth we saw a shepherd coming over the brow of the hill carrying a ewe lamb in his arms.

From Palestine we went to Egypt, now one of the most popular winter resorts. The Suez canal has made it the thorough-fare of the world. Before it was built the Nile and its canal was the most important means of communication. We expected to see the Nile green, instead, it was a dirty brown. At night, though, with the moon shining on the funny little Dhows, it is enchanting. We went up to Bedrechen and wished we could go on up to Luxor, but a week in Cairo is all too short with its Egyptian museum filled with interesting things, notably King Tut's three tombs, one of pure gold, two outer ones of gold and enamel; his chariot (by the way, we discovered it had a speedometer on it); his royal chair and bed which looked very uncomfortable, and the unusual jewels; the pyramids of Gizah, the mosques and the bazaars leave an ineffaceable impression. To be a real tourist one simply must ride a camel. When one is accustomed to the motion it is great fun. We rode out to the Pyramids and on into the desert, where we camped for the night. We rode in the moonlight and were surprised to find how fast the camels travel. My dragoman was most unlike a sheik, very dirty—and he demanded "Backsheesh, Backsheesh," every few minutes, which I discovered meant my money, and not my virtue! The whirling dervishes danced for us and our fortunes were told by the light of the moon in the sand (mysterious dots and dashes with a meaning all their own). We were up early to see the sun rise, a lovely sight, the sky changing every few seconds, then back we went to the Shepherd's Hotel, the famous meeting place of the Far East. We were amused by the fakirs on the terrace. They uttered the magic words, "Gala, Gala, Gala." and out of our pocket appeared a tiny yellow chicken, in our hand we held a two shilling piece; "gala, gala, gala" and we found ourselves madly clutching a penny; that two shillings never did come back. We saw long pieces of hemp on fire disappear into the fakir's mouth, then smoke poured out—we were sure he was burning up inside, when out came a long string of needles. One must not miss a visit to the bazaars, funny old stalls in out of the way streets. Surprisingly one finds Solomon's perfumes in a most elaborate setting. We sat on a beautiful Dumptie with a cup of Turkish coffee, were given Egyptian cigarettes, we smelt a perfect garden of flowers and decided that here at last we had found shopping de luxe. There are a great many Mohammedans in Egypt. The mosques with their tall minarets are very lovely and we liked to hear the call to Allah: "Allah akbar, la ilah illa-la", (Allah is greatest, there is no God but Allah.) We found we had to wear canvas shoes to cover our feet before we were allowed to enter the Mohammedan college where there were students of all ages sitting in circles on the floor, studying the Koran. We were much impressed with the Heliopolis at Memphis, but all too soon we found ourselves on the way to Port Sudan by rail. This is a natural inlet for the Red Sea and is the home of Rudyard Kipling's Fuzzy Wuzzies, so called because of their hair, which is complete with a wooden scratching pin. They persuaded us to buy ivory beads and reed baskets before we embarked once more for Mombassa, a picturesque island where natural beauty abounds. Here there is a marvellous coral reef, beautiful with the sun on it. It is the main entrance to the Kenya Protectorate. Here there are Europeans, Indians, Arabs and Africans—and ancient and modern intermingle. It has been described as the cockpit of the coast of Eastern Africa, and the Fort over 300 years old has seen many a fierce encounter between the Arabs and the Portugese. At Mombassa we saw twenty-four native tribes perform their weird dances. Their costumes consisted of a head dress of feathers, strings of bar-

baric looking beads around the neck, a feather fringe around the tummy and painted legs. They stamped their feet a great deal, swayed from the hips and occasionally uttered piercing cries while the tom toms kept time. In the market place we found East Indians and Arabs in native dress, selling luscious looking fruit, which tasted as good as it looked. Our next stop was Zanzibar, the largest coralline island on the East African coast. At one time it was the great African slave market, but early in the nineteenth century this was suppressed. We arrived by tender and drove in rickshaws through the extremely narrow winding streets to the bazaars, passing some old houses with beautiful Moorish doors inlaid with brass. In the bazaars we found many Chinese, Persian and Indian treasures, and some Arab chests which we were told had come out of the harems. We drove by car to Bububu, stopping on our way to see the Sultan's palace. Here there was a gorgeous lily pond full of blue water lilies, and what a blue! Most of the place is in ruins, but the dungeons for the slaves looked dark and horrible. Turning a corner quickly we came upon an Arab praying to Allah near the lily pond. We wished we could have painted that. The coloring was beyond description.

We saw great groves of cloves. Zanzibar has the world's largest clove industry and pineapples grow everywhere.

From Zanzibar we went to Dar-es-Salaam (the city of peace). At one time the capital of German East Africa it now belongs to the British. The harbor is approached by a narrow channel, so we went in by tender. To the left of the harbor is the old German floating dock which was sunk in an endeavor to block the entrance of the British war ships. The streets are broad and well kept, and while most of the houses are comparatively new, yet they are picturesque. The botanical gardens are extensive and in the centre is the European hospital. The natives are a peculiar mixture. When we asked our driver his name he said, "Well, Missus, it used to be George Washington, but I found out that another feller had the same one, so I changed mine to Abdullah."

Government house is quite an imposing looking building and the drives about Dar-es-Salaam are very beautiful.

When we arrived at Madagascar, our next stop, we found the thermometer registered 140°. We landed at Majunga Bay, and drove by rickshaw around part of the island. Back at the hotel we felt sure the lunch was monkey meat. The day was decidedly not a success. We heard there were to be races. Naturally we expected to see a track, but our rickshaw boy insisted on taking us to the quay. We were very annoyed, and it wasn't until after a heated argument in French, English, Arabic and Chinese that we discovered the races were boat races. After this adventure we had several days at sea, and during one morning, as we crossed the equator, Father Neptune arrived on board to give us the freedom of the seas. He and his court certainly put us through our paces; our mouths were filled with soap, our faces covered with grease, and then we were pushed off a chair into the swimming pool backwards and given a good ducking. We deserved our certificate.

We arrived on Sunday at Lourenco Marques. We are ashamed to say all we remembered about it was the Polana Hotel with its lovely beach and a group of natives lying asleep under an hibiscus tree, in their bright bandanas looking like a Van Gogh painting. Our trip to the Hippo pool was amusing. We went on a little train with rubber tires and basket chairs until we reached the Esperanto Santo River, then by motor launch to the pool. We found

ourselves on the edge of the Kruger Reservation. Here we saw small houses built up in the trees. We were told that they were shelters for the dead, but later that they were hen houses put up there by the natives to protect their hens from the many wild animals. Either way, the effect was very odd. The hippos were most playful, they adored the horn on the motor boat and whenever it sounded heads appeared in every direction. We felt sure they thought it was a call to dinner.

Durban our next stop is quite a modern city. The houses are very much alike. Many attached villas of the English type. The climate is delightful and the flowers make a riot of color. The market is well worth a trip. There are splendid beaches here and a delightful country club. The drives about Durban are very fine, particularly the Valley of A Thousand Hills, which is just what its name implies, and at the foot of the valley we found the Zulus in their kraals or huts made of mud, the floors, of ant deposit, pounded by their feet until it becomes as hard as cement, then polished by hand and covered with matting. The Zulus are a husky lot and live principally on mealie meal. In the valley they seemed delighted to see us, danced and were very pleasant, so we were surprised with the reception we received in another village some distance from Durban. The chief was having a beer party, apparently a very important occasion. One hundred native men in their war paint huddled together in one hut; outside their wives were having a friendly pow wow until we appeared. We were greeted with black looks and ugly muttering. When we asked the chief to show himself, offered him money to do so, we found a man without a price. He refused and rather rudely asked us to begone. We thought discretion the better part of valor and hastily beat a retreat. This was decidedly not a show put on for tourists. Later, however, we did have an exhibition of Zulu dancing in the parade grounds, well done too; the dance of love, marriage, hate, quite unlike the dances in Mombassa, plenty of action, leaping in the air, pounding their feet, uttering loud cries and keeping time with their drums. Sitting outside under an enormous moon it seemed a trifle unreal. Durban would be an ideal place to spend the winter, good hotels, splendid golf links, and on the surface, as that, of course, is all we had a chance to see during our week there, it appeared to be very gay and filled with many charming visitors.

The drives to Mount Edgecombe, Uumllange Rocks, the blue lagoon are truly lovely. Everywhere there are Zulus in magnificent head dress, white painted legs and feathers, pulling rickshaws, every now and again leaping in the air like kangaroos.

In Durban there is a small zoo. The monkeys are fascinating, almost human, and we saw an ant bear, a strange animal something like a pig with its long nose in the ground most of the time. Like the bush baby he is quite an unusual sight.

Leaving Durban we went on to Cape Town. Approaching the harbor Table Mountain appeared to tower over the city wrapped in a white cloth of mist. It looked rather forbidding, but as we came closer we saw the harbor was really beautiful and Cape Town nestled in the shadow of the mountain. The city is charming with quite an old world atmosphere. The Dutch influence can be plainly seen in the houses. The museum is a pleasant surprise because it is in a beautiful old Dutch house, at one time owned by Captain Hoopman DeWet. It is full of treasures, the copper and the brass shine, and there are rare bits of Ming, no doubt brought over by the Captain from

China. The furniture is mostly early Dutch combined with Georgian pieces, which strangely enough appear to agree. We visited the grape vineyards at Constantia Nek and Groot Constantia. We drove through Franch Hook Pass and Voght Pass, the roads cut straight through the side of the mountain, up to Stellenbosh, but what we enjoyed most was our trip to the Cape of Good Hope. From the lighthouse we had a view of the Indian Ocean on one side, the Atlantic on the other. We travelled up to Table Mountain by cable way and found an inn perched at the top. We must confess we thought our car appeared to be going on a very slender cable, but it makes a great many trips in a day and is quite safe. We visited the Rhodes memorial. It is very imposing, high up on the hill it appears to look down protectingly over the city. We visited, too, the old castle prison and on the door of cell number four we saw the following lines:

"MRS. REEVE'S HOTEL
Lodging for Single Gentlemen Only

Unwelcome stranger to this woeful place
Adieu to friendship and to mental peace
When sad reflections ponder o'er crime
No cheering comforts gladden the weary eye
As the incessant hours in dull rotation fly.

HICKEY, 2½ years for desertion."

Muizenburg is within easy distance of Cape Town. Here we found marvelous sea bathing. It has one of the finest beaches in the world. There are sunken gardens, and myriad twinkling lights sweeping along the promenade make it possible to continue bathing long after night fall. The temperature of the water during the summer months is about 70°. We noticed that all South Africans were excellent swimmers. Regretfully, we said good-bye to South Africa.

Our next stop we hoped would be Tristan da Cunha, a lonely island halfway between South Africa and South America. A ship calls there only once a year, taking supplies from Her Majesty The Queen, sugar, rice, tea and flour. We sighted the island with its grim volcano rising sheer from the sea, its apex lost in the clouds, towering 8,000 feet above sea level. Fortunately, we were able to come within two miles of Tristan. On our starboard side we sighted a submarine, which we later learned was a Dutch one on a trip around the world. It had caused great consternation among the islanders when it arrived, as they imagined it to be a huge sea monster, never having seen a submarine. This was indeed a gala day for Tristan. Never before had two boats been there at the same time. A crowd quickly gathered on the shore and then a row boat put off. At times we lost sight of it the waves were so high. Presently it arrived bringing the Padre and four husky looking oarsmen. We saw it was made of canvas stretched over a wooden frame with extremely long oars. Only our doctors were allowed ashore to examine the natives as there are no doctors or dentists on the island, but, in spite of that, sickness is practically unknown and their teeth are excellent. Back they went in the home-made boat and we watched anxiously to see them safely land on the shore. On a plateau about five miles long there are thirty-five tiny houses. These are built of the porous volcanic soft stone hewn with almost incredible labor from the side of the mountain. The roofs are thatched with a reed grass called

"tussock", which is grown on the island. Many tales were told us of how the island was originally settled. It was discovered by a Portuguese navigator called Tristao da Cunha in 1506, but it was not until nearly 300 years later that formal possession was taken in the name of Great Britain by troops on the Falmouth. It is thought that the object was to prevent Napoleon from taking refuge there in the event of his escape from St. Helena, about 1,300 miles away. A small garrison was formed and wives were brought from St. Helena. The present settlement was founded by William Glass, an N.C.O. of the garrison. Our doctors told us they appeared a happy, kindly people and, in spite of the fact that grants of land had been offered them in South Africa, they preferred to remain on Tristan, and few of them have ever been off the island. Apart from the supplies sent to them they live principally on birds' eggs, fish and potatoes, a few of which are grown on Tristan, but nearly all on Nightingale, an island 25 miles distant. On Tristan can be seen a wingless bird about the size of our partridge, which so cleverly hides its eggs that no one has ever been able to find them. Rats infest the island and one day a week is "ratting day." Asked why only one day a week, they replied the rats were so clever they entirely disappeared for a short time after the hunt. They have no money, but there are rich and poor in terms of sheep and cattle, lazy and industrious. Their day begins at dawn and ends at dark. They are all devout Christians. With truth Tristan da Cunha may be said to be one year away, not in actual distance but due to the fact that communication is only established once a year. No airplanes reach the island, no cables have been laid, no wireless has ever functioned, and the daily newspaper is an old man who sits on a huge rock and tells of the doings of the Cottons, the Greens and the Glasses. As we sailed away we saw the natives carrying their supplies up the steep hills to their homes.

Buenos Aires in the Argentine was our first stop in South America. It is the largest city south of the equator, and the second largest Latin city. Situated on the river Plate, it is actually a modern city, constructed practically in the last forty years. There are few old buildings to be seen, except the cathedral, built in the sixteenth century. The main thoroughfares are modelled after those in Paris, the Avenida Florida is filled with fascinating shops and from four to eight is closed to traffic and is a fashionable promenade for the beautiful Spanish girls in fashions brought by plane from Paris. Everywhere we saw Bolivian silver made up in fascinating designs. At Buenos Aires there is one of the finest race courses in the world and races are held every Sunday. Buenos Aires is the premier Spanish speaking city, and we were frightfully handicapped, not being able to speak it. We stopped at the Opera House. In the distance we heard the ballet rehearsing. We wanted to see it, but when we said ballet to the caretaker, smiling brightly he took us to the star's dressing room, from there to the loggia, and it was only after we did a small song and dance, to everyone's amusement, that he took us downstairs to a huge room with walls of mirrors. Here they were getting ready for the season, which opened too late for us to see. We were fortunate in meeting many charming people here and found them most hospitable. While there are many old Spanish customs, the race is cosmopolitan and will in time, no doubt, become entirely distinct from what originally constituted a nation.

Montevideo, our next stop, has been called the Athens of South America, owing to its really magnificent buildings. We were particularly impressed with the Capitol building. Of marble, granite and gold, the inside made us

think of a rainbow, and must be seen to be believed. The paintings, especially the one celebrating the independence of Uruguay, were most interesting and the senate chamber, a very impressive room, is panelled in female mahogany. The drives about are lovely and the beaches around the Parque Hotel are long stretches of fine white sand.

Santos, situated on the northern shore of Sao Vicente, was our next port of call. We found a beautiful bay, and the surrounding hills are clothed in a mantle of tropical growth. There are three miles of quays. The streets are broad and well kept and about four miles from the city is one of the finest beaches in Brazil. To explore its entire length it would be necessary to ford many streams. Sao Paulo, several thousand feet above Santos, is connected by motor road and by rail, a tremendous engineering feat. Here we found the famous snake farm, snakes of all kinds and descriptions. Some of them hidden away in their cement houses, which looked exactly like enormous bee hives. Above is the hospital where the snake serum is extracted and, if one can forget the snakes, there are lovely donnimaria trees in the background and the "Pride of Brazil" makes splashes of color against the green of the panama trees. The museum is interesting. There we saw the painting of independence and at Sao Paulo, too, is a marvelous bronze monument celebrating the freedom of Brazil. The aquarium was filled with many strange fish and all about us we saw tropical plants and orchids of every variety.

We were up at dawn to see the most beautiful harbor in the world, the bay of Rio de Janeiro, discovered by the Portugese navigator, Goncalo Caelho, on the first of January. It was thought to be the mouth of a river, hence the name. As we entered the harbor we saw the Corcovado (Hunch Back) and Sugar Loaf Mountain in the distance. The natural beauty of Rio is almost unbelievable, a fascinating bay on one side and majestic mountains on the other. The main streets resemble the principal thoroughfares of many European countries, shops of all kinds, many featuring the blue butterfly wings made into all sorts of souvenirs. Later we saw the butterflies on our way to Pao de Assuear. We went by aerial line to the top of the mountain. The various views from Sugar Loaf, the Corcavada and the Vista Chineza were such that we wished a longer opportunity to appreciate them. At night Rio resembles fairy land, with its many lights like a necklace of pearls, and the tremendous statue of Christ, 125 ft. high and 40 ft. wide, appearing to come out of the sky as it towers over the city, strangely enough, due no doubt to the lighting, it seems to do so from every angle. There are many Portuguese in Rio, and it is the official residence of the Portuguese Royal Family. The beaches are superb, mostly surf bathing, and stationed all along the Capacabana beach are life guards with their boats ready to go to the swimmers rescue should they need help, as the undertow is tremendous. The climate is delightful, so one can truthfully say, Rio has everything. On board again we sailed for Trinidad, the second largest of the West Indies Islands.

Here there are several mud volcanoes, mineral springs, and non-navigable streams, such as the Maracus Falls, which leap in a foaming torrent over a sheer wall of rock, 300 feet high. But the most remarkable thing is the Pitch lake, 60 miles from Port of Spain, the capital of Trinidad. It contains an apparently inexhaustible supply of asphalt that bubbles up in large mushroom shaped formations and supplies practically the whole world. We were able to walk over it in spots as it is quite hard in some places. We drove over the Saddle Back pass, one of the prettiest drives in Trinidad to the Coolie village

of St. James. Here there are East Indians in native dress, complete with nose ring. In the tropics there is no twilight, just a sudden change from daylight to dark, the moon always looks enormous and the air is filled with sweet smells, in spite of the cynic who said, "The flowers have no scent, the birds no song, and the women no virtue."

Jamaica, our next stop, is one of the most fascinating of the West Indies Islands. Kingston, the capital, is very gay and filled with visitors during the winter months. We drove through Fern Gully to Duns River, where we had a swim in the salt water followed by a fresh shower in the falls that run into the sea. From there we went to Shaw Park for luncheon, and driving on to Montego Bay we saw the ruins of an interesting old house on a sugar plantation which we were told was Rose Hall, said to be haunted by the ghost of the lady who lived there many years ago and murdered three of her husbands. There is an interesting book written about it called "The White Witch of Rose Hall," and it gives a number of legends of the island. At Montego Bay we found a marvellous beach and delightfully warm water. We drove back to Kingston over the Cockpit. During the rebellion the maroons hid there and it is quite unlike the rest of the island. The hills are rather bare and the huts are scattered. It is said there are still Voodoo doctors among the natives, so we hurried to avoid the evil eye. The climate in Jamaica varies very much, in Kingston it is rather hot, and during the summer months many people go up to the hills to Meningue, Shaw Park, Good Hope, or Greenwich, and if we could have had time to climb the Blue Mountains where the famous coffee comes from, we were told we would have had to sleep under many blankets, as it is quite cold up there.

From Jamaica we went to Havana. It carries all the witchery of Paris in its gaiety, its carefree crowds who frequent the cafes and clubs. It is impossible not to have a good time in Havana. There is the Prado, with its smart shops, there are wonderful golf courses, bathing beaches, races and theatres. In the evening nothing is more amusing than to watch Jai-alai, the Spanish National game. We were thrilled with it, and fortunate enough to see some very swift games, faster than tennis. It is only for the young. The Centro Asturiana Club was closed. We had just a glimpse of it and of the Casino, but all tourists feel that they must see China town, the Sans-Souci, and Sloppy Joe's. We found it hard to believe that Havana was our last port of call.

Safely back again in New York we felt that this would indeed be a cruise of happy memories.

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A NEW VICTORIA GENERAL HOSPITAL HAS BECOME A NECESSITY.

THE Victoria General Hospital is more than a mere curative institution for the city and county of Halifax. If it is not, it most assuredly should be. In the first place it should constitute a sort of medical court of last appeal for the ailing public of Nova Scotia, a place to which they can go to receive the last thing in the way of medical care that this province can give. Obviously it cannot be expected that the smaller hospitals of Nova Scotia, supported largely by local philanthropy, should be able to present the medical armamentarium that a government supported hospital can. In the second place the Victoria General forms the basis of the clinical teaching of the Dalhousie Medical School, and should therefore provide the best possible facilities for that purpose.

Let us apply both these desiderata to the present institution. Here we have an antiquated building, erected largely before medical education had become so vital a matter in Halifax, and physically able to handle properly not more than two-thirds of its present average inmates. It contains no proper examining rooms. Modern equipment of various important types cannot be put into it because of the lack of space. Modern nursing cannot be carried out in its wards because of a lack of proper facilities. The medical staff is constantly hampered for the need of that room without which the really scientific approach to the patient can be made. As a result of this we are able to treat our patients only at a disadvantage and without that scientific method that at least one hospital in Nova Scotia should present facilities for—particularly if it is a teaching hospital. There can be no doubt then that from a medical and nursing standpoint the present building is insufficient and inefficient.

From the standpoint of medical education it is likewise inadequate. One often wonders if hospital authorities realize the tremendous value teaching is to their institutions. For where there is teaching the clinician has constantly upon him the eyes of questioning students. This factor alone plays

a tremendous part in keeping him on his toes, and therefore ensuring better service to the patient. But more than that the presence of teaching tends to bring into the institution more and more of that scientific approach to disease through which alone ultimate prevention will be realized. Teaching, then, is of great benefit to the Victoria General Hospital, and the better the quality of the teaching the better the quality of the service that its patients will receive. We are unable to teach our medical students and nurses properly at the V. G. now for the lack of room and facilities.

Medical teaching at Dalhousie becomes every year of more moment to the profession in the province. For one thing a steadily increasing proportion of the province's profession graduates from Dalhousie. For another thing the Refresher Course seems to be playing an increasingly important part in the life of the profession. Those members who come to the Course every year will agree that the present clinic room at the hospital is not only physically inadequate but that it permits no opportunity for easy lantern demonstration, etc. Nor are there examining rooms off the wards to which small groups of men could be taken to see the complete examination of gynecological and urological or eye, ear, nose and throat cases.

For all these reasons, then, we as a profession should have a profound interest in the replacement of the present antiquated and inadequate building by something that will enable us as students to receive better training, and as graduates to obtain not only closer opportunities for clinical post-graduate work, but that our patients sent to it will receive the best medical and nursing facilities available to the cure of their disease. To that end we should not rest until an adequate institution is erected. Nor should we be content merely with a modern hospital. If a new Victoria General Hospital does not contain within it the facilities for adequate clinical instruction we and the public through our loss will be the sufferers. As a profession we should impress this on the Hospital Commissioners. For if these facilities are lacking, medical education in this province will be held back for fifty years.

H. B. A.

The Editors wish to convey to all the readers of the BULLETIN such greetings as are peculiar to the season. Lacking in experience in writing Christmas editorials we will not attempt to sermonize; however, we do wish to echo the words of Tiny Tim, "God bless us, everyone."

CASE REPORTS

Intestinal Obstruction Following Acute Appendicitis.

THIS patient, a male, aged 17 years, was first seen on 13th October, 1936, when he complained of vague abdominal pain and dysuria. He did not appear sick, was not nauseated, and showed no elevation of temperature or pulse rate. The urine contained albumin as the only pathological constitutent, and the abdominal examination was negative for pain or tenderness. He was advised to stay in bed and was allowed water only by mouth.

At noon on the following day he volunteered the information that during the early hours of the morning he had had violent cramp-like pains in the abdomen, and had vomited shortly afterwards, that these pains had entirely passed off, and that at the present time he felt well. The temperature was 99°, pulse 80. On examining the abdomen tenderness was felt in the supra-pubic region. Dysuria and frequency although not marked were still present. At this time he stated that three days previously he had lain on the damp ground beneath a car for several hours doing repair work. A second examination of the urine again showed the presence of albumin, and also pus cells and a few red cells. Upon abdominal examination I could not be satisfied that there was any inflammation in the peritoneal cavity, and the rectal examination revealed only diffuse tenderness. Accordingly, a temporary diagnosis of genit-urinary tract inflammation was made.

I saw the patient again at ten o'clock on the same evening, and noticed a slight change. The temperature and pulse rate were slightly elevated, 99° and 90 per minute, respectively. Abdominal pain and tenderness were more marked and were localised in the *left* lower quadrant, and, what impressed me most, the patient looked definitely toxic. He was admitted to hospital immediately, and it was found that he had a leucocyte count of 23,000 per cu. mm., made up as follows in percentage: Lymphocytes, 1; Monocytes, 4; Eosinophiles, 0; Basophiles, 0;

Juveniles	6
Bandcells	14
Segmented	75
Neutrophiles	95

He was prepared for operation immediately, although at the time I was not completely satisfied that this was a typical clinical picture of acute appendicitis.

Through a paramedian, subumbilical incision the peritoneal cavity was opened to reveal the presence of a small quantity of dirty brown fluid. After packing off the loops of small bowel, the appendix was found lying over the brim of the pelvis. Acute suppuration and perforation were evident at a glance. After removing the appendix, but before invaginating the stump, a catheter was inserted through the stump and threaded into the ileum via the ileo-caecal valve. This catheter was then drawn through the abdominal wall at a separate stab wound in the right iliac fossa. A rubber tube was

inserted into the pelvic cavity and a cigarette drain to the ileo-caecal area, after which the usual closure of the abdominal wound in layers was carried out.

After care. After the first day during which he received two litres of 5% glucose in saline intravenously, he was allowed small quantities of fluid by mouth. The drainage tubes were gradually shortened, and the ileostomy tube drained freely. He received irrigations with warm saline through this tube periodically. The cigarette drain was removed on the second day, and the pelvic tube on the fourth. Flatus and fluid bowel content were expelled through ileostomy tube freely. The carbon arc lamp relieved considerably the distress from slight abdominal distension. On the fourth day he had a satisfactory normal bowel movement, and thereafter movements occurred daily without artificial means. By the sixth day a light diet was being well tolerated, the abdomen was soft and the patient comfortable. Sutures were removed on the tenth day, the skin suture securing the ileostomy tube having been removed forty-eight hours previously.

On the evening of the eleventh day the patient complained of nausea, and the following morning vomited after breakfast and complained of cramp-like pain in the lower part of the abdomen. Although there were two small liquid movements on that day containing moderate amounts of mucus, the abdomen became distended. An X-ray photograph gave evidence of much gas in the small intestine which had formed itself into so-called ladder-patterns. The colon showed no gas. A diagnosis of small bowel obstruction was apparent.

With a view to operation the patient was prepared with intravenous salines, and was decompressed by the continuous duodenal suction and lavage described by Wagensteen. An estimation of urinary chlorides to determine the degree of dehydration showed an amount present in the proportion of 4.4 gms. per litre. Accordingly, under spinal anaesthetic, through a right rectus splitting incision the peritoneal cavity was again opened. Collapsed small intestine was followed proximally, and two separate bands of adherent lymph were divided and found to have been the cause of mechanical obstruction. Following the introduction of an ileostomy tube the abdomen was closed with through and through silk sutures.

Continuous intravenous salines with glucose were administered through a needle placed in the great saphenous vein at the ankle, and the Wagensteen continuous duodenal suction and lavage apparatus was set up. The patient was now very ill, abdominal distension was marked and increasing, pulse rapid and weak. On the third post-operative day 1 amp. of acetylcholine was administered every four hours, and he was given a soapsuds enema. It was returned with a medium sized soft movement and flatus was expelled freely. Thereafter, with repeated enemas the abdominal distension subsided. The salines infusions and duodental drainage were discontinued, feeding by mouth reestablished, and with the exception of infection of the incisional wound treated alternately with hot saline fomentations and Ensol packing, he made an uninterrupted recovery, being discharged on the forty-fourth day, rapidly putting on weight and with a voracious appetite.

This has been a long story for the kind of case that we see rather frequently. But it seems to emphasize several important points. The first concerns diagnosis. It is never safe to leave a patient complaining of abdominal pain without frequent examinations. Perhaps especially does this obtain in cases first seen in hospital when the temperature and pulse are normal, and the abdominal examination negative. How frequently we find that

repeated examinations and recordings of temperature, pulse and white count indicate recourse to operation, before the abdominal signs develop sufficiently themselves to warrant the procedure. It is to be remembered that in the obstructional type of appendicitis there is a latent period when pain is absent, and pulse and temperature are normal, as occurred in this case.

Secondly, in acute appendicitis with peritonitis, the period requiring most careful observation may be between the seventh and twelfth days. During this time when the plastic lymphy exudate is organizing, mechanical obstruction is prone to occur. Upon the first evidence of abdominal pain a thorough examination is essential. In this regard the value of a flat plate is considerable.

The value of urinary chloride estimation to determine the degree of achloraemia following vomiting in intestinal obstruction is becoming established.

Whether of undoubted value or not, acetylcholine has been advocated in the presence of paralytic obstruction. Certainly, in this case, after a preliminary period of three days with hot stoops to the abdomen and absolute rest, the paralytic distension subsided consequent upon the injection of acetylcholine four hourly, and the administration of enemas.

This case was interesting because of the development of and recovery from first mechanical obstruction, then paralytic distension, following acute perforation of the appendix. Fortunately, he was spared the catastrophy of peritonitis.

J. A. NOBLE.

Torsion of Spermatic Cord.

M. H., aet. 26; laborer; single; admitted Oct. 4th., 1936.

Complaint. Painful rupture in the right groin.

Duration. 3 days.

Family History. Mother has varicose veins. Father, 5 brothers and 4 sisters are living and well.

Personal History. Has done different types of laboring work, on roads, farming, etc.; always out of doors. His meals are regular. He uses tea, coffee and tobacco moderately; alcohol rarely. Diseases of childhood with good recovery. No serious illnesses; no operations; no accidents. He has had a rupture in the right groin for 22 years.

Present Illness. Normally the rupture forms a lump in the right groin which disappears on lying down. It has frequently come down into the scrotum on exertion. At such times it would disappear on lying down or after he pushed it back. The right testicle does not always lie in the scrotum but sometimes slides up to form a tender lump in the groin.

Three days ago, he felt the rupture come down with a snap and it caused severe pain, much more than on any other occasion. He was unable to reduce it. The pain persisted. He has had no vomiting but little appetite.

There has been no bowel movement since the onset of the pain. Urinary function has not been disturbed.

Special Examination. There is a swelling in the right inguinal region. It is superior and lateral to the pubic spine and appears to be external to the external inguinal ring. It is well circumscribed, oval in form with its long axis in the line of the inguinal canal. It measures 2" by 1", approximately. The skin is of normal appearance. Respiratory movement in the right lower quadrant is restricted.

On palpation the mass is found to be subcutaneous. It is very tender. There is no tenderness or induration of surrounding tissues. It moves slightly in all planes; movement causes extreme pain. In reply to a leading question the patient describes the pain as similar to that experienced on compressing the normal testicle. The mass transmits an impulse on coughing. Auscultation does not reveal any borborygmi. The mass seems to be made up of a testicle of about normal size with a small, irreducible, oblique inguinal hernia above it. The testicle is external to the external inguinal ring, the hernia in the canal.

Physical Examination. Negative, except for special findings. Temp. 98.4. Pulse, 92. W. B. C. 9,600. Urinalysis negative.

Pre-operative Diagnosis. Gangrene of testicle, due to pressure of irreducible hernia on cord structures.

Operation. The hernial sac is of congenital variety but collapsed distally, the bowel not extending beyond the upper pole of the testicle. The testicle is of apparently normal development, but mottled, dusky blue in color, due to congestion and haemorrhagic effusion. At its upper pole is a torsion of the cord through a full 180 degrees. This can be reduced, and reproduced readily by rotation in the transverse axis of the cord. There is generalized thrombosis in the pampiniform plexus. The application of hot compresses to the testicle, after relieving the torsion, results in the appearance of several bright haemorrhagic pin points on its surface but does not affect one area in particular, about $\frac{1}{2}$" square at the base of the epididymis.

The testicle is removed by amputation of the cord and its structures high up, allowing them to drop back through the internal ring. The hernia is reduced readily, the sac tied off and a repair done.

Anaesthetic. Spinal, 120 mgms. of Novocaine.

Post-operative Diagnosis. Torsion of the spermatic cord.

Pathological Report. Gangrene of the testicle.

Progress. October 19th. 1936, the patient was discharged after an uneventful recovery.

Comment. The most common type of torsion of the cord is that in which the testicle turns pole over pole on itself, that is, in the long axis of the cord. In this case, the torsion obviously took place in the transverse axis. The patient was advised before, and again during, the operation of the necessity of removing the testicle, and his consent obtained.

A. L. MURPHY.

A Case of Hyperthyroidism, Graded Operations, with Post-operative Complications of Recurrent Laryngeal Nerve Paralysis and Tetany.

Mrs. B. Aet. 46.

This patient was admitted to the Victoria General Hospital in January, 1936, complaining of a swelling in her neck and extreme nervousness. Her past history revealed that she had satisfactorily recovered from measles, typhoid, pneumonia and an appendectomy seven years ago.

The present swelling in her neck began four years ago accompanied by some shortness of breath, and palpitation particularly after moderate exertion. She consulted her physician who diagnosed goitre and recommended operation which advice, however, was not followed. Her symptoms became worse in a gradual manner with nothing to suggest a thyroid crisis of any degree. She has been particularly nervous during the past year during which time she lost 15-20 lbs. in weight, despite the fact that her appetite was unusually good, which is a quite frequent thing in such cases.

On admission to hospital she presented an almost obvious diagnosis; toxicity being quite marked as evidenced by the extreme nervousness and flushing. She was quite emaciated on admission weight being 87 lbs. Exophthalmos, widening of the palpebral fissure, lid-lag, inability to converge at very near objects, tremor, and a very firm, diffusely enlarged thyroid gland all helped to establish the diagnosis of Graves disease. Her pulse rate averaged 130 with a very definite auricular fibrillation. General examination was negative, her Basal Metabolism Rate was plus fifty.

After our first impression of the degree of toxicity it was decided to do the operation in three stages, after proper preliminary treatment. Accordingly she was given (1) Lugol's solution M.XV,t.i.d.; (2) Tr. Digitalis M.XX,t.i.d.; (3) Intravenous glucose saline, given in 500 c.c. quantities to improve her nutrition.

Her toxicity became less and following a gradual improvement the first operative procedure which consisted of ligation of both superior thyroid arteries under local anaesthesia was performed on February 18th. This caused very little reaction and resulted in considerable improvement. On February 28th under Avertin-Ether anaesthesia the right lobe of the gland was resected. Her immediate recovery from this procedure was satisfactory, but it was soon observed that she had a definite hoarseness. Laryngeal examination revealed a paralysed right vocal cord; consequently, under gas-oxygen anaesthesia the wound was re-opened and the catgut sutures used to enfold the gland were removed and closure made as much as possible by more superficial sutures. Her subsequent course was satisfactory and her voice became normal with the vocal cord again active. Her B. M. R. on March 22nd was minus seven, and her heart ceased to show evidence of fibrillation. She was discharged from hospital to report again in six weeks time.

Re-admission May 10th, 1936, very much improved in health, less nervous, no evidence of auricular fibrillation, weight 98 lbs. and B. M. R. plus twenty-three. During her stay at home she rested very assiduously and took no iodine.

Following one week of preliminary treatment the left lobe of the thyroid was resected under Avertin-Ether anaesthesia. At this time the recurrent laryngeal nerve was exposed where it is associated with the inferior thyroid artery. By this means we were able to know the position of the nerve and

consequently avoid its injury. The following day after operation she exhibited the typical signs of tetany, carpo-pedal spasm being very marked. These symptoms usually were at their worst between four and six o'clock A.M., and were always controlled by the intra-venous administration of calcium gluconate or chloride using from five to ten cc's. They were, however, not relieved by the oral administration of calcium lactate nor of dessicated parathyroid extract intensively administered. It was, however, found that the hypodermic injection of parathormone, a parathyroid hormone elaborated by Collip, did successfully prevent the seizures when given before the usual time at which they occurred. It was given in 3 cc. doses q.12h. at first. Also it was found after two weeks administration that the tendency to tetany was much less and the hormone was discontinued after three weeks use and she was well for a time on a high calcium diet. Soon, however, she began to exhibit signs of depression and what she described as a "smothering feeling", associated with atypical signs of tetany. These were superseded by definite mental symptoms which were later diagnosed by a neuro-psychiatrist as dementia praecox, which subsequently improved greatly. On her discharge from hospital she showed no signs of thyroid disease, nor of parathyroid deficiency.

Summary. A severe case of Graves disease with graded operation is presented; the occurrence of recurrent laryngeal nerve paralysis which recovered when the causative factors i.e. pressure by sutures, were removed by secondary operation. Here is emphasized the usefulness and importance of exposure of the recurrent laryngeal nerve to avoid its injury. The development of tetany was unusual, but return to normal did gradually occur. The tetanic spasms were immediately controlled by intravenous administration of calcium salts; they were prevented by the hypodermic use of parathormone. Lahey advises inspection of removed thyroids and if parathyroid bodies are seen they should be imbedded in sterno-mastoid muscle. The effect of preliminary ligation of the superior thyroid arteries is only transitory and should be followed by more radical operation. First impressions of the toxicity are the best upon which to decide the modus operandi.

E. F. Ross.

A Case of Spinal Tumour.

This case is reported as an example of the curability of many spinal growths. They have a very much better prognosis and are much more accessible for removal than tumours of the brain.

The patient, a young man of eighteen years of age, came under observation first in 1932, complaining of pain in the left lumbar region. The character of the pain suggested nerve root irritation. No neurological objective signs were noted and as the X-Ray showed a slight narrowing of the intervertebral space between the 1st and 2nd lumbar vertebrae, a provisional diagnosis of early spinal caries was made. He was put at rest in a plaster cast. He was checked up clinically and by X-ray several times in the next two years, without any change in the diagnosis. An unexplainable scoliosis developed and the root pains seemed to improve. On re-admission to the Victoria General Hospital in November 1935, he complained of weakness of his legs and incontinence of the bladder and rectum.

Neurological examination was carried out by Dr. K. A. MacKenzie. There was motor weakness of both legs, more marked in the left. There was well marked muscular wasting of the left, and slight of the right leg. Sensation was impaired on left leg to touch, pain, heat and cold, at first patchy, but later involving the whole leg, with a distinct upper limit corresponding anatomically to the 12th dorsal segment. Knee and ankle jerks were absent on both sides. No Babinski. Bladder control was lost, at first retention, later incontinence. Spinal puncture showed the fluid under a very low pressure. On compressing the jugular veins, there was not any rise in the pressure (Queckenstedt test). The fluid was a yellow colour, contained a great excess of protein and no increase in the cell count (Froin syndrome). The Kahn test was negative. It was not considered advisable to carry out injection of lipiodol.

Physical examination of the spine was negative except for a well marked scoliosis. X-Ray examination at this time showed a partial absorption of the left side of body of the 12th dorsal vertebra. Dr. S. R. Johnston expressed the opinion that the absorption was probably due to pressure from a tumour in the spinal canal, rather than a primary or metastatic one in the vertebra.

A diagnosis of extramedullary spinal tumour was made. On account of the long duration of the root pains over several years, the tumour was probably benign. The level of the lesion was determined by neurological and X-Ray findings.

A laminectomy was performed, Dr. E. Ross assisting. On separating the erector spinae muscles, a soft greyish tumour appeared, which had absorbed the lamina of the 11th and 12th dorsal and 1st lumbar vertebrae, on the left side. The spinous processes and remaining laminae were removed and the dura exposed. A large extradural tumour was then seen. It measured 8 x 5 x 3 cms. The tumour had a definite capsule, except where it had absorbed the laminae. The cord was sharply angulated opposite the 1st lumbar vertebra by pressure of the growth. The dura pulsated above but not below. The tumour was enucleated by blunt dissection. A strip of gauze packing was left in situ to control persistent oozing. The dura was not opened. There was considerable shock following the operation, which was counteracted by a blood transfusion.

Dr. R. P. Smith reported the growth to be a benign neurinoma.

The patient made a good recovery and in a few days his root pains had disappeared. He returned to hospital for examination in September, nine months after the operation. He is able to walk half a mile, sensation has returned to normal, and he has good control of bladder and rectum.

Comments. Spinal tumours have a relatively good prognosis, if they can be diagnosed early. Quite a large percentage are benign. The early symptoms of the extramedullary variety are root pains, which are often labelled rheumatism, neuralgia, etc. These pains may exist for years, before compression of the cord manifests itself by motor paralysis, changes in sensation and loss of control of the bladder and rectum.

W. ALAN CURRY.

Nephroptosis—A Report of Four Cases.

Nephroptosis, or "Floating Kidneys" has long been recognised as a clinical entity. Various remedies have been employed for the correction of this condition, remedies which vary from dietary measures and special exercises, to radical operative procedures designed to suspend and anchor the kidney in a position for efficient drainage. There is at present considerable of a controversy taking place among urologists regarding the proper procedure in such cases. Opinions have divided generally into two classes:

1. The conservative or non-operative procedure.
2. The radical or operative treatment.

It is not my wish to take either side in this controversy at the present time, or to even enter into a discussion of the merits of either. I wish to report briefly four cases seen in private practice during the past year or so, in whom to date, excellent results have been obtained by non-operative methods.

Nephroptosis occurs usually in those individuals in whom one would suspect a general visceroptosis, the tall slender, asthenic type. It is more common in women than in men, and is indeed, frequently accompanied by a general visceroptosis, which, however, may not give rise to symptoms.

The chief complaint is pain, of a dull aching character located in the costovertebral angles or in the lower back. The patient will state that the pain is relieved by rest in the recumbent position. Frequently such patients will feel well on rising in the morning, after a nights rest, the pain coming on with increasing intensity as the day progresses and they remain on their feet. Occasionally sharp pain simulating renal colic may be present. Not infrequently there is an accompanying frequency and dysuria, and the urine may give a positive culture (usually B Coli) and contain pus. This means renal infection, the result of poor drainage.

As the patient assumes the upright position, the kidneys drop, causing a kink in the ureters. There follows blocking of the renal pelvis, distension and pain. A condition of intermittent hydronephrosis results. If the intermittent blocking exists over a period of time, infection may occur, with pyuria.

The diagnosis may often be suspected clinically from the history and the type of patient presenting it. It may be further substantiated by palpating one or both kidneys with the patient in the sitting position. Postural pyelography will clinch the diagnosis. Cystoscopy is indicated in order to determine the amount of infection present in differential specimens. The first pyelogram should be taken with the patient in the recumbent position, the next with her upright, or sitting. The excursion of the kidneys may then be measured. The condition must be differentiated from so called congenitally low kidneys. In nephroptosis there is kinking of the ureter when the patient is in the upright position, due to renal excursion. This does not occur in the congenital kidney above mentioned, the ureter remaining perfectly straight.

The following four cases were treated by conservative methods, as will be described. Only the pertinent details of the case histories and findings are mentioned. All patients were fitted with a Camp nephroptosis belt, kidney pads being included where necessary. The patient was carefully instructed to apply the belt before rising, that is while still in the recumbent position. This point is not infrequently overlooked, and may account for some of the poor results obtained. If the belt is applied with the patient in the upright position, the kidneys are simply locked in their low position, and the condition

aggravated. The ideal would be to apply the belt with the patient standing on her head. Where necessary urinary antiseptics have been prescribed for the control of urinary infection, and have been uniformly successful. Exercises designed to improve posture and musculature, especially that of the abdomen, and a diet to promote a moderate increase in weight, have been routinely prescribed. The same treatment has been used in all four cases reported, and so will not be mentioned again in detail.

Case 1.—*June* 6, 1935.

A young girl of twenty, referred because of a dull aching pain in the right kidney region. The pain had been present for over three months. It was increased on exercise, and relieved by rest. There had been no frequency or dysuria. The patient had lost some thirty pounds in weight, part of which had been due to a "slimming" diet. General examination was negative. Examination of the differential urines showed an occasional pus cell from the common and right. The right urine gave a positive culture for B Coli. The others were sterile. Postural pyelograms showed a double right kidney, with some ureteral dilatation. The pelves and calyces appeared normal. The upright film showed a marked excursion of the kidneys, particularly the right, the movement being almost three inches.

The treatment described above was instituted. Her symptoms disappeared, she regained her weight, and when last heard of three months ago she was in excellent health and without complaints.

Case 2.—*December* 2, 1935.

A lady of 54, referred with the following history: For more than a year she had had intermittent attacks of cystitis with marked frequency and dysuria. There had been two especially severe attacks. The first had occurred a year previously, and had been fairly well controlled with the usual urinary antiseptics. The second, the present attack, had lasted two months, and had failed to respond to treatment. She had been confined to bed for two weeks, and had lost some ten pounds in weight. The dysuria and frequency were marked. She also stated that she had frequent attacks of rather severe backache, worse in the right kidney region, increased by exercise and relieved somewhat by rest. The cystitis usually followed these attacks of pain. She was very miserable, having to void almost every hour.

On examination she appeared pale, and apparently ill. She was a tall, rather thin woman, and inclined to be very active. The lower pole of the right kidney was palpable with the patient in a sitting position.

The common urine was alkaline in reaction and showed 5-15 pus cells per high power field, phosphates and urates. The right urine showed an occasional pus cell, the left none. Both ureteral specimens were sterile, but the common specimen gave a heavy growth of B Coli.

Postural pyelograms showed a bifuricated right kidney pelvis, with the calyces sharply defined. The lower portion of the right ureter was tortuous and irregular. The kidney outlines were normal in size and shape, but in the upright film showed marked ptosis.

The patient was given an acid bladder mixture, a diet designed to promote gain in weight, and fitted with a ptosis belt including a right renal pad. Her recovery was rapid, and she was soon able to resume her active life. At present she has more than regained her weight, the backache has completely

disappeared, the frequency and dysuria are gone, and the urine shows no pus. During the past year she had one slight recurrence, which occurred when the belt was discarded. The belt is perfectly comfortable and causes her no inconvenience.

Case 3.—*May*, 1936.

A young girl of twenty-one referred because of intermittent attacks of severe backache, over the past three years. There had been intermittent attacks of frequency and dysuria. She had frequently passed pus in the urine, and on one occasion after a particularly severe attack, blood had been noted. The past attack had confined her to bed. The attacks were worse when she was on her feet, and relieved by rest.

General examination revealed a tall thin girl obviously visceroptotic. The lower pole of the right kidney was palpable on deep inspiration.

The urines in this case were negative for pus or organisms. Postural pyelograms showed bilateral renal ptosis, with an excursion of the kidneys of some two inches, and rather marked ureteral kinking.

She was advised to rest in bed for a month, after which a ptosis belt was fitted and the routine prescribed. When last heard of, some few weeks ago, she was symptom free.

Case 4.—*June*, 1936.

A married lady of about twenty-five, referred because of frequency and nocturia, three times a night, and dysuria. The complaints dated back three months, and she had failed to respond to the usual type of treatment. Her frequency and dysuria were so great that the presence of a vesical calculus was suspected. On general examination she appeared thin and of the visceroptotic type. There was some suprapubic tenderness but neither kidney was palpable.

Examination of the differential urines showed the ureteral specimens to be negative for pus or organisms. The common showed an occasional pus cell and gave a heavy growth of B Coli.

Postural pyelograms showed a slight right hydronephrosis with some tortuosity of the ureter. The left kidney appeared normal except for slight anterior rotation. The kidney outlines appeared normal in size, but showed considerable ptosis, which appeared equal on both sides.

Following the institution of treatment this patient's symptoms rapidly disappeared, and a communication from her doctor five months later stated that the patient was in perfect health.

Summary.

Four cases of nephroptosis treated by conservative methods are reported. All are well, two after one year, one after six and one after five months.

G. A. WINFIELD.

SPINAL CONDITIONS.

(a) Traumatic.

R. A. 24, Farmer, accident case, admitted 8 p.m. Aug. 20/34. The history was that at 4.30 that afternoon while unloading hay into a large barn the lift fell and hit him, one of the "prongs" entering his back. He was picked up with both his lower limbs paralysed, his doctor called and very shortly afterwards was brought by car to hospital. Muscular power had returned in the right limb very soon after the accident.

Condition on admission: Tall thin, asthenic type complaining of moderate amount of pain in his back, and inability to use the left lower limb. Temperature 101, (axilla) pulse 130. There was a punctured wound to the right of the 4th thoracic spine the edges of which were lacerated. There was paralysis of the left lower limb, motor power being completely lost below the knee and almost completely lost above. Hyperaesthesia was noted over the whole left side below 6th rib. There was a positive Babinsky on the left side only. There was tenderness and some swelling over the right costal margin anteriorly. The paralysed limb soon became swollen and remained so during most of his time in hospital, and there was tenderness along the course of the femoral vein.

X-ray report: "Examination of dorsal spine shows fracture through laminae and inferior margin of the body of 5th dorsal vertebra. The line of fracture extends from above downwards and to the right. There is slight irregularity of the superior margin of the body of the 6th vertebra."

1500 units of A. T. S. were given and as soon as possible the patient was taken to the operating room. The wound was excised and tissues opened to expose the laminae of 5th and 6th D. V., both of which were removed. That of the 5th was fractured, and on the left side comminuted, the fragments making pressure upon the dura. There was a moderate amount of extradural haemorrhage but the dura itself seemed to have escaped injury. The tissues were closed in layers around a small rubber-dam drain.

On the fifth day 19 ounces of bloody fluid was aspirated from the right thoracic cavity and five days later 21 ounces of slightly blood-stained fluid was removed. No further aspiration was found necessary. This was the result of traumatic pleurisy and incidental.

Power in the affected limb began to improve very soon but anything like complete restoration of function took rather more than a year. Even now, more than two years later, there is some impairment for there is sometimes a bit of a limp. He is however doing his work on his farm.

(b) Tuberculous, (Atypical).

W. L. 25, Student, presented himself February 1935 complaining of (a) Pain and stiffness in the back. (b) Swelling in the back. (c) Discharging sinus in the back.

The back pain was first noticed about two years ago. It was dull aching in character, was located in the lower dorsal and upper lumbar regions, and was non-radiating. Stiffness was especially noticed when straightening up from a stooping position. He had consulted several physicians both in the Maritimes and in the west, during that time, and was given the impression

that it was of no importance, though on one occasion he was given a bottle of medicine for it.

The swelling appeared about six months ago to the left of the lumbar spine. It was soft and painless and though at first it was localized and fairly prominent, later it flattened out and was more diffuse. A week ago a reddened area appeared and a day or two later the centre of this broke down and discharged a very large amount of thin purulent fluid.

The general health was only fair. For at least a year he had been experiencing loss of pep and was easily tired. Back and stomach gave out on slight extra exertion. Appetite was fair but digestion easily upset. There was moderate loss of weight.

Examination: Haemoglobin 60%, W. B. C. 8600, R. B. C. 4,200,000. Temp. 97. Pulse 94. Kahn and Hinton tests negative. Excepting the skeletal, no other system showed any abnormal signs. There was only moderate spasm of the lumbar muscles, with some limitation of forward bending. Almost the whole of the lumbar region of the back was involved in a subcutaneous abscess extending almost from one iliac crest to the other, and upward on both sides, towards the tips of the lowest ribs. At the right inferior angle of this area there was an irregular opening discharging sero-pus, and pressure over the fluctuant mass on the opposite side of the back caused more fluid to pour out, proving it to be a continuous cavity covering the region. There were none of the usual signs of inflammation. X-ray examination showed involvement of the 3rd and 4th lumbar vertebrae in very atypical lesions. The laminae and spinous processes were involved in several separate and distinct areas, and there was some question from the X-ray angle as to the nature of the lesions. Clinically, it was regarded as being tuberculous.

Treatment: The abscess cavity was emptied as fully as possible, the sinus was widely excised and the wound tightly closed. (The tissue removed was submitted to the pathologist and a report received that it was typical tuberculous tissue). This incision healed, the patient was put in a plaster cast and sent home where he lived under a regime of the best anti-tuberculosis treatment imaginable. In three months there was no evidence of the abscess but no improvement in the appearance of the spinal lesions nor of the patient. He was given a further similar period under the same conditions and when again examined three months later there was very definite X-ray evidence of extension of the disease.

The subsequent treatment is unusual, to say the least. It was desirable to secure local rest for the parts by some form of bone splint, even though the disease was involving the posterior vertebral processes. The lumbar spine was exposed in the usual manner and obvious disease of spinous processes and laminae was removed. A modified Hibb's fusion was then effected, from the first lumbar vertebra to the sacrum inclusive, and this was reinforced with an osteoplastic strip of the same length from the tibia. The muscles and fascia were closed tightly over it with stainless steel wire and the skin in the usual fashion.

The tibia was found to be almost like flint for hardness and much too compact and brittle for the usual thin type of graft required. Misgivings were expressed when it was put in, as to the possibility of its being incorporated as a graft. Most of it fused, but in two areas part of it formed sequestra.

He returned in less than three months with a small sinus in the lumbar incision, and a psoas abscess draining just medial to the anterior superior spine of the ilium and extending into the thigh beneath Poupart's Ligament.

The old scar and sinus were then excised and the bone exposed. Two thin pieces of sequestra were removed but *the fusion of the vertebrae seemed very satisfactory.* The iliac abscess was irrigated frequently with Dakin's solution and it eventually dried up. The wound on the back had closed, and he was allowed to go home to continue bed rest but without cast or shell. Six months later he is back. He has gained about thirty pounds, and the back and iliac sinus have been dry for six months. X-ray shows fusion of the whole involved area. He is now allowed to get up and about and appears to be in excellent health.

(c) **Developmental and Traumatic (Spondylolisthetic).**

E. S., 24, iceman. First admitted August 22nd, 1934, complaining of pain in back and in left leg.

History. Eight years ago while carrying a heavy stick of wood on his back he fell and he has had back pain and pain in the leg ever since. There are occasional remissions in the back pain, and it is always worse when it recurs. The pain in the leg has been continuous and there has been some stiffness in it. The movements of the spine have not been restricted.

Examination. Apart from the knee jerks which were exaggerated but equal, physical examination revealed nothing important. Kahn and Hinton, negative. X-ray reported "no evidence of a pathological condition in the lumbar vertebrae, except marked scoliosis to the left." It was suggested that sacro-iliac strain was probably at the root of his symptoms. Rest and posture were given for six weeks, and he was discharged with a symptomatic cure.

He was readmitted four months later, February 11th, 1934, with a return of the old symptoms. The X-ray report was "no change since previous admission, marked scoliosis to left."

There was, however, a definitely forward position of the fifth lumbar upon the sacrum, and a sharpening of the angle between the back of the sacrum and the lumbar spinous processes.

Treatment. Bradford frame and moderate extension for nearly four weeks. On March 11th lateral X-ray of spine was not satisfactory. On March 12th operation: lower three lumbar spinous processes and laminae and the upper sacrum were exposed. The spinous process and laminae of the fifth lumbar were found to be improperly developed. A very thin structure of connective tissue and thin plates of cartilage was all that represented them. The spinous process was quite rudimentary and cartilaginous, and was quite dissociated from the other vertebral parts.

A fusion of the third, fourth and fifth vertebrae with each other and with the sacrum was effected by a modified Hibbs' method. While an attempt was made to use the fifth lumbar vertebrae as much as possible more dependence was placed upon the bridging of the gap between L4 and S1 and 2, both by bone flaps turned down from the former and long chips turned up from the latter. The whole was then covered, with an osteoplastic strip removed from the tibia and the soft tissues securely closed.

Correspondence

To the Editor, Bulletin of the Medical Society of Nova Scotia:

Dear Sir:

There are rumors, in Halifax and elsewhere, that on the retirement of His Honor, Lieutenant Governor Covert, next summer, Dr. John G. McDougall will be appointed to the gubernacular chair. There may be nothing in these reports. I do not know if Dr. McDougall would accept the position; nor can I determine what the mind of the government authorities may be in the matter. So I write as one less wise concerning the facts, but fully imbued nevertheless with the supreme fitness of the suggested appointment.

To tell doctors of Nova Scotia of Dr. McDougall's fitness for the high office of governor were to waste time. He qualifies at every point; for, as is well known to those of us who have been intimate with him, he has a wide range of knowledge covering the economic, social and industrial life of our province. His services to Nova Scotia as a surgeon need no platitudes from a confrere. They stand on their own feet, silent and eloquent.

But however excellent Dr. McDougall's qualifications, there is a greater reason for our interest and co-operation. It is this. Is not some recognition of this nature long overdue the medical profession of our province? So far as I know, no member of our profession has ever been appointed governor of Nova Scotia. Some of our best statesmanship has been drawn from the ranks of our ancient calling, but none seem to have held the office of governor. I daresay there is no specific reason for this rather unique omission, particularly unique in a province where such appointments usually come from the learned professions.

New Brunswick and Ontario have now two eminent medical governors. I suggest we join the procession. My suggestions go to some 400 doctors in our Province. All of them are either grits or tories when someone talks politics to them, but they are doctors all the time, and would rejoice, every one of them, to see one of their very best called by the State to a position of distinction and honor.

This letter is written in the hope it may stir up some interest in our ranks and that action may follow. I am not signing my name. The cause should speak for tself.

Yours truly,

PRO BONO MEDICO.

Minutes of the Annual Business Meeting

CONTINUATION of the Annual Meeting of the Medical Society of Nova Scotia was held at the Nova Scotian Hotel, Halifax, N. S., on September 2nd, 1936, at 8.15 P.M.

The meeting was called to order by the President who stated that at the last meeting we had pretty well covered the routine and also agreed that it would be shortened in future meetings. The first report was that of the Secretary, as follows:

"To the President,

The Executive, and Members of the Medical Society of Nova Scotia.
Gentlemen:

Herewith is submitted the report of the General Secretary for the year ending June 30th, 1936.

Membership: The membership remains practically the same as last year. The number of active members is 245 (as a rule from 10 to 15 pay at the annual meeting); the number of honorary members 14; making a total of 259. In comparison with other medical societies we have a very creditable membership. I would, however, again point out that there are about 420 physicians in active practice in the province and that annually, usually not more than 235 support the Medical Society of Nova Scotia and its BULLETIN. The annual fee of the Society as prescribed in the By-Laws is $10.00. If all the physicians were to support the Society, a fee of one-half the amount would suffice.

The customary method of collecting dues has been followed, namely, the issuing of drafts during the month of February, followed later in the year by letters to those who did not respond. A number of our members object to bank drafts and have asked that statements be mailed directly to them.

The Bulletin: The BULLETIN again shows a profit, although less than the year 1934-35. The cost of printing was greater, due to publishing more articles necessitating the use of cuts and diagrams, and the amount received from advertisements was less. Although it is not my intention to trespass on the rights of the Editors, having spent considerable time and effort in securing articles and advertising for the BULLETIN, it is felt that Nova Scotia is perhaps too small a field to support a successful journal. Would the Medical Societies of New Brunswick and Prince Edward Island join with us in a Maritime Journal, or be interested in contributing to provincial sections of our BULLETIN?

Obituary: It is our sad duty to record the deaths of the following members, who passed away during the year:

DANIEL MCNEIL, M.D., Dalhousie Medical School, 1913, died at Glace Bay on September 10th, 1935. Dr. McNeil was born at Mabou, Cape Breton in 1883, received his early education there and graduated from St. Francis

Xavier University in 1904. He practised in Glace Bay from the time he received his M.D. degree until his death. Dr. McNeil had been on several occasions Medical Health Officer for the Town of Glace Bay, and at the time of his death was immediate Past-President of the Medical Society of Nova Scotia.

GEORGE R. MORSE, M.D., Dalhousie Medical School, 1902, died at Saskatoon, on August 5th, 1935. Dr. Morse was born at Melvern Square, Annapolis County in 1875. Dr. Morse practised in Chester and other places in Nova Scotia and moved to Saskatoon in 1908.

ALFRED ROSCOE ANDREWS, M.D., Halifax Medical College, 1879, died at Auburn, Kings County, September 20th, 1935. Dr. Andrews was born in London, England in 1849 and came to Canada when quite young. He spent several years teaching school and after graduating took a special course for the eye, ear, nose and throat and practised for a number of years in Middleton. From Middleton he moved to Malden, Mass., where he practised for thirty years, and returned to Nova Scotia two years prior to his death.

MONTAGUE ALBERT BLOWERS SMITH, M.D., Bellevue Hospital Medical School, New York, 1883, died at Dartmouth, November 13th, 1935. Dr. Smith graduated from Kings College, Windsor, and after receiving his M.D. from Bellevue practised in Halifax and Dartmouth. Dr. Smith was on the staff of the Halifax Medical College and Dalhousie University, and was an Honorary member of the Medical Society of Nova Scotia.

I. F. LONGLEY, M.D., Queen's University, 1910, died at Saint John, N. B., on November 21st, 1936. Dr. Longley was a native of Granville Ferry, N.S., and following graduation practised in Regina. He had a brilliant career overseas in medical service during the World War, and since that time practised in Saint John.

SAMUEL NELSON MILLER, M.D., New York University, 1875, died at Middleton on December 16th, 1935. Dr. Miller was born at Mount Hanley, Annapolis County in 1850, where he received his early education. At first he taught school and studied for a year or so at the Halifax Medical College. After graduating from New York University he located in Victoria Vale, Annapolis County, moving shortly to Middleton, where he built up a large practice. Dr. Miller was an Honorary member of the Medical Society of Nova Scotia.

ISRAEL MELBOURNE LOVITT, M.D., Harvard Medical School, 1885, died at Yarmouth on December 7th, 1935. Dr. Lovitt was born at Yarmouth in 1863 where he received his early education. He attended Mount Allison Academy and College. After graduating from Harvard he practised in Yarmouth where he also opened a drug store which he ran for some years. On the death of his father and coming into an independent fortune he gave up his practice and devoted himself to travel and farming.

LAUGHLIN JAMES O'SHAUGHNESSY, M.D., McGill University, 1898, died at Halifax on December 14th, 1935. Dr. O'Shaughnessy was born at Oldham, Halifax County, and after attending the common schools entered St. Francis Xavier University in 1892. The Doctor practised in the north of Halifax where he also maintained a hospital.

FREDERICK ERNEST LAWLOR, M.D., McGill University, 1901, died at Bermuda on January 23rd, 1936. Dr. Lawlor was born at Dartmouth in 1878. Dr. Lawlor was educated in private schools in Halifax, and after graduating

from McGill he was appointed Assistant Physician to the Nova Scotia Hospital for the Insane, Dartmouth, then Assistant Superintendent, and in 1911 was appointed Superintendent, but had to retire in the spring of 1935 on account of ill-health.

JOHN RODERICK BETHUNE MACLEOD, M.D., Dalhousie 1911, died at Port Hawkesbury on January 17th, 1936. Dr. MacLeod was a native of Grand River and practised in Port Hawkesbury for nearly twenty-five years.

ROSS LIVINGSTON BLACKADAR, M.D., Dalhousie 1902, died at Port Maitland on January 19th, 1936. Dr. Blackadar was born in 1874 and practised for many years in Port Maitland.

DUNCAN MACINTOSH CHISHOLM, M.D., University of New York, 1882, died at Port Hood on December 29th, 1935, at the age of eighty-three. Dr. Chisholm was born in Antigonish County in 1852. He entered St. Francis Xavier University and after graduating in Medicine from New York practised at the Strait of Canso and then settled in Port Hood where he practised for over fifty years.

EDGAR JAMES TOREY, M.D., University of New York, 1890, died at Albany, New York, on February 3rd, 1936. Dr. Torey, a native of Guysboro, went to Windsor as a young man as principal of the Windsor schools, and later went into partnership with J. A. B. Shaw, a druggist. He then took up the study of Medicine at New York and graduating settled at Dectaur, Ill. Later he moved to Albany where he remained until his death.

WILLIAM S. FULLERTON, M.D., Bell Hospital Medical Schools, 1882, died early in 1936 at St. Paul, Minnesota. Dr. Fullerton was born in Nova Scotia and taught school in Bear River.

GEOFFREY MARSHALL MORRIS, M.D., Dalhousie University, 1928, died at Gila, Arizona, on February 24th, 1936. Dr. Morris was born in 1900, received his early education at Kings Collegiate School and in 1918 was a cadet at the Royal Military College at Kingston. He entered McGill University but transferred to Dalhousie and received his Medical degree in 1928. He served in the State Public Health Departments of Arizona and Tennessee and previous to the time of his death he was Director of the Gila County Health Unit of the Arizona State Health Department.

LEWIS W. JOHNSTONE, M.D., Bell Hospital Medical College, 1886, died at Sydney Mines on March 9th at the age of seventy-five. Dr. Johnstone was born at Sydney and after graduation practised at Sydney Mines. He took an active part in political life and was Mayor of the Town in 1925, was elected M. P. to North Cape Breton and Victoria and remained its representative until 1935.

JOHN W. MCLEAN, M.D., McGill University, 1883, died at North Sydney on March 28th. Dr. McLean was born at Lake Ainslie. He attended Pictou Academy, graduated in Medicine from McGill and afterwards did post graduate work in Edinburgh. He practised for a time in Port Hawkesbury but later moved to North Sydney where he practised for about fifty years.

CHARLES M. BAYNE, M.D., Dalhousie 1920, died at Halifax on March 19th in his forty-first year. Dr. Bayne was born at Halifax and after graduation

served for eight years on the staff of the Nova Scotia Sanatorium. Early in 1930 Dr. Bayne became attached to the Department of the Public Health, as Divisional Health Officer and tuberculosis travelling diagnositician for the eastern division of the Province, which position he filled until the time of his death, at Sydney.

FRANK WOODLAND TAYLOR, M.D., Dalhousie 1900, died at Oakland, California at the age of sixty-four. Dr. Taylor was born at Port LaTour, Shelburne County, and after graduation first started practising at Wood's Harbour. Later he went to the Hawaiian Islands, but on account of ill health was forced to leave and finally settled at Oakland.

ALBERT ERNEST FORBES, M.D., Dalhousie 1900, died at Moncton, N.B. Dr. Forbes was born at Loch Katrine, Antigonish County, and after graduation served for some time at the Victoria General Hospital, Halifax. He then located at Sydney. Leaving there he practised in Upper Stewiacke for five years, then in Maccan for eleven years, and in 1920 moved to Moncton.

WILLIAM PEARSON REYNOLDS, M.D., Dalhousie 1900, died at Stevensville, Montana, on April 13th, at the age of sixty-seven. Dr. Reynolds was born at Upper Musquodoboit and for over thirty years practised his profession in Montana.

ALEXANDER P. MCKAY, M.D., Jefferson University 1881, died in Newfoundland early in June, 1936. Dr. McKay was born in Merigomish, Pictou County, and received his education at Pictou Academy and Dalhousie University. He went to Newfoundland in 1880 and began his practice at Bay Roberts, later moving to Catalina where he continued his work until advancing years compelled him to retire.

The Canadian Medical Association. The Secretary's office has had frequent communication with the Canadian Medical Association. As in the past year, most of the correspondence has dealt with the question of Federation. The Committee appointed at our last annual meeting at Sydney will report on this. We were honoured last year by a visit from the President, Dr. J. C. Meakins, and the Secretary, Dr. T. C. Routley, and we are looking forward with pleasure this year to meeting the new President, Dr. H. M. Robertson of Victoria.

Branch Societies. All of the branch societies have been active and accounts of several of the annual meetings have been sent to this office and published in the BULLETIN. The Halifax Branch had a most successful year, meeting every fortnight from autumn until late spring. Your Secretary visited the Valley Medical Society at the annual meeting held in Annapolis Royal in May.

The Annual Meeting. The annual meeting is being held this year in conjunction with the Refresher Course of the Medical School of Dalhousie University. The scientific part of the programme has been arranged by them; the entertainment, after consultation with the President, the members of the Executive resident in Halifax, and the Executive of the Halifax Branch of the Medical Society of Nova Scotia.

The Society is indebted to the Halifax Branch, and to the Ladies' Committee of the Halifax Branch for the delightful entertainment which has been arranged for members and their families.

The following contributions and prizes have been received:

Colwell Brothers—rug, golf prize.
Phinney Music Co., Ltd.—3 best quality Spalding Kro-Flight Golf Balls, gold prize.
J. F. Hartz Co., Ltd.—$10.00.
Laboratory Poulenc Freres of Canada, Ltd.—
Mead Johnson & Co. of Canada, Ltd.—$10.00 for golf prizes.
National Canadian Drugs Ltd.—$10.00.
Reed & Carnrick (Canada) Ltd.—$5.00 for golf prizes.
E. B. Shuttleworth Chemical Co., Ltd.—Eversharp pen and pencil set, golf prize.
Ingram & Bell, Ltd.—$25.00.
Maritime Surgical Supplies—Physician's Bag, golf prize.
T. Eaton Co. Maritimes Ltd.—1 doz. golf balls, golf prize.
Ciba Co., Ltd.—$10.00 for golf prizes.
Parke, Davis & Co.—$10.00
W. W. Clinger—Shield, golf prize.
Imperial Publishing Co., Ltd.—½ doz. golf balls, golf prize.
Moirs Limited—Chocolates, dance favours.
The Robert Simpson Eastern Ltd.—Eveready 5-cell focusing searchlight, golf prize.
MacLeod-Balcom, Ltd.—Box Yardley's Toilet Set, golf prize, and $10.00.
Buckley's Ltd.—Box Cigars, golf prize.
Abbott Laboratories Ltd., Montreal—$10.00.
Ayerst, McKenna & Harrison, Ltd., Montreal—$10.00.

The clerical secretary, Mrs. M. G. Currie, has rendered conscientious, painstaking, and thorough service in connection with the publication of the BULLETIN and general Society correspondence.

I take this opportunity of thanking the many members in Halifax and throughout the Province who have helped to further the interests of the Society.

Respectfully,

(Sgd.) H. G. GRANT, Secretary."

The Secretary reported that the Executive had suggested he should write to the Secretaries of the New Brunswick and Prince Edward Island Medical Societies and have them consider the matter of sending articles to the BULLETIN from their respective Societies. It was moved by Dr. Robert Sutherland, second by Dr. K. A. MacKenzie, and carried, that the Secretary's report be adopted.

The report of the Nominating Committee was next presented as follows.

Place of Meeting—Pictou Lodge if Pictou County Medical Society is agreeable.

President—Dr. J. R. Corston, Halifax.
First Vice-President—Dr. A. Calder, Glace Bay.
Second Vice-President—Dr. J. H. L. Simpson, Springhill.
Secretary—Dr. H. G. Grant, Halifax.
Treasurer—Dr. W. L. Muir, Halifax.

Cogswell Library Committee: Drs. J. R. Corston, G. H. Murphy, W. L. Muir, N. H. Gosse, H. L. Scammell, all of Halifax.

*Council C. M. A.: Dr. K. A. MacKenzie and Dr. C. S. Morton of Halifax; Dr. W. N. Rehfuss, Bridgewater; Dr. Dan Murray, Tatamagouche.

Narcotic Drugs: Recommend that this Committee be abolished.

Legislative Committee: Dr. J. G. MacDougall, Halifax; Dr. J. L. McIsaac, Antigonish.

Editorial Committee: Dr. N. H. Gosse, Dr. A. L. Murphy, Dr. J. R. Corston, all of Halifax.

Cancer Committee: Dr. H. W. Schwartz, Dr. S. R. Johnston, Dr. N. H. Gosse, all of Halifax.

Public Health Committee: Executive of Public Health Officer's Association.

Crippled Children: Recommend abolition and that Executive handle this.

Historical Medicine: Drs. G. W. T. Farish and T. A. Lebbetter, Yarmouth; Dr. J. E. LeBlanc, West Pubnico.

Workmen's Compensation Board: Recommend that the Executive care for this or if one insisted on return same Committee as before.

Nursing Education: Recommend abolition.

Advisors to Editorial Board of C. M. A.: Recommend abolition.

Relation of Medical Society of Nova Scotia to C. M. A.: Drs. J. R. Corston, G. H. Murphy, K. A. MacKenzie, Chairman, G. R. Burns and H. B. Atlee, all of Halifax.

Provincial Medical Board: Drs. J. G. MacDougall and H. K. MacDonald, Halifax; Dr. R. M. Benvie, Stellarton; Dr. T. A. Lebbetter, Yarmouth; Dr. J. C. Morrison, New Waterford; Dr. A. B. Campbell, Bear River.

Dr. John McKay's Banquet: Dr. J. G. MacDougall, Dr. H. K. MacDonald, of Halifax and Dr. Dan Murray of Tatamagouche.

(Sgd.) H. B. ATLEE,
JOHN J. ROY,
D. MURRAY,
H. A. CREIGHTON,
H. L. SCAMMELL.

*Added by nomination from the floor: Dr. W. F. MacKinnon, Antigonish; Dr. J. W. Smith, Liverpool; Dr. M. G. Burris, Dartmouth.

Dr. Atlee moved the adoption of this report which was seconded by Dr. Sutherland who stated he wanted to congratulate the Committee on their choice of President and also on the place of meeting, and that he had much pleasure in seconding the report of the Nominating Committee. Carried.

As the Council of C. M. A. should consist of seven members, it was moved and seconded and carried that Dr. W. F. MacKinnon of Antigonish, Dr. J. W. Smith of Liverpool and Dr. M. G. Burris of Dartmouth, be added.

The Secretary reported that it had been suggested that Dr. C. A. S. McQueen of Amherst be made an Honorary member of the Society and that it had been approved by the Executive. It was moved by Dr. H. K. MacDonald and seconded by Dr. G. R. Forbes that Dr. McQueen be made an Honorary member. Carried.

The Secretary stated that three new members wished to join the Medical Society of Nova Scotia, namely, Dr. W. R. Barlow of Centreville, Dr. H. A. Giovannetti of Sydney and Dr. C. C. Archibald of Truro, and that they had been approved by the Executive. It was moved by Dr. Dunbar and seconded that these members be accepted. Carried.

The meeting was then addressed by Dr. H. M. Robertson, President of the Canadian Medical Association. Dr. Robertson spoke in general of the benefits derived by the physicians in membership of the Canadian Medical Association. He referred particularly to the question of Health Insurance and spoke of the unsatisfactory conditions which pertained at present in the Province of British Columbia. He also talked on cancer, referring to

the King George V Jubilee Fund and especially to the interest the Association is taking in cancer through Dr. McEachern and his committee. He then brought up the question of federation of the Provincial Societies with the Canadian Medical Association, pointing out the advantages in general of having a strong central organization.

Dr. Robertson was followed by Dr. T. C. Routley, General Secretary of the Canadian Medical Association. His first announcement was that His Majesty the King had graciously consented to be the patron of the Canadian Medical Association. Dr. Routley told us something of the meeting at Victoria and announced that plans had been made in advance for the next three annual meetings of the Canadian Medical Association. In 1937 the meeting will be in Ottawa, in 1938 in Halifax, and in 1939 in Toronto. After this Dr. Routley referred to the activities of the Canadian Medical Association. He spoke of the good work they had done in the past in the way of post-graduate medical education, and expressed the opinion that as soon as funds were available this work would be continued. The Department of Hospital Service, under the very competent direction of Dr. Agnew, was pointed out as another of their activities. He referred to the question of maternal and infant welfare and stressed the necessity of more education to bring about a reduction in mortality in these groups. The matter of specialization He also dealt with and asked for our opinion on the question of separate examinations for specialists. In dealing with federation he reviewed briefly the situation from coast to coast. In British Columbia federation has been approved but action delayed as the interest in the Province now is wrapped up in State Medicine. Alberta is already a Division of the Canadian Medical Association. In all the other Provinces, except Quebec, the situation is somewhat similar, and that is, the principle of federation has been approved, but it is felt desirable that action be delayed on this question until it be given further study. In Quebec, as the matter of language is important, it is under consideration that two divisions be established in that Province, an English and a French one, and that for the French speaking physicians the Journal be published in French.

At the conclusion of Dr. Routley's speech a short discussion followed on federation.

Dr. Gosse said that he had intended in his report as Editor of the BULLETIN to be accepted as the "retiring Editor," but found after his arrival at the meeting that he had been re-elected, and if a nomination from the floor were in order he would like someone to take his place.

Dr. Atlee explained that when the Nominating Committee met they knew nothing of Dr. Gosse's resignation and it seemed a great pity that Dr. Gosse would not reconsider his decision, as the publishing of the BULLETIN is one of the most outstanding activities of the Society.

Dr. Gosse stated that he had been six years with the BULLETIN and for the last two years he had tried to resign, and asked that he be not nominated again.

Dr. Dunbar said he agreed with everything that Dr. Atlee said in regard to Dr. Gosse, and hoped that he would not leave the BULLETIN this year. Dr. Gosse said he would not be able to act as Editor, and Dr. G. H. Murphy recommended the appointment of an Editor from the floor. It was moved by Dr. Gosse and seconded by Dr. G. H. Murphy that Dr. H. W. Schwartz be Editor of the MEDICAL BULLETIN. Carried.

Meeting adjourned at 10.25 P.M.

Society Meetings

Reports on the last annual meeting of the Canadian Medical Association by our two delegates, Dr. G. W. T. Farish and Dr. J. K. McLeod.

THE 67th annual meeting of the Canadian Medical Society was held this year at Victoria, at which I had the privilege and pleasure of being present.

As there were only two representatives from Nova Scotia, Dr. McLeod and myself, we were both asked to act on the Council.

The programme began on Monday, the 22nd of June, at the Empress Hotel, an ideal situation for such an assemblage.

The first two days, Monday and Tuesday, were taken up almost exclusively with meetings of the General Council, at which there was a goodly sized attendance.

It was not until Wednesday that the scientific papers were presented continuing Thursday and part of Friday.

The meetings of the Council of course had to do with a number of various conditions affecting the Society and which had to be dealt with under the able chairmanship of Dr. Young.

The first report on the agenda was of the Committee on Archives. This dealt with the deaths amongst the medical profession of Canada, amounting in 1935 to 74. The respect for those departed was exemplified by one minute standing.

The annual meeting for this year was alluded to in comparison with that held in Atlantic City last year and Dr. Herman M. Robertson, the newly elected president, with his capable committee, was eulogized for having done a lot of hard work for months previous to the meeting, and in this way to have consummated a very successful meet.

The constitution and bye-laws came in for its share of discussion, as well as code of ethics. This matter was reported by Dr. D. A. Stewart as chairman and related principally with radio advertising as pertaining to the medical profession. The letter of Dr. Stewart to the members was very amusing as well as edifying.

The Frederic Newton Gisborne Starr award was spoken of and in Council. This award may be conferred upon any Canadian physician for achievement in any field of endeavour, and at this year's meeting the medals were presented to Sir Frederick Banting, Dr. Charles Herbert Best, and Dr. James Bertram Collip. Mrs. Starr was present and very graciously presented the medals on the evening of the public meeting.

The selection of President was discussed and it was pointed out that under the present system, of a man being selected from the place of meeting, many desirable men may be debarred from occupying the Presidential chair, and so after thorough discussion the Executive Committee was of the opinion that the President elect should be chosen from any part of Canada provided that he has been a member of good standing in the Association for the past

ten years, and has attended meetings of General Council for one or more years during his period of membership.

The matter of Federation was freely discussed, some provinces for and some against, but on the whole there appeared to be a tendency on the side of Federation—Alberta had already announced that she is willing to become the Canadian Medical Association Alberta Division. I know that the matter will be brought up at the annual meeting of the Nova Scotia Medical Society and discussed freely.

The Lister oration was delivered this year by Dr. E. W. Archibald of Montreal and was very creditable. Of course, always at this oration our minds go back to Dr. John Stewart who was the first Doctor in Canada to be distinguished by giving the oration in 1924.

Health Insurance came in for quite a discussion and the Canadian Medical Association is evidently in favor of some method of enacting it but a commission will be formed to make a survey, and this Commission should be given the widest possible powers.

The Council then progressed to report of the Treasurer, the report of the Committee on Public Health and Medical Publicity, the report of the Editor, Dr. Nicholls, the report of the Managing Editor, the report of the Study Committee on Cancer, the report of the Committee on Maternal Welfare, the report of the Committee on Education which by the way is a lengthy one, and so the deliberations of the Council ended, and none of us sorry that it was over, so that we could have some respite in listening to some scientific papers, or possibly a game of golf. As I referred before to Dr. Robertson, the newly elected President, being so indefatigable in his endeavours to make the meet a success, that I fear it would not have been the success it was, without his endeavours.

After the meeting of the Council the scientific papers were given in their respective rooms and were all of a high order.

It would be infringing on your time for me to enumerate any of them. You will be able to judge for yourselves when they appear from time to time in the Canadian Medical Journal.

The social side was well organized by the ladies committees, and all were well looked after.

Victoria was an ideal city in which to hold the meet, and the Empress Hotel an ideal hotel in which to hold the meetings. Kindness and courtesy were shown on every side.

(Sgd.) G. W. T. FARISH.

July 29th, 1936.

To the President and Members
of the Medical Society of Nova Scotia.

Gentlemen:—

In the very beginning may I thank you for the courtesy extended to me in appointing me to represent the Nova Scotia Society on the Council at the recent meeting of the Canadian Medical Association in Victoria, B. C. Dr. Farish of Yarmouth the other Nova Scotia representative attended all the meetings and gave his support to every question of importance.

The trip out was a long but most interesting one, and the many confreres one meets on a journey of this kind and at the various meetings is one of the most enjoyable experiences of such a gathering.

As the notice stated our meetings were held in one of the large rooms of the "Empress Hotel" in Victoria, an hotel noted everywhere for its fine situation, its beautiful surroundings unsurpassed perhaps anywhere in Canada. Here we met noted men from all parts of Canada as well as leading physicians and surgeons from the neighbouring republic, men who not only brought to our meetings medical knowledge of great interest, but perhaps even more important the fine fellowship and good wishes which they carried from the great nation to the south of us.

The Council had as its presiding officer Dr. Young of Toronto, and it is not too much to say that he made an ideal Chairman with a thorough and correct knowledge of the rules of procedure, and an ever courteous manner which always made for harmony and progress.

Many important questions came before the Council for consideration, each Province having its own problems. Owing to the depression which perhaps has been felt more in the Western Provinces than in the East the attitude of the different Provincial Governments in medical matters was frequently brought before us. However, the great problem in which we were all interested was the question of Federation. There was a most interesting discussion participated in by the representatives of each Province and it was decided to approve of the principle of Federation with a strong committee to deal with the whole question at a future meeting of the Association.

It may be pointed out however that there were some differences of opinion as to the effect of such a Federation on our Provincial Societies—as for instance the cost per member—the liberty of the members as to whether they should be compelled to belong to one or both Societies—the danger of the smaller provinces being overwhelmed by Ontario and Quebec with its large and influential membership. It was felt however that with a strong and wise committee these differences could be ironed out and an organization along the lines of the British Medical Association could be brought into being with the best results.

There can be no doubt that rarely, if ever, has there been a medical meeting where the visitors and their lady friends received a more cordial and kindly greeting than in Victoria, and on all sides there was the greatest praise heard of the attention and kindness shown by the ladies of this beautiful city. In the east we have magnificient scenery unsurpassed in Canada which we look upon with just pride, but Victoria is a veritable garden from one end to the other, and our meeting there will be long remembered as one of the most enjoyable and profitable on record.

Yours truly,

(Sgd.) J. K. McLeod.

ANNUAL FALL MEETING.

Western Nova Scotia Medical Society.

The Annual Fall Meeting of the Western Nova Scotia Medical Society was held at 7.30 P.M. in the Grand Hotel at Yarmouth on Thursday, November 12th. It was in the form of a Complimentary Dinner in honour of Drs. George W. T. Farish and Charles A. Webster of Yarmouth, both of whom

have been practising continuously in Yarmouth for the past fifty years. Twenty-four Doctors attended.

The Toast List was as follows:

THE KING

Toastmaster.....Dr. C. K. Fuller, President.

"OUR PROVINCE"

Proposed by.....Dr. J. E. LeBlanc, West Pubnico.
Responded to by.....Hon. F. R. Davis, Minister of Health.

"OUR PROFESSION"

Proposed by.....Dr. K. A. MacKenzie, Professor of Medicine, Dalhousie University.
Responded to by.....Dr. James Corston, President Nova Scotia Medical Society.

"OUR HONOURED GUESTS"

(1) Proposed by.....Dr. H. G. Grant, Dean of the Faculty of Medicine, Dalhousie University.
(2) .....Dr. S. W. Williamson, Yarmouth.
Responded to by.....Drs. G. W. T. Farish and C. A. Webster.

Presentation of gifts.

Musical selection by Dr. L. M. Morton.

GOD SAVE THE KING.

Dr. O. R. Stone, President of the Valley Medical Society, brought the felicitations and congratulations of his organization.

All the speakers emphasized the fine professional standing enjoyed by the guests of the evening; their years of service as general practitioners had been unbroken since they first came to Yarmouth in 1886. There was an unusual family tradition behind each of these men. There had been a Farish practising Medicine in Yarmouth, in an unbroken line, for the past 133 years. Dr. Frederick Webster, grandfather of the present Physician, first started to practise in Yarmouth in 1833. There has been a Webster practising here ever since and in this same family continuously in Nova Scotia since 1791. One of Dr. Webster's sons is at present in his fourth year at Dalhousie, while Dr. Farish has a nephew studying in the West.

Both Drs. Farish and Webster responded feelingly; they told of their early years in practice, with the changes which they had both personally witnessed. They had seen the coming of Antiseptics, Sera and Modern Surgery; they touched on the great things that had revolutionized the practice of Medicine during those fifty years, and ended with grateful appreciation of this occasion and a note of helpful advice to the younger members of our Society.

Telegrams of congratulations were then read from their many professional friends throughout the Province.

Following the Meeting an informal round-table conference took place re the proposed fifteen dollar rate for conjoined membership in the C. M. A. and the Nova Scotia Medical Society. Drs. MacKenzie, Grant and Corston discussed this, answering questions and giving helpful advice to the Society members.

A presentation from our Society, of two suitably engraved silver trays, was made to each of the Honoured Guests.

T. A. LEBBETTER,
Secretary.

Annual Meeting Eastern Counties Medical Society.

The fifteenth annual meeting of the Eastern Counties Medical Society was held at St. Martha's Hospital, Antigonish on November 10th, with the President, Dr. D. J. MacMaster, in the chair. The programme was as follows: "Surgical Diseases of Children", Dr. L. R. Meech, North Sydney; "Diagnostic Methods in Tuberculosis and a Discussion on X-ray Interpretation," Dr. H. R. Corbett, Kentville; "Un-united Fractures", Dr. A. L. Murphy, Halifax. The annual dinner was served at the hospital at six, and after a programme of speeches, the work of the convention was resumed. Officers elected for the coming year were: Honorary President, Dr. J. J. Cameron, Antigonish; Honorary Secretary, Dr. P. S. Campbell, Halifax; President, Dr. D. J. MacMaster, Antigonish; 1st Vice-President, Dr. T. R. Deveau, Arichat; 2nd Vice-President, Dr. C. B. Smith, Goldboro; Secretary-Treasurer, Dr. Thomas B. Murphy, Antigonish; Executive, Dr. W. F. MacKinnon and Dr. J. J. Carroll, Antigonish; Dr. G. W. Sodero, Guysboro; Dr. T. T. Monaghan, Sherbrooke, Dr. E. A. Brassett, Canso; Dr. F. J. MacLeod, Inverness; representatives on Executive of the Medical Society of Nova Scotia, Dr. J. S. Brean, Mulgrave, and Dr. T. B. Murphy, Antigonish.

Executive Meeting of the Canadian Medical Association.

This committee met on Oct. 29th and 30th at the Chateau Laurier, Ottawa, all provinces being represented. A large volume of work was transacted occupying a period of two full days. Of special interest was the discussion on federation and the cancer problem. Federation;—Reports were received from all provinces and acceptance of the principle was reiterated. Some objections which arose were dealt with and in the main satisfactorily met. Several phrases in the proposed constitution were so amended as to meet the objections. It would appear that the proposal is going along satisfactorily and that in a short time a greater unity of the profession in Canada will be an accomplished fact.

Cancer:—This subject was discussed fully. Dr. McEachern who has succeeded Dr. Primrose as Chairman of the Cancer committee submitted his scheme for approaching the King George Jubilee Cancer Fund with the object of getting prompt action. Cancer research and immediate aid was for the time being set aside and stress laid on the importance of putting a full time secretary in the field at the earliest possible moment. The duty of this official would be to visit all parts of Canada, stimulate interest in cancer work, assist present agencies and endeavour to start new ones. This subject was dealt with at the recent annual meeting of the Medical Society of Nova Scotia. Arrangements for the annual meeting at Ottawa next year were discussed and it is expected that a large and successful meeting will be held. Of special interest to Nova Scotians was the acceptance of a proposition by which our members may be given full membership in both societies for a fee of fifteen dollars. Further reference to this will be found elsewhere in this BULLETIN.

Royal College of Physicians and Surgeons of Canada.

The Annual Meeting was held at Ottawa on Oct. 31st. Papers were delivered by Dr. Henry A. Christian of Boston, Dr. C. Leonard Huskins of McGill University and Dr. Paul H. Thorlakson of University of Manitoba. Of special interest this year was the conferring of Honorary Fellowships on His Excellency, Lord Tweedsmuir, Governor General of Canada, and Dr. H. A. Christian of Boston. Four members were admitted to Fellowship, three on examination and one ad audum gradum. At the annual dinner the College was charmed by an interesting address by His Excellency, Lord Tweedsmuir.

The programme of the meeting is given below:

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
ANNUAL MEETING.

Ottawa, October 31st. 1936.

9.00 a.m. Meeting of Council—Board Room, National Research Building, Sussex Street.
2.00 p.m. Scientific Programme—Auditorium, National Research Building.
Doctor Henry A. Christian, Hersey Professor of Physic, Harvard University, Physician in Chief of the Peter Bent Brigham Hospital, Boston.
"Some Changing Views about Oedema and Diuresis."
Doctor C. Leonard Huskins, B.S.A.,M.Sc. (Alberta), Ph.D.,D.Sc. (London), Professor of Genetics, McGill University.
"Some Factors in the Development of Cancer in Mice."
Doctor Paul H. Thorlakson, M.R.C.S. (England), L.R.C.P. (London), Assistant Professor of Clinical Surgery, University of Manitoba.
"Gastroscopy its Indications and Value."
4.00 p.m. Annual Meeting—Auditorium National Research Building.
Order of Business—as in By-Laws.
5.30 p.m. Convocation for conferring Fellowships.
Honorary Fellowships will be conferred upon—
His Excellency The Right Honourable, The Lord Tweedsmuir, G.C.M.G.,C.H., Governor General of Canada.
Presented by Dr. Duncan Graham—Immediate Past President.
Honorary Fellowship in the Division of Medicine—
Professor Henry Asbury Christian.
Presented by Dr. Alvah H. Gordon, Vice President, Division of Medicine.
Fellowships to successful candidates in the recent examinations.
7.30 p.m. Annual Dinner—Chateau Laurier.

Canadian Rheumatic Disease Association.

A meeting of the Council of this organization was held in Ottawa Oct. 31st. 1936. It is expected that this organization will initiate interest in the subject of arthritic diseases in Canada similar to existing organizations in United States, Great Britain and other countries. At present the greatest cause of morbidity and loss of time from work is arthritis in its many forms. Discussions took place on classification, methods of raising funds, and methods of dealing with the problem in a practical manner. A survey is essential to any scheme and inasmuch as no money was immediately available for a complete survey it was decided to use existing bodies as far as possible. It is hoped that clinics will be organized in hospitals and that Provincial Boards of Health will render valuable assistance. A general meeting of the Association will be held at the time of the Canadian Medical Meeting in Ottawa next June.

Department of the Public Health

PROVINCE OF NOVA SCOTIA

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

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

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Chief Health Officer - - - - - DR. P. S. CAMPBELL, Halifax.
Divisional Medical Health Officer - - DR. J. S. ROBERTSON, Sydney.
Divisional Medical Health Officer - - DR. J. J. MACRITCHIE, Halifax.
Director of Public Health Laboratory - - DR. D. J. MACKENZIE, Halifax.
Pathologist - - - - - - - - - DR. R. P. SMITH, Halifax.
Psychiatrist - - - - - - - - - DR. ELIZA P. BRISON, Halifax.
Superintendent Nursing Service - - - MISS M. E. MACKENZIE, Reg. N., Halifax.

OFFICERS OF THE PROVINCIAL HEALTH OFFICERS' ASSOCIATION

President - - - - DR. F. F. EATON - - - - Truro.
1st Vice-President - - Dr. P. E. BELLIVEAU - - - - Meteghan
2nd Vice-President - - DR. H. J. TOWNSEND - - - - Louisburg
Secretary - - - - DR. P. S. CAMPBELL - - - - Halifax.

COUNCIL

DR. F. O'NEIL - - - - - - - - - Sydney
DR. G. V. BURTON - - - - - - - - - Yarmouth
DR. R. M. BENVIE - - - - - - - - - Stellarton

MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

ANNAPOLIS COUNTY

Hall, E. B., Bridgetown.
Braine, L. B. W., Annapolis Royal.
Kelley, H. E., Middleton (Mcpy. & Town).

ANTIGONISH COUNTY

Cameron, J. J., Antigonish (Mcpy).
MacKinnon, W. F., Antigonish.

CAPE BRETON COUNTY

Tompkins, M. G., Dominion.
Fraser, R. H., New Waterford.
Martin, H. J., Sydney Mines.
McNeil, J. R., Glace Bay.
McLeod, J. K., Sydney.
O'Neil, F., Sydney (County), South Side.
Murray, R. L., North Sydney.
Townsend, H. J., Louisburg.
Gouthro, A. C., Little Bras d'Or Bridge, (Co. North Side).

COLCHESTER COUNTY

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

CUMBERLAND COUNTY

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

DIGBY COUNTY

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

GUYSBORO COUNTY

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

HALIFAX COUNTY

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

HANTS COUNTY

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

INVERNESS COUNTY

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

KINGS COUNTY

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

LUNENBURG COUNTY

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

PICTOU COUNTY

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

QUEENS COUNTY

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

RICHMOND COUNTY

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

SHELBURNE COUNTY

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

VICTORIA COUNTY

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

YARMOUTH COUNTY

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

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

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

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

Report on Tissues sectioned and examined at the Provincial Pathological Laboratory from November 1st, 1936, to December 1st, 1936.

During the month, 197 tissues were sectioned and examined, which with 44 tissues from 9 autoposies, makes a total of 241 tissues.

Tumours, simple	28	
Tumours, malignant	28	
Tumours, suspicious of malignancy	..	
Other conditions	141	
Tissues from 9 autopsies	44	
		—241

Communicable Diseases Reported by the Medical Health Officers for the month of November, 1936.

County	Chickenpox	Diphtheria	Cerebro Spinal Meningitis	Influenza	Measles	Mumps	Paratyphoid	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. Pulmonary	Tbc.-other Forms	V. D. G.	V. D. S.	Whooping Cough	Pink Eyes	Eyrsipelas	German Measles	TOTAL
Annapolis	3	..	..	..	..	..	..	1	2	..	..	..	2	..	..	..	..	..	8
Antigonish	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Cape Breton	..	6	..	..	..	16	..	..	20	..	..	..	..	..	..	2	..	..	44
Colchester	..	..	..	..	..	..	..	..	20	..	..	..	..	..	20	..	..	..	40
Cumberland	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
Digby	..	1	..	..	..	..	..	1	6	2	..	..	..	..	9	..	..	..	19
Guysboro	..	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	3
Halifax City	1	4	..	..	..	..	..	..	5	..	1	..	..	..	16	..	1	1	29
Halifax	1	2	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	..	6
Hants	..	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	2
Inverness	..	1	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	3
Kings	..	..	..	10	..	..	..	1	..	..	1	..	..	..	2	..	..	2	16
Lunenburg	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Pictou	..	..	..	3	..	..	..	..	1	..	..	..	1	..	16	..	..	..	21
Queens	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Richmond	..	..	..	..	..	1	..	..	..	..	..	..	..	1	5	..	..	..	7
Shelburne	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Victoria	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Yarmouth	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
TOTAL	5	17	..	13	..	17	..	3	59	2	5	..	3	1	68	2	1	3	199

Positive cases Tbc. reported by D. M. H. O's. 101.

RETURNS VITAL STATISTICS FOR OCTOBER, 1936.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis	21	9	8	5	7	0
Antigonish	10	10	5	11	4	0
Cape Breton	84	77	75	33	28	4
Colchester	22	31	16	9	9	0
Cumberland	45	30	19	14	22	0
Digby	23	13	7	13	4	0
Guysboro	19	14	15	4	6	0
Halifax	105	90	109	62	55	6
Hants	18	20	8	11	8	1
Inverness	23	19	16	2	6	1
Kings	17	23	14	16	13	2
Lunenburg	23	16	18	6	4	2
Pictou	26	28	17	11	12	3
Queens	9	9	13	1	2	0
Richmond	14	19	2	9	7	0
Shelburne	8	14	7	4	5	0
Victoria	0	3	3	1	1	0
Yarmouth	16	8	16	10	8	1
	483	433	368	222	201	20

OBITUARY

The death occurred on November 15th, 1936, of Dr. Starr Ford of Cincinnati, a brother of Dr. T. R. Ford of Liverpool. Dr. Ford had practised internal medicine in Cincinnati for forty years. He was a member of the staff of several hospitals and was also Professor of Medicine at the University of Cincinnati Medical College for the past twenty-five years. Dr. Ford was born at Milton, Nova Scotia, April 15, 1865. He graduated from Acadia College, Wolfville and then took his medical course at the Ohio Medical College, and completed his studies at Vienna.

We regret to learn of the death of Rev. James Ross, D.D., for many years Superintendent of the Presbyterian Home Missions, who passed away at Halifax in November. Dr. Ross was the father of Mrs. Atlee, wife of Dr. H. B. Atlee of Halifax. He is survived by Mrs. Ross, four sons and four daughters, and two sisters on the old homestead at Earltown, Colchester County. An evening funeral service was held at Dr. Atlee's, and interment was made at Tiverton, Pictou County

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We extend sympathy to Dr. R. H. Sutherland of Pictou on the passing of his sister, Miss Lavinia J. Sutherland of River John, on November 19th. She died in Sutherland Memorial Hospital of pneumonia, aged sixty-one years. Miss Sutherland was born in River John and lived there the greater part of her life. The funeral was held from the home of Dr. Sutherland and interment was in the family lot at River John. She is survived by four brothers, two being Doctor "Bob" of Pictou and Dr. James A. Sutherland of Vancouver.

Citrated Ferrous Chloride B.D.H.

Ferrous chloride (citrated) is a new iron preparation (British Drug Houses Ltd.) which promises to be of considerable service in the treatment of anaemia. In recent years it has been shown that preparations such as reduced iron, Blaud's pill, and iron and ammonium citrate are only effective when given in massive doses. The disproportion between the minimum effective dose and the maximum amount of iron absorbed is indeed very striking. It is believed that the absorption of iron depends on the formation of ferrous chloride in the stomach, and hence this salt appears to be the rational form in which to administer iron. Unfortunately ferrous chloride is easily oxidized to ferric chloride, and this has hindered its clinical use. The new preparation consists of tablets of citrated ferrous chloride, which are protected from oxidation by a coating of a special varnish. These tablets promise to provide an effective means of iron therapy which avoids the difficulties sometimes associated with massive treatment.

Personal Interest Notes

WE regret to hear that Dr. J. W. Smith of Liverpool recently suffered a fall resulting in a fracture of one of the bones of his foot. The Doctor, however, is getting around on crutches and we sincerely trust that it will only be a few weeks before he has completely recovered.

Dr. Allan Morton is at present in New York where he is taking post-graduate work in neurology.

Dr. Audley A. Giffen, a graduate of Dalhousie, who spent three years on the medical staff at the Sanatorium at Kentville, and then went to Montreal where he spent two years as house surgeon at the Royal Victoria Hospital, has established himself in Bridgetown.

We are delighted to hear that Dr. W. R. Dunbar of Truro has been discharged from hospital and apparently is getting better every day.

Dr. W. S. Phinney of Yarmouth recently visited officially a number of Masonic Lodges in Yarmouth County.

Dr. J. S. Munro has been re-elected Vice-President of the North Sydney Curling Club.

Dr. F. E. Walsh of Springhill spent the last two weeks of November in post-graduate work in Montreal. The Doctor attended the Montreal General and the Royal Victoria Hospitals and devoted his time to the study of general medicine and X-Ray.

Dr. and Mrs. M. J. Wardrope of Springhill recently spent a short vacation visiting their former homes at Milford and Dartmouth.

Dr. and Mrs. J. G. B. Lynch of Sydney have returned from a visit to New York.

Dr. and Mrs. Edward DuVernet of Digby left December first on a five month's trip, during which time they expect to visit many of the principal cities of the United States and Canada. The Doctor also expects to visit many of the leading hospitals.

Staff changes at the Nova Scotia Sanatorium.

On account of the absence of Dr. C. J. W. Beckwith, Assistant Medical Superintendent, who is now taking a course in Public Health at Toronto University, certain changes have been necessary in the staff of the Nova Scotia Sanatorium. Dr. J. E. Hiltz, of Truro, who graduated from Dalhousie in 1934, and who has been on the Sanatorium Staff since graduation, has been appointed Acting Assistant Medical Superintendent, and Dr. Eric M. Found of New London, P. E. I., a graduate of Dalhousie 1935, has been appointed a new member of the staff.

During the middle of November we learned of the serious illness in Montreal of Dr. A. W. Miller of New Waterford. We trust by this time that he has been completely restored to health.

Our good friend Dr. W. W. Chipman of Montreal has been a recent visitor to Nova Scotia, and was the guest speaker on November 19th at the Founders' Day exercises at Acadia University, Wolfville. Dr. Chipman, Emeritus Professor of Gynaecology at McGill, was born in Kings County and graduated from Acadia in 1890. He is one of the most versatile and polished speakers in our profession.

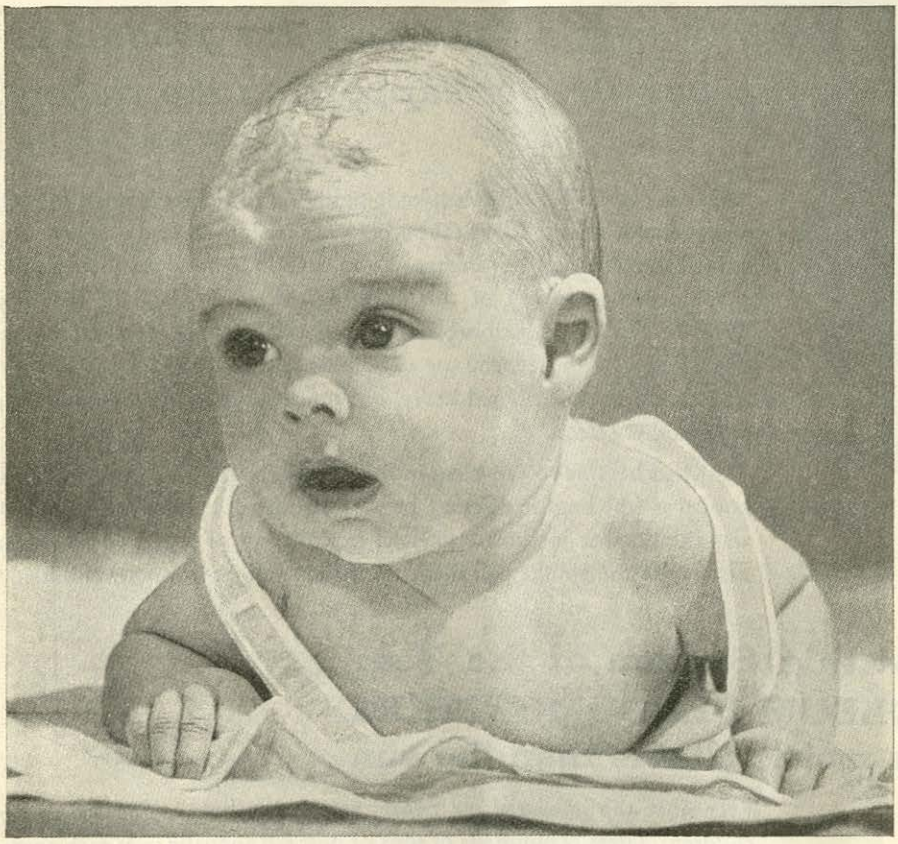
Hospital at Digby Menaced.

Spontaneous combustion in the coal bin of the Digby General hospital almost spelt disaster to that institution Saturday night, and although the blaze was soon placed under control by the Digby fire department, several men worked all night removing the smouldering coal from the basement. Damage to the building was light, although some of the woodwork was scorched and burned.

Correction.

In the last edition of the BULLETIN the following statement was made concerning the hospitals in Nova Scotia—"In Nova Scotia twenty-one hospitals were approved, seven receiving the 'Class A' rating, and the remaining fourteen have been approved provisionally. This should have read—"Fourteen receiving the 'Class A' rating, and the remaining seven have been approved provisionally.

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



Life is not all Milk and Rattles

Life is not as gentle to a tiny baby as it seems to be.

He comes into this world, never having breathed, never having eaten, never having digested food. Almost immediately, his little body must adjust itself to these vital functions.

If he is like most babies, he doubles his weight in the first few months; *triples* it in the first year. Every part of his body must make adjustments to accommodate this proportionately tremendous growth.

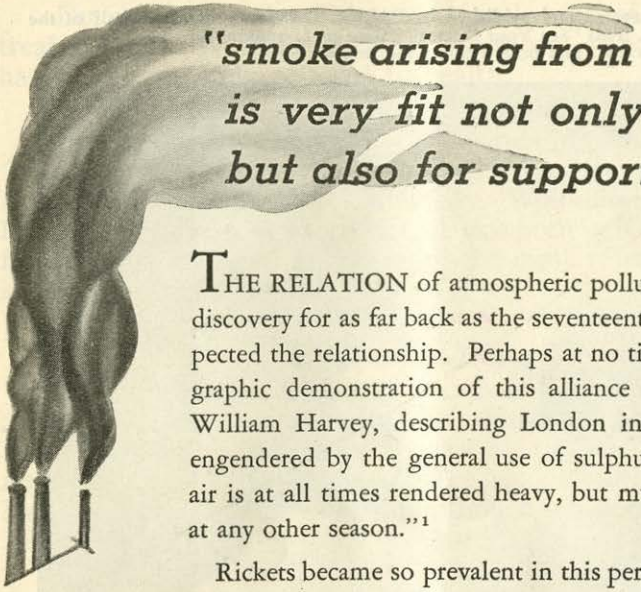
A new baby encounters disease-producing germs for the first time, and must build up resistance against them. If he does become ill, he is without the power to tell what the trouble is or where it lies. And when upset, he frequently is further endangered by the well-meant, but often harmful, suggestions of relatives and friends who "know *just* what to do."

Yes, infancy is so hazardous a period that, last year, the number of deaths among babies under one year of age was more than *three times* the number of deaths from automobile accidents.

The doctor is the one person equipped to give parents competent guidance through this dangerous period of a baby's life.

The doctor who sees the baby regularly can often detect sickness or physical trouble *in its early stages*. He can prescribe correct diet, proper hours of sleep, healthful and sensible handling of the habit problem. And he can start an important immunization program, to prevent such diseases as smallpox, diptheria, and whooping cough.

Enlisting the doctor's help—entrusting growth, diet, and general health to his supervision—is one of the most sensible precautions parents can take in those dangerous days of the child's first year.



"smoke arising from the fossile coal is very fit not only for producing but also for supporting the rickets"

—William Farrer, 1773

THE RELATION of atmospheric pollution to rickets is not a modern discovery for as far back as the seventeenth century shrewd observers suspected the relationship. Perhaps at no time in history was there a more graphic demonstration of this alliance than in England of that day. William Harvey, describing London in 1657, spoke of "the smoke engendered by the general use of sulphureous coal as fuel, whereby the air is at all times rendered heavy, but much more so in the autumn than at any other season."[1]

Rickets became so prevalent in this period that on the continent it was known as "the English disease," because, Rutherfurd points out, "England was the pioneer in the commercial exploitation of coal, and so passed first under the smoke pall that cut off the sunlight from city children."[1]

At this Season of the Year OLEUM PERCOMORPHUM is more reliable than the sun

Ever since the industrial era began, smoke has been a menace to city children. Literally hundreds of tons of dust fall annually over each square mile of the larger urban centers, according to a recent survey by the U. S. Public Health Service.[2] Fortunately, winter sunlight need no longer be depended upon to prevent rickets. A few drops of Oleum Percomorphum, at a cost of less than one cent a day, furnish ample vitamin D — in measured and controlled dosage. At no additional cost, at least 7,000 units of vitamin A are also furnished. Oleum Percomorphum makes it possible to prescribe natural vitamins A and D in 1/100 the dose of U.S.P. cod liver oil, and in the same ratio as the latter. Each gram of Oleum Percomorphum offers not less than 60,000 vitamin A units and 8,500 D units (U.S.P).

[1]Brit. J Child. Dis. 33:40, Jan.-Mar. 1936

[2]U. S. Public Health Bulletin No. 224

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