

# The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia Canadian  
Medical Association Nova Scotia Division.

**FEBRUARY, 1951**

Editorial Board, The Medical Society of Nova Scotia

DR. MARGARET E. B. GOSSE, Halifax, N. S.

Editor-in-Chief

Dr. C. B. Stewart, Halifax, N. S.,  
and the Secretaries of Local Societies

Published on the 20th of each month and mailed to all physicians and hospitals in Nova Scotia. Advertising forms close on the last day of the preceding month. Manuscripts should be in the hands of the editors on or before the 1st of the month. Subscription Price: \$3.00 per year.

It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors.

1. Manuscripts should be typewritten, on one side only of the paper and double spaced.
2. Should proof be sent to a contributor, corrections must be clearly marked and no additional matter added, and the proof returned promptly.
3. Orders for reprints should accompany the proofs.
4. Communications should be sent to the Secretary, Dr. H. G. Grant, Dalhousie Public Health Clinic, Morris Street, Halifax, N. S.
5. Please mention the BULLETIN when replying to advertisements.

## OFFICERS

### The Medical Society of Nova Scotia

President - - - - -	DR. E. F. ROSS, Halifax, N. S.
1st Vice-President - - - - -	DR. J. J. CARROLL, Antigonish, N. S.
2nd Vice-President - - - - -	DR. L. M. MORTON, Yarmouth, N. S.
Secretary - - - - -	DR. H. G. GRANT, Halifax, N. S.
Treasurer - - - - -	DR. R. O. JONES, Halifax, N. S.

### Antigonish-Guysborough Medical Society

President - - - - -	DR. O. C. MACINTOSH, Antigonish, N. S.
---------------------	--

### Cape Breton Medical Society

President - - - - -	DR. G. C. MACDONALD, Sydney, N. S.
---------------------	------------------------------------

### Colchester-East Hants Medical Society

President - - - - -	DR. S. G. MACKENZIE, SR., 681 Prince St., Truro, N.S.
---------------------	---

### Cumberland Medical Society

President - - - - -	DR. F. L. HILL, Parrsboro, N. S.
---------------------	----------------------------------

### Halifax Medical Society

President - - - - -	DR. A. R. MORTON, 30 Armview Avenue, Halifax, N.S.
---------------------	--

### Lunenburg-Queens Medical Society

President - - - - -	DR. A. L. CUNNINGHAM, New Germany, N. S.
---------------------	--

### Pictou County Medical Society

President - - - - -	DR. H. B. WHITMAN, Westville, N. S.
---------------------	-------------------------------------

### Valley Medical Society

President - - - - -	DR. H. E. KELLEY, Middleton, N. S.
---------------------	------------------------------------

### Western Nova Scotia Medical Society

President - - - - -	DR. J. E. LEBLANC, West Pubnico, N. S.
---------------------	--

### Nova Scotia Association of Radiologists

President - - - - -	DR. S. R. JOHNSTON, Halifax, N. S.
---------------------	------------------------------------

### The Nova Scotia Society of Ophthalmology and Otolaryngology

President - - - - -	DR. D. M. MACRAE, Halifax, N. S.
---------------------	----------------------------------



# Principles in The Management of Abdominal Hernias

A. J. GRACE, F. R. C. S. (Eng. & C.),

London, Ontario

**T**HERE can be little doubt that operative procedures are employed more frequently for inguinal hernias than for any other elective condition in the field of general surgery. A host of publications indicate that in the main the results leave much to be desired; for example, Watson, in his most comprehensive monograph, quotes recurrence rates in the hands of experienced surgeons amounting to ten per cent in the case of indirect hernias, and from ten to twenty per cent in the direct type. Personal observation of many series of cases that are not publicized has impressed me greatly with the crying need for improvement in this old but large field of surgical endeavour.

For some considerable time, my Assistant and I have been carrying out a critical review of my own end results in hernias of all sorts related to the abdominal cavity. By far the largest group of these is made up of the inguinal hernias. The remarks that follow will be directed primarily towards this one type.

Following the current surgical literature on this subject in general, one can hardly escape bewilderment at the confusing variety of methods advocated for the treatment of these cases. Many lengthy articles appear with no other apparent purpose than the enthusiastic endorsement of some minor detail or modification. It must be difficult indeed for any but the most wary and best informed to maintain any sort of reasonable perspective when viewing this problem as a whole.

The leading methods in common use will be listed here, together with some of the modifications. Mechanical devices include various external supports (trusses; belts) together with appropriate ordering of the life of the patient. Today such purely palliative handling is reserved by common consent for patients refusing operation or absolutely unsuitable for such. The injection technic is revived from time to time, but it has serious drawbacks and very few ardent supporters today. Operative treatment is accepted by most men as correct, but agreement ceases there. Simple excision of the hernial sac is the basis of the Hamilton Russell technic (introduced originally for young children in whom this remains adequate in the main,) while others have preferred inversion or plication of the sac. Various plastic procedures utilize neighbouring soft tissues. The fibers of the internal oblique muscle, or of the conjoined tendon, are sutured to the inguinal ligament in the Bassini and Ferguson methods, behind and in front of the cord respectively; these are attached to Cooper's ligament in the McVay technic. Certain methods, e.g. Halsted's, include direct passage of the cord through all layers of the abdominal wall, to lie thereafter in a subcutaneous position. Many have favored the grafting of living tissues to strengthen the wall and fill any gaps. Fascia has been widely employed in the form of flaps from the rectus sheath, sheets or strips from the fascia lata (Gallie), or a strip taken from the overlying external oblique aponeurosis.



eurosis (McArthur). Foreign barriers appear to be coming into vogue once more. The silver filigree had its day several decades ago; tantalum mesh and plastic inlays have ardent supporters today, while Rodney Maingot advocates darning with floss silk and others utilize nylon similarly. Most workers have preferences in the way of suture material used, and the merits of fine, unabsorbable sutures and ligatures (stainless steel, cotton or silk) should need little discussion in this day. An unlimited number of combinations of method are available for those who desire to exercise their ingenuity in this direction.

So much confusion touching the handling of a common condition, and genuine difference of opinion, surely cries out for a fresh examination of the basic principles involved and restatement of these in unmistakable terms.

Abdominal hernias comprise all protrusions, actual or potential, of abdominal contents through the retraining wall, from the diaphragm above to the pelvic floor. Inguinal hernias include all those emerging in relation to the inguinal canal and its contents. In the case of all true hernias, indirect or direct, there is a gap in the tissues of the wall permitting escape of a peritoneal sac which may be empty or contain any of the nearby viscera.

Regarding the production of inguinal hernias, too much emphasis is placed on the forces acting on the abdominal wall. These are important, especially if intermittently excessive, as resulting from chronic coughing or constipation, or from bladder neck obstruction. In the main, however, a "strain" does no more than make evident a defect that exists already, or enlarges a hernia which is present but has not been recognized. The deficiency of the wall is primarily developmental in the case of indirect hernias, but weakness may result from local trauma (surgical as well as other forms of injury, or infection), and atrophy of muscles from any cause is antecedent to most direct hernias, as well as contributing to the growth of any hernia once it has appeared. Obviously it is the "open door" that plays the leading role, yielding to tension demands that may or may not be far out of line with the normal. It should be appreciated at this juncture that every abdominal wall is designed to function in relation to a positive intra-abdominal pressure, and that the one type of tissue capable of adjusting its strength to the load is the skeletal muscle.

Diagnosis in the case of inguinal hernias seldom presents real difficulty. The history is fundamental, from a competent observer in the matter of young children, from the patient otherwise. Frequently the statement concerning a swelling, its exact site and characters, and changes induced by alterations in posture or exertion, will leave no doubt in one's mind. Physical examination seeks to demonstrate an impulse on coughing (usually better seen than felt), the presence and characteristics of a swelling, the relation of such to the inguinal canal and external ring, and other data including condition of the scrotal contents and surrounding structures. Finally, clinical assessment aims at establishing the presence of a hernia, its type and size, the exact size of the defect in the wall, the nature of any contents, the presence or imminence of complications, and other points assisting in a complete differential diagnostic evaluation.

It is important to appreciate that hernias are sources of danger as well as of discomfort. Distress may be physical or mental, and from the hernia directly due to a truss. With the passage of time changes tend to occur in the structures making up and surrounding the hernia. Enlargement is usual



with pressure effects and likelihood of inflammatory adhesions; symptoms are likely to increase. Complications may ensue at any time, notably inflammation, irreducibility, incarceration and (most important of all) strangulation; very rarely contained bowel may be ruptured, or intra-abdominal pathological processes may arise, as torsion of gut or omentum. Neglect of a hernia until complications supervene converts a simple physical handicap into a serious threat to life. This difference, on the part of both sufferers and medical practitioners, is the outstanding cause of mortality and morbidity attributable to this essentially simple lesion. The number of longstanding and truly enormous hernias that comes under my own care disturbs me not a little. Cure then becomes a major problem and hazardous after a prolonged period of needless disability. The sac is generally large, contents may be numerous and adherent, the cord structures are commonly hypertrophied and bulky, the muscles and other soft tissues are thinned out and inadequate about a huge defect, and the overlying skin may be unhealthy. This undesirable pathological situation is encountered particularly in men of advanced years; their procrastination has too often been permitted, if not actively encouraged, by medical advisers. Nearly fifty per cent of the inguinal hernia patients in my own series belong to this "avoidable" group. Surely there can be little disagreement with the contention that competent operation at an early stage should be the accepted standard for all ordinary hernias. The stitch in time may save more than nine.

Some general rules may be suggested at this time designed towards the prevention of hernias as far as possible, and the avoidance of late and complicated examples. Early discovery of developmental defects is most desirable, with prompt correction. The abdominal wall should be protected against all manner of noxious influences, as supports that lead to deficient muscles (corsets, girdles, belts and trusses), and trauma of all sorts. Every effort should be made to build up and maintain the voluntary muscle fibers, of the lower wall in particular, in the best possible functional state. This sort of thing could be done on a large scale in school children as part of a program of physical training, or under direction of a school nurse who has had the necessary training. Simple exercises are sufficient, at least if carried out regularly and faithfully, such as firm contraction of the abdominal wall (pulling in hard), held up to one minute, then released and repeated up to perhaps ten times; this sequence being performed many times each day. This sort of thing has a place in all, but it should be obligatory in everyone who has any demonstrable weakness of the lower wall, or a "potential hernia." Causes of abnormal tension within the abdomen should receive early appropriate correction. Weak walls should be sought actively and improved as outlined above; actual hernias deserve early sound repair and careful follow up. In all cases supervision should be thorough. This should apply especially to the patient, with or without a truss, who defers operation for any reason whatever.

The choice of treatment to be followed for a given hernia should be governed by several important considerations. The patient as a whole calls for full evaluation first of all, with particular reference to his vital functions and cerebration. Advanced age alone should not influence one's decision significantly. Two years ago I repaired successfully bilateral large hernias in a doughty warrior aged 87, in order to have him "in shape" for his annual deer hunting expedition in northern Ontario. He did remarkably well. In the



second place, the hernia, or hernias, must be assessed with regard to size, type, contents, symptoms caused, danger of complications, results in relation to any previous management, etc. Lastly, the surgeon should be accorded the same critical scrutiny with respect to his training, ability and experience, and the facilities at his disposal.

Assuming a reasonably satisfactory situation with respect to the circumstances enumerated above, one may proceed to outline the essential steps pertaining to the repair of inguinal hernias. It is my personal belief, and practice, that certain board sub-groups of inguinal hernias may be distinguished from each other, with certain fundamental differences in the appropriate technical repair of the wall. Before these are reviewed, it may be well to list some of the leading requirements of all such operations. The high demands of modern aseptic surgery must be met at all times: careful anatomical dissection, delicate handling of all living tissues, meticulous hemostasis, use of fine, selected, material for sutures and ligatures, and coaptation of tissues without undue tension. The chief steps of any complete hernia operation may be outlined briefly as follows: the sac must be isolated fully, any contents returned to the abdomen, the excess removed after secure transfixion ligation of the neck high up, a bulky spermatic cord should be reduced in size without injury to its component parts; trauma should be minimized, especially to the ilio-inguinal nerve (and frequently the ilio-hypogastric nerve also calls for visualization and protection from injury by instruments or sutures): repair of the wall must be of a proven type, effecting lasting closure of weak and vital regions.

In the first group of cases to be considered the hernia is of the congenital indirect sort as seen in infants and young children in the first few years of life. Simple removal of the sac is adequate for all but occasional large defects.

In a second group may be placed the straightforward indirect hernias of comparatively small size, in persons of any age, in whom the back wall of the inguinal canal is protected by reasonably good fibro-muscular tissues. These call for removal of the empty sac and pruning away of useless fibro-lipomatous tissue from a hypertrophied cord, followed by steps to ensure a snug and lasting closure of the vulnerable internal ring. This is accomplished readily by placement of several fine unabsorbable sutures, attaching the lowermost fibers of the internal oblique muscle plus transversalis fascia down to the inguinal ligament, creating a tight ring, displaced upwards and laterally.

It is suggested that the third group should comprise all inguinal hernias with large defects in the wall. Its elastic limits may be stretched sufficiently to take in hernias that are indirect, direct, combined, or recurrent. The common denominator is this heterogeneous collection, and a most vital requirement for successful management, is repair of the entire posterior wall of this inguinal region. Following the usual preliminary steps, it is my custom to insert a series of interrupted cotton sutures (never heavier than size No. 30), approximating the transversalis fascia, and possibly including some fibers of the internal oblique, to the inguinal ligament below. The average case requires six or seven sutures to bridge the deficiency from the pubic spine up to the elevated and constricted cord in its newly formed internal ring. Snug closure is demanded. It may be aided occasionally by insertion of additional sutures lateral to the cord.

Each case is an individual problem calling for sound judgment at every



stage. Should any uncertainty arise, the more complete operation is performed. Direct hernias are handled by "sliding" the excess peritoneum behind the inferior epigastric vessels to become part of an indirect sac, which is removed in the usual manner. Complicated situations are dealt with on their merits. Prompt recognition is most important in hernias of the interparietal variety, and the "sliding" type. Very rare instances of the latter may benefit from a separate abdominal incision. In strangulation, the requirements of the patient as a whole, and of the compromised bowel, take precedence over those related directly to the hernia. In only a very few patients have I felt compelled to remove a testis and cord in order to facilitate the repair of an enormous hernia, and then only when the risk is truly desperate.

In all types of case, following attention to the sac and the cord as described and thorough repair of the back wall of the canal, it is my practice to drop the cord into a somewhat elongated canal and repair the front wall by overlapping the external oblique aponeurosis considerably. The lower leaf, left large to facilitate this step, is sutured to the surface aspect of the rectus sheath, in front of the cord. The upper leaf is fixed then to the superficial portion of the inguinal ligament. This method strengthens and reinforces the whole wall.

There is much truth in the ancient scriptural injunction, "By their fruits ye shall know them." No series of hernia repairs is completed until treated through the postoperative phase, supervised closely until full rehabilitation, and then followed until end results can be assessed critically at a later stage. If one accepts an early submission in this paper, that the abdominal muscles should be maintained efficiently, he will find the after-care remarkably simple in the vast majority of hernia patients. It is my policy to encourage active muscle exercises at all times and ambulation the day of operation. The normal patient is allowed to go home when he desires, after twenty-four hours have elapsed, returning to the office for removal of sutures and follow-up. An attempt is made to evaluate the result in each case.

At the present time a critical assessment of end results in my own cases, operated upon between 1938 and 1948, is in progress. Of 637 operative inguinal hernias in this period, in 483 patients, we have thus far personally examined and analysed 188. A complete statistical analysis of the whole series is planned in the future. At this time one or two noteworthy features may be mentioned, based on the preliminary survey to date. There were 19 "congenital" hernias (patients up to 6 years of age), with result classed as "excellent" in all but one who had minimal complaints and no true disability. Indirect hernias of reasonable size occurred in 79 instances: the results were "excellent" in 65, "good" in 11 (slight complaints but no disability), "fair" in 3 (some disability). In these two groups there was not one recurrence. Large defects were present in 74 cases, yielding 51 "excellent" results, 11 "good", 2 "fair" and 5 recurrences (every one suppuration in wounds following repair of enormous hernias). There were 16 operations for recurrent hernia in this series, all giving excellent or good results.

In the results found in this small group of 188 cases studied fully from two to twelve years subsequent to the repair, certain facts stand out. The results proved to be excellent or good in 94.7% of the series. Notable discomfort or complaint, or objective findings not fully satisfactory but short of recurrence, were discovered in only 2.6%. True recurrence developed in



2.6% of the series. It should be stressed that with careful technic, there was no recurrence in three of the groups separated, including indirect hernias in children and adults and previously recurrent cases. It is firmly believed that these results are in no wise better than the general figures for my entire series, which has included a very high proportion of truly tough and mean hernias.

One cannot but think that there is strong support here for the principles which he has sought to establish on a solid foundation.

### SUMMARY

1. The bewildering assortment of methods in vogue for handling inguinal hernias has been noted and the logical conclusion drawn, that basic principles should be clarified and kept in mind at all times.
2. Brief consideration has been given to the factors that favor production of such hernias, the objections and dangers related directly to hernias, and the essentials regarding diagnosis.
3. A greater degree of awareness to hernias and the related problems is called for on the part of the medical profession and the public. Certain rules have been laid down to aid in a preventative way. The importance of a good muscular abdominal wall has received great emphasis with recommendations concerning its maintenance.
4. It has been stressed that maximum success in this leading surgical field depends upon critical and honest evaluation at all times of the hernia, the patient as a whole, and the surgeon—especially in relation to his methods and facilities.
5. Some fundamental requirements of modern operations for inguinal hernias have been enumerated concisely. Competent operation early is the desirable standard.
6. The need for individualized planning at every stage for each case has been appreciated. Certain broad groups of hernias have been suggested with special technical considerations applicable to each.
7. The active and intelligent cooperation of the patient should be sought throughout treatment. He alone can keep up his muscles to withstand intra-abdominal pressures. He will do this effectively only when understanding his vital place in the "team". Repeated supervision is desirable, above all in the patient permitted to follow conservative or palliative lines of management.

# The Almons

KENNETH A. MACKENZIE, M. D.

Halifax, N. S.

**T**HE Almon family holds a unique place in the medical annals of Halifax, having served as physicians and surgeons for a period of one hundred and sixty years, from 1780 to 1940.

The ancestor of the family was a James Almon of British stock, who came from Genoa in his own vessel, traded with the West Indies and was later lost at sea. He had settled his family in the New England States, where the first Doctor Almon was born. This Doctor Almon began to practice his profession in Halifax about 1780 and was succeeded in turn, by his son, grandson, great-grandson and great-great-grandson.

Dr. William James Almon, Loyalist, 1754-1817.

Dr. William Bruce Almon, M.L.C., 1788-1840, Edin. 1809.

Dr. William Johnstone Almon, 1816-1901, Glasgow, 1838.

Dr. Thomas Ritchie Almon, 1843-1901, P. & S. N. Y., 1867.

Dr. William Bruce Almon, 1875-1940, Dal. 1899.

These five physicians spent the whole of their professional life in Halifax. All were interested in military affairs and at one time or another wore the King's uniform. They all enjoyed the confidence of their patients and played important roles in medicine and in community affairs.

In the Almon family tree there were four other physicians who did not practice in his Province. Doctor William Bruce Almon, son of Senator Almon, was a surgeon in the Confederate Army and died young. Doctor John Ritchie Almon, son of Doctor W. B. Almon, M.L.C., was for a time in the British Army and later practised in South Africa with two sons, Doctors John and James Ritchie Almon.

## Dr. William James Almon, 1754-1817

The first Doctor Almon was born in Providence, R. I. in 1754. In 1771 he was apprenticed to a Doctor Anderson, physician, and surgeon of New York. He was in Halifax for a short time in 1776 with Lord Howe's Forces and accompanied the troops to New York, where he was on active service for several years. In 1778 he received from Lord Townsend a commission as surgeon's mate to the 4th Battalion of Royal Artillery. Before the close of the war he returned to Halifax and was appointed Surgeon of Artillery and Ordnance. In 1785 he was appointed surgeon to the Halifax Alms House, which for many years served as a civilian hospital. This same year he married Rebecca Byles, daughter of Rev. Doctor Mather Byles, chaplain to the troops. Later he was appointed Surgeon-General of the Forces in Halifax.

He soon became one of the leading practitioners in the City and enjoyed the confidence of a large clientele. He kept interesting records of his cases and these have been preserved and may be seen in the Medical library at Dalhousie University. He was one of a literary coterie which met regularly at the Old Pontac Hotel to discuss social and scientific subjects. They were often joined by distinguished visitors, when evenings were devoted to wit,



song and toasting. The Duke of Kent was a frequent visitor. With Doctor Duncan Clark and Hon. John Haliburton he was physician in Ordinary to the Prince and his household and was frequently entertained at the Duke's residence.

Doctor Almon died at Bath, England, in 1817 at the age of 63.

### **Dr. William Bruce Almon, M.L.C.**

The second Doctor Almon was born in Halifax and was a graduate of Edinburgh University in 1809. He settled in Halifax and rapidly established a large practice. Like many practitioners of his day he conducted a drug business, and had his office in the same building, which was situated on the north side of Duke Street between Hollis and Water Streets. He had a number of medical students as apprentices, one of whom was D. M. Parker, later the Honorable Doctor Parker. The "Indenture of Apprenticeship" was an elaborate legal document, and has sufficient historical interest to be included as an appendix to this narrative.

Doctor Almon married Laleah, daughter of Doctor William Martin Johnston and Elizabeth Lighenstone. He succeeded his father as medical and surgical officer of the Poor House and Gaol, the only civilian hospital in the City at this time. It was situated on the north side of Spring Garden Road near or on the site of the former Baptist Church on the corner of Queen Street. He was much concerned with the first efforts to establish medical registration in this province. The first Medical Act passed in 1828. It was entitled "An Act to exclude ignorant and unskilful persons from the practice of Physic and Surgery." A licensing board, appointed by the Governor-in-Council, conducted oral examinations usually in a doctor's office. Doctor Almon was one of three senior physicians who constituted the first Board. This system was in vogue until 1872 when the present Provincial Medical Board was established. The last members of the old Board were Doctors Edward Jennings, William J. Almon, and D. M. Parker.

Doctor Almon was also medical health officer for the City and in this capacity was called upon to attend sick sailors. While on this duty he contracted a malignant fever, probably typhus, which after a short illness caused his death at the early age of fifty. Mr. Parker, his apprentice, conducted his drug business until the return of his son, Doctor W. J. Almon who was still pursuing his medical studies abroad.

### **Dr. William Johnstone Almon, M.A., M.D., D.C.L., M.P., Senator**

The third member of the group was in many respects the most celebrated. He received his early education at King's College, Windsor, where he had several classmates who became distinguished in later life, Sir John Inglis, Sir Edward Cunard, son of the founder of the Cunard Line, Sir Charles Tupper, Doctor B. DeWolfe Fraser and others who attained a high place in the Church. All of these were life-long friends.

Doctor Almon received his medical degree from Glasgow in 1838 and did some post-graduate work in Edinburgh and London. Coming to Halifax he followed in the footsteps of his father. For a time he conducted a drug business at or near Cronan's wharf, but as practice came rapidly he sold the drug store and devoted his whole time to his profession. He succeeded his father as physician and surgeon to the Halifax Alms House.



It was here that Doctor Almon was the principal actor in an important historical event, the first use of chloroform as an anaesthetic in Nova Scotia, February 5th, 1848. A newspaper item at this time reported as follows: "Successful Experiment. Dr. Almon amputated the thumb of a woman in the Poor Asylum, Tuesday morning in the presence of Dr. Parker of this city and Dr. Brown of Horton. This case is published, not for the purpose of inviting attention to the operation, but to the effects of the agent used to prevent pain. The chloroform was administered by inhaling it from a soft rag applied to the nose and mouth for a few minutes. The patient very soon became insensible to pain and the operation, probably occupying ten minutes, was finished before sensibility returned. The poor woman expressed her gratitude in warmest terms, and, in the judgment of all present, the success of the experiment was complete." On March 11th, Doctor Almon used chloroform again, this time for an amputation of the leg.

It is difficult in a short paper to describe adequately the characteristics of such a dynamic personality as Doctor Almon. A few incidents in his life have more value than wordy eulogies. While still a young man, he challenged the celebrated Joe Howe to a duel for alleged remarks made about his father, Honorable W. B. Almon. The duel was not fought, and these two became good friends in later life. Doctor Almon was one of the pall bearers at Howe's funeral. This incident is cited to illustrate the great courage with perhaps a bit of recklessness, which Doctor Almon exhibited throughout his life in dealing with contentious matters in community affairs, politics and problems relating to the medical profession.

Doctor Almon took an active interest in community affairs. The present generation may be grateful to him for preserving the old Burying Ground as Grafton Park, which now serves as a convenient site for the Public Library. He was also responsible for planting trees on the North Common, thus adding to the beauty of our well-treed City.

In medical affairs he enjoyed the high regard and confidence of a large clientele. He was not unmindful of the interests of the profession as a whole. He was foremost in promoting much needed hospital improvements and was one of the promoters of the City and Provincial Hospital, later the Victoria General. He was a consulting surgeon on the staff and the first president of the Medical Board. He was also consulting surgeon to the Halifax Visiting Dispensary, an important institution in his day. He was one of the founders of the Halifax Medical College and was the first Professor of Obstetrics. He was several times president of The Medical Society of Nova Scotia and his voice was often heard when matters of medical legislation were under discussion.

Some of the most exciting moments in his life occurred during the American Civil War. He sympathized and strongly espoused the cause of the South and his activities brought him in violent contact with the authorities. He harbored refugees and spent some money on what he considered a just cause. On one occasion he was arrested and stood trial but was acquitted. His activities brought high commendation and many influential friends in the South and equally strong condemnation from the North.

In politics he was a good public speaker and a strong debater. He was defeated in the provincial elections but was elected to the Canadian House of Commons as a member of Sir John A. MacDonld's government. In 1879



he was appointed to the Senate, the first medical man to receive the honor. He was active in controversial matters, acted on important committees, and enjoyed the respect of his colleagues in both political parties.

Doctor Almon retired from practice in 1890 after fifty years of faithful and efficient service, and he continued to take an active interest in medical and political affairs until near the end. He had the misfortune to develop cataracts in his last years and was the denied pleasure of reading. He died at his home "Rosebank" in 1901 at the age of 85.

#### **Dr. Thomas Ritchie Almon**

The fourth member of the group received his early education at King's College Windsor. He proceeded to the New England States for his medical training and was graduated from the College of Physicians and Surgeons of New York in 1867. An extract from a New York paper which appeared while Doctor Almon was a medical student is worth including here as an indication of the attitude of Americans to Bluenose students.

"Bluenose effrontery has been more than usually prominent during the present war, albeit, there was no lack of that commodity before they became abettors of secessionists. An instance in point is this:—The notorious Doctor Almon of Halifax, who was so prominent in the Chesapeake affair last year, the friend and correspondent of Jeff Davis, and the boon companion of Southern brass and pirates who hover about the shores of Nova Scotia, has already educated one son at one of our Northern Universities and sent him into the rebel army, and now has at this moment another son studying at a popular medical college in this city, doubtless with a view of putting him into the same service, if the war lasts long enough. Is not this kind of crowding our good nature?"

The notorious Doctor Almon was W. J. Almon, later Senator, and the first son referred to was Doctor W. B. Almon, a surgeon in the Confederate Army. The animosity indicated in the above extract was short-lived. Between 1860 and 1900 Bluenoses to the number of three hundred had received degrees from American schools.

Doctor Thomas R. Almon settled in Halifax and took a prominent part in the medical activities of the city. He was a member of the first Faculty of the Medical School as prosector of Anatomy. He was physician to the Halifax Alms House and the Victoria General Hospital. From 1871 to 1879, he was the efficient secretary of the Provincial Medical Board. He was interested in military affairs and was surgeon to the Halifax Field Artillery, and the Halifax Garrison Artillery. He was also Inspector of Hospitals during the North West Rebellion. He did post-graduate work in London and Paris. He died in 1901, the same year as his father.

#### **Dr. William Bruce Almon**

The fifth member of the group, and the third who carried the same name, is well known to the present generation of Halifax physicians. He was familiarly known as "Bruce." He was a nephew of Doctor Thomas R. and his father was not a physician. He was born in Dufferin, Manitoba, but received his education in Nova Scotia. He was a student at King's College and received his medical degree from Dalhousie University in 1899. After a period of post-



graduate study in London and Paris he settled in Halifax. He taught obstetrics for many years and was Professor of Obstetrics for a time. For years he was health officer for the city and as physician to the City Home completed one hundred and fifty-five years of Almon service to the city. In 1931 he was made a charter member of The Royal College of Physicians and Surgeons of Canada. He was unmarried and with his passing in 1940 the name of Almon ceased to appear in the medical register of the province.

### Indentue of Apprenticeship

This indenture made the ninth day of February, in the year of our Lord one thousand eight hundred and thirty-eight, between Daniel McNeill Parker, the son of Francis Parker of Walton, in the County of Hants, and Province of Nova Scotia, Esquire, which said Daniel McNeill Parker is an infant of the age of fifteen years, of the first part, William Bruce Almon, of Halifax, Nova Scotia, Doctor of Medicine, of the second part, and the said Francis Parker, of the third part, witnesseth that the said Daniel McNeill Parker at the desire and with the consent and approbation of the said Francis Parker hath and by these presents doth put himself apprentice to the said William Bruce Almon, to learn the science, profession ad practice of a physician, and the art and mystery of a surgeon, and the trade and business of an apothecary and druggist, and with him after the manner of such an apprentice to remain, continue and serve, from the date of these presents for, and until the full end and term of four years thence ensuing and fully to be complete and ended.

And the said Daniel McNeill Parker on his behalf, and the said Francis Parker in consideration of the promises herein contained, for himself his exutors and administrators, do severally covenant and promise to and with the said William Bruce Almon, his executors and administrators, that during all the term aforesaid the said Daniel McNeill Parker his said master faithfully shall serve after the manner of such apprentice, his secrets conceal, his lawful and reasonable commands everywhere readily perform and obey, that the said master's goods or estate of any kind he shall not waste, embezzle, purloin or lend unto others without giving notice thereof to his said master. That he shall not frequent taverns or ale-houses or play at any unlawful games or contract matrimony with any person during the said term, whereby or by means of any of the said matters his said master shall or may sustain damage, loss or injury, that he shall not any time by day or night absent himself or depart from his master's service without his leave, but in all things as a good and faithful apprentice shall and will behave and demean himself to his said master during all the said term. And the said Francis Parker for himself doth further covenant and promise that during the whole of the said term he will find and provide for the said Daniel McNeill Parker suitable board, lodging and apparel, will pay all rates, taxes and assessments made upon him, and will well and truly pay or cause to be paid to the said William Bruce Almon the full and just sum of one hundred pounds as an apprentice fee for the instruction which is hereinafter covenanted and agreed to be given to the said Daniel McNeill Parker.

And the said William Bruce Almon for himself, his heirs, executors and administrators doth covenant, promise and agree to and with the said Daniel McNeill Parker separately and also with the said Francis Parker, his execu-



tors and administrators, that he, the said William Bruce Almon, shall will during the said term, to the best of his power and ability, teach and inst or cause to be taught or instructed the said Daniel McNeill Parker in science, profession and practice of a physician, and the art and mystery surgeon, and the trade and business of an apothecary and druggist with the Township of Halifax, according to the manner in which he, the said lian Bruce Almon, now or hereafter during the said term does or shall p tice, use, or carry on the said science, art and business aforesaid, and as t and effectually as the said term of four years and the means afforded o be obtained within the said Township will permit or allow the said Da McNeill Parker to be instructed in the science, art and business afores

In witness whereof the parties to these presents have hereunto t hands and seals subscribed and set on the day and year above written.

SIGNED, SEALED AND DELIVERED IN the presence of

(Sgd.) Daniel McNeill Parker (L.S.)

Francis Parker (L.S.)

William Bruce Almon (L.S.)

It is understood and agreed that the said Daniel McNeill Parker sha the end of three years with his father's consent have the option of ending apprenticeship in order to complete his professional education.

(Sgd.) William Bruce Almon, M.D.



# Recollections of A Stimulant Cupboard

BERTHA O. ARCHIBALD

I AM the Stimulant Cupboard of the old Victoria General. I am still in the Dispensary, but I am wondering what is going to become of me. Externally I am much the same, with my heavy padlock and brass bars, but my shelves are bare. I have come to naught—which is what always happens to people in my business. However, my stores were for the sick, not for the social drinker. The latter's gratification is not the role of a Hospital Stimulant Cupboard.

My stock consisted of various sorts of intoxicating liquors—whiskey, brandy for egg-nogs, champagne, beer to stimulate appetites, gin, some rum, and underneath a case or two of ginger ale and several syphons of soda. Rather a conglomerate collection! In my earlier days I had quite a clientele, but how things change with the passing of the years! After the advent of Sulfa drugs and Penicillin I soon became a back number and my wares were truly 'on the shelf' in more ways than one—The Ambulance Bag was one of my best customers but after the old pharmacist passed away the new pharmacist substituted Spr. Ammonia. Aromat. and my brandy was no longer required. We must have had a great many accident cases in those days, judging by the amount of stimulants needed. Even the alcohol in the spirits lamp of the old bag seemed to evaporate rather quickly, until a good dose of pistachio was administered to it—which seemed to lessen the rate of evaporation.

When the old pharmacist went to town he would always leave an interne on duty in the Dispensary—or the Surgery as he called it. One day one of these internes had what he thought was a bright idea. He went to the carpenter's shop and brought up an auger—or something that bored holes. Yes! A hole was bored right through the bottom of my floor, down to the basement. The whiskey at that time was bought in little jugs. The cork of the jug was removed and a piece of rubber tubing inserted in its neck and run down to the basement, and there a pinch-cock was placed. Well, syphons usually work, and this one seemed to be no exception. The basement was a popular place that night! When the pharmacist opened me the next day he found my jug much depleted. Upon investigation, he needed little explanation.

In the year 1918 I underwent a very serious operation—perhaps you would call it trephining. One night I felt an awful boring sensation. Presently I felt a piece removed from my side—about the size of a whiskey bottle. I immediately collapsed and could not see who my operating surgeon was, but when I revived I was minus one whole bottle of whiskey. Plastic surgery was later performed on me, but I still bear those scars. On another occasion my screws were removed and my whole top was raised, and I was relieved of another of my precious possessions.

I do not like to recall these events, but all this happened in my pioneer days, when internes had not learned how to behave, but as later generations came on, the scene changed. What nice boys they are! They could teach their parents and grandparents—if they were the perpetrators of the atrocities just recorded—that the Stimulant Cupboard in any hospital is a sacred precinct, and should be treated with definite respect!

With the modern trend of medicine, stimulants as now known will be as obsolete as the horse and buggy of yesteryear, and who knows? Before I have quite disintegrated, perhaps you will be receiving stimulants in the form of Atomic Oads.



# Rutherford Memorial Scholarships

To the Members of The Medical Society of Nova Scotia:

Many of you have already heard through your local Branches or directly from Dr. S. R. Johnston that the Royal Society of Canada is setting out to raise \$100,000 as a memorial to Lord Rutherford, probably the greatest experimental physicist of the past 50 years. For some ten years, as MacDonald Research Professor at McGill, he brought great distinction to Canada both by his own discoveries and through the students whom he trained.

The Memorial is to take the form of a permanent endowment and the income is to be used for post-graduate scholarships in science.

This Fund should appeal particularly to the medical profession which is making such effective and far reaching practical use of ideas and theories that have their origin in the work of Rutherford. One need only mention X-rays, radium, radioisotope and tracer techniques that have followed directly from his work.

The nature of the memorial should also appeal to medical men for probably in no branch of science is there a greater shortage of highly trained scientific personnel, and this Fund should encourage and assist more of our able science students to go on with post-graduate work.

A personal canvass is not possible but in order to reach the objective generous contributions are needed from all those who appreciate the greatness of Lord Rutherford and the need for more and better trained scientists.

Contributions can be sent to secretaries of the Local Branches of the Medical Society or to Dr. S. R. Johnston or Dr. M. M. Hoffman at the Victoria General Hospital.

Official receipts for income tax purposes will be issued by the Honorary Treasurer of the Royal Society of Canada.



## Trauma Column

THE Nova Scotia Division of the Committee on Trauma of the American College of Surgeons is happy to announce that the Workmen's Compensation Board will distribute to the profession throughout the province copies of "An Outline of the Treatment of Fractures." This generous contribution to surgical knowledge has been brought about by the intercession of the local committee and the efforts of Dr. A. B. Campbell, Chief Medical Officer of the Board.

The latest edition of the "Treatment of Fractures" was published in 1949 by the American College of Surgeons under the editorship of Henry C. Marble, Paul B. Magnuson and Clay Ray Murray. Dr. Murray died before the volume was off the press but it bears indelibly throughout its pages the imprint of his surgical wisdom and dynamic personality.

It is interesting to note that the book uses the term "open" instead of the term "compound" and the word "closed" in the place of "simple" in speaking of fractures. These terms not only connote a more accurate pathological picture; they are of a profound significance in the history of surgery. It was by study of open and closed flasks containing culture media that Pasteur discovered the ways of infection: it was the similarity between Pasteur's open and closed flasks and his own open and closed fractures, the one reeking with infection the other clean, that led Lister to antiseptic surgery.

The booklet is essentially one for the general practitioner and the practical surgeon. It deals with all the commoner fractures, treating diagnosis and etiology briefly, but giving the treatment from first aid to final restoration of function in good detail. Methods of reduction described are those available to every practitioner and the physiotherapy is always that which the patient can carry out himself under the direction of his surgeon.

The book has an excellent opening section on the general principles of fracture treatment, including the pathology of bone healing and the examination and diagnosis of the fracture, which should be of great value to the medical students to whom it is also being given. There is a chapter on the X-ray examination of fractures, one on the measuring and recording of joint function and one on rehabilitation, which contain information not usually found in much larger volumes.

The Workmen's Compensation Board, as well as being humanitarian, is a hard headed business organization. By far the great part of its funds is extended in disability cheques to workmen. The earlier recognition of fractures, prompt and expert treatment with sound physiotherapy and rehabilitation can sharply reduce the size of these cheques. Any effort toward this end is sound economics for the Board. It is good and humane government for our people. It is good, too, for our profession. The little book will surely find a welcome space on every doctor's shelf or even in his pocket.

A. L. M.



## Post-graduate Week in Obstetrics, Gynaecology and Paediatrics

---

The Department of Obstetrics, Gynaecology and Paediatrics of Dalhousie University and the Victoria General, Grace and Children's Hospitals will put on a course in obstetrics, gynaecology and paediatrics outlined below. This is not a specialists course, but one aimed entirely at helping the general practitioner solve his ordinary obstetrical, gynaecological and paediatric problems.

1. It will be limited to 6 applicants, and the first six who apply will be accepted. Only those intending to take the entire course will be accepted and applicants should state whether or not they will be able to do this.

2. The dates will be May 14th-19th inclusive.

3. Applications should be made to Dr. Carl Tupper, Victoria General Hospital, as soon as possible.

4. Men taking the course will be given a bed in a dormitory at the Grace Hospital for the entire week, so that they can see all public cases delivered at the hospital that week. They will pay the Grace \$5.00 for this purpose at the beginning of the course.

5. They will be able to get their meals in the cafeteria of the Victoria General Hospital at the usual meal rate charged there.

6. They should be in the front hall of the Grace Maternity Hospital at 8.45 p m. on Monday, May 14th, where they will be met and have further details explained.



Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9-9.50 Management of labour	Infant Feeding	Ca. Cervix Diagnostic Pts.	Wet Smears Vaginal Discharge	Rheumatic Fever in Childhood	9-10.30 Symposium on Ante Partum & Post partum Bleeding
10-10.50 Care of baby in first hour of life	Diarrhoea and Fluid balance	X-ray Pelvimetry	Ward Walk	Nephritis in Childhood	10.30-11.30 Feminie Hygiene
11-11.50 Induction of labour & indie. for C.S.	Endocrine Prob. in Childhood	Manikin Demonst. with Forceps	Endocrine Therapy	Symposium on Meni- ngitis	
12-1 Abortions		Panel on Toxaemias of Pregnancy	Panel on anything new in Literature		

## NOON RECESS

2-5 Gynaecological Out Patient Clinic at V.G.H.	2-2.30 Natural Childbirth  3.30-4.30 Difficult labour & Breech Presentations	Problems of the new born. Resuscitation Prematurity & In- fections at Grace Hospital.	Problems of Office Paediatrics at D.P. H.C.	Pre Natal Clinic at D.P.H.C.	
--	---	--	---	---------------------------------	--



# Society Meetings

---

The annual meeting of the Nova Scotia Society of Ophthalmology and Otolaryngology was held on Wednesday, September 6th, 1950 at the Dalhousie Public Health Clinic, Halifax, Nova Scotia. The President, Dr. D. M. MacRae of Halifax, was in the chair. It was solely a business meeting, the chief business being the election of officers.

A nominating committee consisting of Dr. Schwartz, Dr. Langille and Dr. McKean brought in the report and the following officers were elected for the coming year.

President—Dr. H. F. Sutherland, Sydney, N. S.

Vice-President—Dr. C. K. Fuller, Yarmouth, N. S.

Secretary-Treasurer—Dr. E. I. Glenister, Halifax, N. S.

Members of the Executive—Dr. L. F. Doiron, Digby, N. S., Dr. A. E. Doull, Jr., Halifax, N. S., Dr. W. MacIsaac, Sydney, N. S., and Dr. H. R. McKean, Truro, N. S.

Representatives to the Executive of the Canadian Medical Association, Nova Scotia Division, Dr. E. I. Glenister, Secretary-Treasurer and Dr. R. H. Fraser, Antigonish, N. S.

There was some discussion on the advisability of holding a clinical meeting later in the fall. It was moved by Dr. McKean and seconded by Dr. Sutherland that a clinical meeting be held in Halifax in November, at a date to be determined by the Executive.

E. I. Glenister, M.D.,  
Secretary-Treasurer.

---

The regular monthly meeting of The Cape Breton County Medical Society was held in St. Rita Hospital, Sydney, on December 14th; there were forty-five members in attendance.

Doctor A. G. MacLeod of Dartmouth, President of the recently organized General Practitioners Association, presented a brief outline of the aims and objects of the Society.

Doctor C. Henry Reardon of Halifax, in his capacity as Chairman of the Public Relations Committee of The Medical Society of Nova Scotia, led the discussion which followed.

The President of The Cape Breton County Medical Society, Doctor Gordon C. Macdonald, welcomed visiting doctors, including Doctor N. J. MacLean of Inverness and Doctor J. K. Morrison of St. Peters.

HERBERT R. CORBETT, Secretary.



## Personal Interest Notes

Doctor C. S. Morton of Halifax left on January 17th aboard the Lady Rodney for a holiday in British Guiana.

Doctor and Mrs. J. J. Carroll of Antigonish sailed on January 17th aboard the Canadian Constructor on a three weeks holiday to Jamaica.

Doctor O. C. MacIntosh, Dal. 1940, of Antigonish, who recently passed his examinations at the Royal College of Surgeons, of Montreal, as a certified pathologist, has been appointed to the staff of St. Martha's Hospital, Antigonish.

Doctor J. R. Kerr, W. D. Crosby, J. A. Ruffee and Nelson Patterson of Annapolis, narrowly escaped death when the car in which they were driving was completely demolished when in collision with a truck on the main highway near Middleton in January. The impact threw the car into the ditch, crashing into a hydro-pole. Doctor Kerr, owner and driver of the car, suffered an injury to his knee, but was able to give first aid to Mr. Crosby, who suffered a fractured shoulder and to Mr. Ruffee who was cut about the head. Mr. Patterson escaped uninjured.

The Bulletin extends congratulations to Doctor and Mrs. W. I. Morse of Halifax on the birth of a daughter, Ann Louise, on February 5th.

---

### DOCTOR NEEDED

A doctor is required for the district of West Bay, Inverness County, Cape Breton, N. S. Anyone interested will kindly apply to Mr. Edgar H. MacLean, Secretary of Men's Club, West Bay, Inverness County, N. S.



## Obituaries

Doctor Albert Culton of Wallace passed away on January 19th at the home of Mr. and Mrs. J. A. Kirkpatrick, Shubenacadie, following a week's illness, at the age of 87.

Doctor Culton graduated from Baltimore Medical College in 1897, and practised in Shubenacadie from 1912 and 1919. In 1919 he went to England where he took a post-graduate course. Following that he practised in Sydney and later settled in Wallace permanently.

Surviving is a half-sister, Mrs. George MacKay, Stellarton, a niece, Miss Pearl Purvis, Stellarton, a niece, Norma, Victoria, B. C., and a nephew, Doctor Mackintosh of Amherst. His wife predeceased him ten years ago.

The death occurred at Guelph, Ontario, on January 25th, of Doctor Edward Kirkpatrick MacLellan, following a long illness.

Doctor Maclellan was born at Pictou, N. S. on July 30, 1888, son of the late William Edward and Margaret Jane MacKenzie Maclellan. He graduated from Dalhousie Medical School in 1909 before he was twenty-one, and did post-graduate work at Sloane Hospital, New York, and then opened a practice at Mahone Bay. Subsequently he returned to Halifax where he opened the Halifax Hospital for Women, first maternity hospital in the province. At the outbreak of the First World War, he sold the hospital and enlisted for service overseas. From 1915 to 1918 he was a member of the Dalhousie Medical Unit in England and France. In 1918 he became Chief Medical Officer of Pine Hill Military Hospital in Halifax, and in November, 1919 he joined the staff of Camp Hill Hospital and remained there until December, 1938, when he was stricken with a heart attack.

Doctor Maclellan was honored by Canadian colleagues in 1929 when he was made a Charter Fellow of the Royal College of Surgeons, founded in Canada that year. Three years later he was elected member of the Royal College of Obstetricians and Gynaecologists, and in 1935 was raised to Fellowship.

For many years he was Professor of Obstetrics at Dalhousie University. He was a past president of the Dalhousie Alumni, a former member of the University Senate and of the University Board of Governors, and a senior member of the Grace Maternity Hospital and Halifax Infirmary medical staffs. Doctor Maclellan is survived by his wife, the former Helen Stewart MacKay of Bridgewater, one daughter, Jean, one son, David, and three granddaughters. An older son, Doctor Robert W. MacLellan died in 1941. The funeral service was held in Halifax, followed by interment at Camp Hill cemetery.

The Bulletin extends sympathy to Doctor J. M. Stewart of Halifax on the death of his mother, Mrs. Julia Frances Stewart, which occurred on January 16th at the age of 94; and to Doctor W. W. Bennett of Bridgewater on the death of his father, Rev. Sidney Bennett, which occurred at Bridgewater, in February, at the age of 77.