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Intracapsular Fractures of the Hip Joint

H. K. MACDONALD, M.D.C.M., (McGill), F.R.C.S., (C.)

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THE most common fracture of the upper end of the femur is one in the vicinity of the neck. It was formerly the custom to divide fractures of the neck into intra-capsular and extra-capsular, and from a clinical standpoint into impacted or non-impacted fractures. So far as the anatomical classification is concerned the terms are incorrect, as every fracture of the neck must be intra-capsular, and some recommend that these terms should be dropped. Posteriorly the neck is longer than in front, and is somewhat concave. Anteriorly, the base of the neck corresponds to the anterior intertrochanteric line and here the anterior and strongest part of the capsule of the hip joint is attached. Posteriorly, on the other hand, the capsule is attached not to the prominent ridge known as the posterior intertrochanteric line, but to a place on the neck about half an inch internal to this. The superior border of the great trochanter over-looking the neck is about three-quarters of an inch lower than the upper surface of the head. There are four places where fractures are very likely to occur in the upper end of the femur—

- (a) just below the head,
 - (b) about the middle of the neck,
 - (c) at the base of the neck,
- and (d) near the line of joining the trochanters.

And someone has suggested the following as being reasonably explicit and concise—

- (a) sub-capital,
- (b) mid-cervical,
- (c) pre-trochanteric,
- (d) inter-trochanteric.

The cause of a fracture of the hip is a fall upon the great trochanter. It is generally believed that frequently the femoral neck is broken before the patient actually falls, having been cracked by the violent muscular effort exerted to avoid falling. Occasionally we have reason to believe that such is the case, and I will show you the X-Ray plate of a case to-day where this unquestionably occurred. But there is no doubt that in the vast majority of cases it is the fall on the hip which causes the break. The neck becomes compressed between the acetabulum and the great trochanter, and the bone gives way at the weakest spot.

The pre-trochanteric variety of fracture is the type most frequently impacted, the base of the neck being driven half an inch or so in the great trochanter, or, to be more correct, in the upper part of the shaft. Occasionally the top of the great trochanter is pulled off without an associated hip fracture. This is extremely rare.

Women suffer from fracture of the hip much more frequently than men, and the average age at which such fractures occur is at the age of seventy. It occurs also in childhood, but is much more rare.

The Diagnosis. The recognition of a fractured hip is usually very easy. In a typical case a woman well past middle age has fallen and is unable to rise unassisted. If she is lying on her back, the outer side of the leg will be posterior with the foot turned well out; the limb, particularly from the knee up, appears shorter than its fellow: the patient cannot raise the foot from the ground, and any such attempt is productive of pain.

Examination of the hip seldom reveals evidence of bruising, but with such a history no further examination should be necessary until the patient is placed in the hospital and further confirmatory evidence can be looked for. As a fractured hip nearly always results in some shortening the next procedure is measurement of the legs. To accomplish this, the leg should be placed in the same relative position to the pelvis before making the measurements, otherwise small amounts of shortening may be entirely overlooked, as so frequently occurs in an impacted fracture.

I will not weary you with the measurements known as Bryant's triangle or Nelaton's line, all of which when carried out properly will serve as confirmatory evidence.

A method which I have used and demonstrated to our students for years in estimating the relative heights of the trochanters, is by placing our thumbs firmly beneath the anterior superior iliac spines, our middle fingers firmly on the tops of the trochanters, and taking care that our hands have the same relative position to the pelvis, compare the distance on each side between the middle fingers and the thumb. This method is, in our opinion, just as reliable as if the line of Bryant's triangle were drawn upon the skin. Another important diagnostic sign is relaxation of the ilio tibial band on the affected side. This ilio tibial band is, as you know, a continuation of the tensor fasciae femoris which merges with the fascia lata of the thigh about the junction of the upper and middle thirds. From that point downwards as it passes from the outer surface of the external conyle to be inserted into the external tuberosity of the tibia, it can be felt, in the normal standing out prominently like a tendon about an inch in front of the tendon of the biceps. If the great trochanter has been suddenly raised above its normal position by a fracture, there will be a relaxation in this muscle and its fascial prolongation; consequently the fingers can be more readily pressed into the tissue above the trochanter on the affected side; and in comparing the two ilio-tibial bands, there will be found that the one on the injured side is relaxed. The elicitation of crepitus is unnecessary, believing that the diagnosis should be made without the necessity of causing undue pain. Gentle lifting of the foot with little movement at the hip to make sure that the pain is in the joint may be permissible, but rough handling of the leg to elicit crepitus is never justifiable. If the fracture is well impacted a considerable range of passive movement may be carried out without any crepitus, so that many mistakes may be made by depending too much on crepitus as a sign of fracture. External rotation of the whole leg is almost constant. Two factors are responsible, first, the natural tendency of the leg to roll out wards, and second, the manner in which the neck is attached to the main portion of the bone, for it is not placed centrally in relation to the upper end of the shaft but springs from the anterior three-fourths; so that if a nail were driven into the centre of the great trochanter and parallel to the neck,

it would enter the latter well behind its centre. It follows, therefore, that when a crushing blow is delivered squarely against the great trochanter, the posterior part of the neck will give way more readily than the anterior, and external rotation will result. The shortening is obviously due to the contraction of the powerful muscles running from the pelvis to the femur and upper ends of the tibia and fibula.

The treatment. The treatment of a fractured hip depends in large measure upon the physical condition of the patient. Age is not, in itself, of paramount importance, as some people at eighty are younger than others at sixty. Wherever possible, the patient should be removed and treated in a hospital, and provided that the patient is in reasonably good health, the limb should be immediately put in plaster in the Whitman position; and, since in this position the leg is fully abducted, it presupposes that impaction, if present, is broken down. It is very generally believed that the breaking down of impaction in a fractured hip is a very dangerous thing. It is, if the fragments are subsequently left so that the broken surfaces are not in contact. But if a correct anatomical alignment, with close contact between the fractured surfaces, is submitted for the impaction with deformity, then is the breaking down of impaction not a dangerous procedure, but the only rational plan to follow if the patient is to be given the chance of a perfect limb. That a neck impacted in the great trochanter will unite, goes without saying, but there is no evidence to prove that it will unite any better than when the broken ends are closely co-apted, a proper alignment of the neck re-established and carefully maintained. Undoubtedly the fear of disimpaction has been responsible for many badly treated fractures of the hip, and no less an authority than Scudder of the Massachusetts General Hospital says—"the impacted fracture has lost its former significance because the abduction method assures reduction without violence, supplemented by immediate and secure fixation." X-Ray shows in three to four weeks that the ends of bones in impaction become absorbed and shortening results from muscular contraction.

Long trousers of stockinette should be properly applied, so that they fit snug over the chest, abdomen and both legs to the ankles. A properly designed fluoroscopic fracture table is the ideal, though seldom available. Spats made of heavy factory cotton are now adjusted to each foot over a liberal supply of raw cotton, and the foot of the good leg is fixed to the foot piece and under moderate extension that leg is abducted to about forty-five degrees, or as far as possible without causing pain, and locked in that position. At this stage an anaesthetic, such as gas and oxygen, or other anaesthetic from which the patient comes out quickly should be administered, and during this short period of anaesthesia the broken hip is lifted forward, rotated inward, fixed to the foot piece and fully abducted and extended. Nothing now remains but to fix the pelvis and thigh in this position. Provision is made against pressure sores from the plaster. The free use of saddler's felt, adjusted to the back and strips along the spine to protect the spinous processes and the base of the sacrum. There must be no creases over bony prominences. Wide plaster bandages are then evenly applied from the nipple line to the ankle, and, in order to lessen the number of bandages and therefore the weight of the cast, a reinforcement should be put in. Slight flexion of the knee is desirable, and just before that portion of the plaster sets, with the flat of the hand, pressure is made beneath and to the inner side of the knee sufficient to produce a per-

ceptible bending in an upward and slightly outward direction, and maintained until fixation has occurred.

The reason for placing the leg in abduction in fractures of this class is not far to seek. During abduction the top of the great trochanter infringes upon the tissues above the acetabulum, not upon the bone as is frequently stated, and as soon as the trochanter tip stops moving any further abduction pulls on the capsule of the joint and renders it taut; the upper fragment, pressed upon by the tense capsule, then automatically falls into its natural place.

After treatment. If the check-up plates are satisfactory, the after treatment is largely a question of good nursing. Broncho-pneumonia is the greatest danger to which the patient is liable, hence the choice of anaesthetic is of importance. The cast should remain on for twelve weeks, and as soon as convenient after its removal, an X-Ray should be taken in order to determine the amount of bony union present. The subsequent treatment is based upon what the X-Ray discloses. In any case, the patient should not be allowed up, but for the next month she should remain in bed, moving the leg about as much as she likes, and getting the stiffness out of the knee. A course of massage to aid in restoring the tone of the atrophied muscles and the movements of the knee is indicated. If there is bony union after the expiration of five or six weeks, by which time the movements should have become fairly free, the patient is allowed up on crutches or a walking caliper, but no weight bearing is permissible for another month; if the fracture is of the sub-capital or mid-cervical variety, it is well to put off weight bearing for another month or longer, particularly if the patient is stout.

In any case, the process of walking must be a gradual one, commencing with very little weight bearing until the whole can be borne without discomfort. On the other hand, if the union is fibrous, weight bearing will be painful and therefore must be discontinued for a very long time.

Prognosis. The prognosis as to life in this type of fracture depends to a great extent upon the condition of the circulation. That a man is as old as his arteries is particularly true when his hip is broken. A certain proportion die within the first ten days whether anything is done for the fracture or not. Broncho-pneumonia is responsible for the great majority of the deaths.

Results. The results in fractures of the type are on the whole bad. It is largely due to the fact that the treatment has been faulty, in that there has been a failure to obtain proper apposition of the fragments, and to keep them together long enough to allow the bones to unite. It is not sufficient when the cast has been removed to find the hip in good position; excellent it is so far, but unless it is fully realized that early weight bearing may spoil the good work, the patient will not get the benefit of his setting; for, unless the bone is united by osseous tissue, the patient will have a disability so long as fibrous union persists. Assuredly, fractured hips are the cause of much concern to the attending physician.

An inquiry into the causes of non-union centres about the blood supply. It is well known that the nearer the fracture is to the head, the more likely is fibrous union to occur, and this is generally believed to be due to the poorer blood supply to that part. There are four possible sources of blood to the head; (a) through the ligamentum teres; (b) the periosteum; (c) from the nutrient artery to the femur by way of the cancellous tissue, and lastly, vessels in the capsule of the joint. In the adult, the ligamentum teres may be neglected

as far as supplying blood is concerned, and as the periosteal and supply direct from bone are both gone, nothing remains but the capsule to nourish the head.

Non-union. Non-union of the neck constitutes a very serious disability, for even with strong fibrous union a man can never compete in the general labour market. In an older person good fibrous union is compatible with a fair amount of comfort, and although there will be a limp accompanied by more or less pain many of these people are able to enjoy life provided they have the means; so that, when it is evident that fibrous union is to be the end result, it is important that this should be as firm as possible, and therefore weight bearing should be prohibited until this has reached the maximum strength. Should osteoarthritic changes supervene chronic invalidism is sure to follow. Occasionally, after many months, the X-Ray plate shows a dense whitish-looking head with a dark gap separating it from the head. Such a head is dead, having undergone aseptic necrosis, and is proof that no circulation is present. Absorption of the neck is common, and where these latter complications have occurred, if the patient be not too old some form of reconstruction operation may be advisable, which may greatly benefit the patient, but will never place him where he will again become a competitor in the general labour market. In older people, non-union in the great majority of cases is best left alone, and the patient should be told that she will have to rest content with a more or less considerable curtailment of her activities. If the fibrous union is strong and the hip in fair position, it is remarkable how well some of them get about.

Canadian Medical Association Enjoys "Sweet Caporal" Cigarettes.

When the Canadian Medical Association met at Saint John, N. B., the local entertainment committee, with Dr. H. S. McDonald as chairman, worked indefatigably to provide a series of entertainments that proved to be most welcome interludes to the business sessions of the Association.

One of the committee's most enjoyable provisions was a sea-food dinner which was held up the Saint John River at Crystal Beach. Approximately one hundred and fifty attended, and in spite of the inclement weather, had a very enjoyable time. Through the courtesy of Imperial Tobacco Sales Company of Canada, Limited, there were distributed to the guests at the dinner a generous supply of Sweet Caporal Cigarettes. Many were the exclamations of delight when the guests found beside each plate a package containing 25 of these famous cigarettes, because "Sweet Caporals" have always been prime favourites with the medical profession. At the Medical Dinner of the Association, a similar courtesy was extended, and the Doctors found the supply of cigars and cigarettes a most welcome complement to the excellent menu and programme.

The ladies of the Association also had their share of delightful activity. Imperial Tobacco Sales Company of Canada, Limited, saw to it that the fair sex were also plentifully supplied with their favourite cigarettes.

Pelvic Contraction

E. K. MACLELLAN, M.D.C.M., F.R.C.S., (C.), M.C.O.G.

Professor of Obstetrics, Dalhousie University.

THERE are various ways in which the pelvis may be contracted—and distorted in form. From the obstetric point of view we have ceased to think and teach in terms of pelvic contraction. The trend to-day is directed rather to consideration of the question of the relationship of the canal to its passenger. A pelvis presenting the classical normal measurements might very easily cause insuperable difficulty to the descent and successful delivery of a very large foetus with defective flexion or with an occiput posterior position. On the other hand, it is frequently a pleasant surprise to the attending obstetrician to have his patient deliver herself with ease—when his pelvimeter has revealed a fairly extreme degree of contraction, and when he has feared great difficulty with the labor.

A few years ago a patient was sent to me by a practitioner in the province. This man had told the patient that she must have Caesarean Section. She was one of a family of four girls, who were all practically dwarfs. On investigation, the pelvis was found to be contracted to the third degree, which was formerly considered an absolute indication for Caesarean Section. I confirmed the opinion that the case was one for Caesarean Section. Labor started in this case at three o'clock in the morning. I took the patient to hospital, and, as a routine, made a rectal examination, which revealed the head almost on the perinaeum. The delivery was completed with the greatest ease at eight o'clock in the morning, the child weighing six pounds.

Another case was sent to the Victorial General Hospital some years ago to the late Dr. Hogan, under similar circumstances, for Caesarean Section. Labor started in the early hours of the morning, but the patient did not tell the nurse that she was in pain for some time. By the time she finally told the nurse, and the interne was summoned, the patient precipitated on the wheel carriage on the way to the delivery room. The man who had referred this case in to Dr. Hogan was being subjected to a good deal of ridicule about the hospital, and Dr. Hogan asked me to go over and take the pelvic measurements. This case was also found to be one of third degree contraction, and, according to the teaching of the time, her attendant was perfectly right in having referred her for operation.

I am not going to deal with the more rare forms of pelvic contraction which one occasionally meets. These are usually accompanied by very obvious deformities which direct special attention to the pelvis—with the result that a thorough investigation is carried out. Types such as the Malacosteon, the Naegele and the transversely contracted pelvis, will require a very high percentage of Caesarean Sections.

There are some types of contraction and distortion of the pelvis which are, unfortunately, relatively common. The flat pelvis is probably the most frequently met. It might better be described as a distorted rather than a contracted pelvis. The distortion is due to Rickets in early life. Writers on

obstetrics have for a long time adhered to the old division of flat pelvis into the two types—Rachitic and Non-Rachitic. This division is confusing to the student and is misleading. There can be little reasonable doubt that all cases of flat pelvis are the result of Rickets. The first, or so called Non-Rachitic variety, is one in which there is a simple pushing forward of the promontory with a heaping up or lipping, and a resulting encroachment on the true conjugate. No other pelvic measurements are affected. In the second, or so called Rachitic variety, there is the same heaping up of the promontory, usually to a more pronounced degree, and added to this there is an axial rotation of the sacrum which causes an increase in all measurements below the plane of inlet. The distortion of the sacral promontory in these cases is due to the fact that the lumbo sacral articulation is the distributing point for the weight of the upper part of the body, which is transmitted from this point to the acetabulum and thence to the lower extremities.

Due to the fact that Rickets is a nutritional disorder, it is commonly associated with underdevelopment and consequently we not infrequently find some degree of general contraction associated with the flat pelvis. If this is definite, we speak of a generally contracted flat pelvis.

A pelvis which is perfectly normal in its contour and proportions, but which has all measurements proportionally lessened, is variously referred to as generally contracted, justo-minor or small round. General contraction seems to describe this pelvis adequately and synonyms are burdensome. This type of pelvis is found in women of small stature, where the lack of development is due to heredity and not to nutritional defects.

Contractions of the pelvic outlet, without corresponding contracture of the upper planes, are fortunately not very common. These cases of funnel pelvis are, however, sufficiently frequent to make a routine investigation of the outlet, an essential part of every pre-natal examination. Contractions of the outlet which cause gross disproportion and which are not discovered until the head is "On the perinaeum," place one in an extremely unenviable position. This variety of pelvis is usually found in women who are of the masculine type, the pelvis being deep and the sub pubic angle markedly narrowed.

The importance of a careful study of each individual case with regard to the pelvis—and its relation to its passenger, will be realized when one considers that disproportion predisposes to and increases the incidence of (1) Malposition, (2) Foetal death, (3) Trauma to maternal soft tissues, (4) Secondary uterine inertia and its bedfellow post partum haemorrhage, (5) Puerperal Infection.

Relatively few cases of contracted pelvis necessitate delivery by abdominal section. On the other hand, a very large percentage of cases in which definite disproportion exists, will require delivery by this means. Reasonably accurate determination of this question is essentially one of experience. Careful routine pelvimetry should be invariable and is valuable as a guide. One should not, however, rush into delivery by the abdominal route because measurements are small, nor should one place too much confidence in a pelvis in which the measurements approach the normal. There is, unfortunately, no way by which the foetus can be accurately measured. The experienced examiner can, however, make a fairly accurate estimate. The case in which no engagement takes place should be strongly suspected. This applies particularly to primigravida. In cases of disproportion the head may be felt to over-ride the pelvic inlet and it cannot be made to engage. Suspicious cases and borderline cases should invariably be investigated by X-Ray.

A careful diagnosis of position and presentation should always be made. A head which will come through the birth canal with ease in a vertex anterior position will often be impossible with one of the posterior positions, in which there is so often very decided loss of the usual attitude of flexion, which is so desirable.

In dealing with multigravida, one should inquire fully into the history of previous labors. Age should be taken into account. In elderly primigravida, the pelvic joints are much more solid than in younger patients, and the unusually long first stage labor with older women, leaves the uterus much less reserve to successfully terminate the second stage of labor.

Contractions at the inlet may be temporized with to a greater extent than those cases which present contraction through the whole canal and still more especially in those with funnel pelvis.

Each case should be considered on its own merits and every factor given careful study. Caesarean Section should be done in those cases in which the attendant honestly feels, after a thorough investigation, that this method of delivery is safer and less likely to be mutilating. There have been two rather sharply opposed schools of opinion in regard to this operation. There are those who rush into operating on the slightest pretext and who are inclined to boast of the vast number they have performed. The opposite extreme is exemplified by the man who boasts of the very few he has done. This extremist is usually not so conservative in his use of that most deadly and damaging weapon, the obstetric forceps. It is certainly not good practice to drag a dead foetus through lacerated tissues and leave the patient with trebled risks of infection and haemorrhage. The cases which are permitted to go into labor will require most careful handling and watching. Examinations should be made per rectum. The greatest care must be maintained to insure asepsis. The bladder must be watched. Various measures now at our disposal, which give great relief of pain, are most valuable in that they permit us to carry a patient through a very long labor. So much damage has been done in the past by well meaning, but ill-advised, men, who have used forceps prematurely in order to put an end to severe suffering. There is no excuse for this to-day. Food and fluids should be given from time to time. The foetal heart must be carefully watched, especially during the second stage of labor. Pituitary in these cases is very dangerous.

There is very definite hope or even certainty that the growing girl of to-day is going to be much better equipped for child-birth than the woman of the past has been. Flat pelvis especially should be almost unknown in a very few years. Modern knowledge of infant feeding and exposure to sunshine have accomplished wonders in this regard. One can already see a marked improvement in the assistance given to the uterus by the auxilliary muscles since the armour of the gay nineties gave way to the near nudity of the gayer "thirties."

It would be incomplete to conclude without some reference to induction at the thirty-sixth week. This procedure has possibly some very small place in the treatment of these cases. Induction is by no means a simple procedure—it is uncertain in its results in many cases and is not entirely without risk. There is also no guarantee of a living child. A short test of labor in doubtful cases of disproportion is always desirable. As pointed out previously, a certain number will give one a pleasant surprise by descending with ease. Longer tests of labor may be tried in cases of flat pelvis of a moderate degree. These test labors are undesirable, however, when there is general contraction, or with marked contraction at the outlet.

A Twentieth Anniversary

H. L. SCAMMELL, M.D.

ON October 9th the Clinical Congress of the American College of Surgeons will meet in Chicago. It will be a notable event for several reasons. The Congress will mark the twentieth anniversary of the foundation of the College. The fact that Chicago has been chosen this year assures the success of the meeting. That city, being the official home of the organization is at all times distinctly conscious of the fact. The hospitals in particular will co-operate to produce a programme altogether fine. Each day towards its close the leading hospitals phone the American College of Surgeons informing it of the proposed surgery for the day following. In this way throughout the year the visiting surgeon to Chicago may by a visit to the College map out his programme for the day following, and see exactly what he needs. Such a daily routine makes it certain that called upon for this special effort the Chicago hospitals will excel themselves to provide the best possible for their guests. Then there is the Century of Progress where amongst the thousands of exhibits will be seen a graphic representation of the progress of surgery through the ages as well as what the modern hospital requires to satisfy modern needs. But to Fellows of the College and to those who are this year to enter its portals, the Supreme moment will be the Convocation, held in the John B. Murphy Memorial Hall of the College. There from the Continents of North and South America, from the British Isles, Europe and the Orient will gather the Knights of Surgery, old friends to meet the new. Once again they will greet Dr. Franklin Martin, their Director General since the beginning of the College, indeed its Grand Old Man.

One cannot visualize this gathering and what it represents without remembering that from time to time one hears disparaging remarks made regarding the American College of Surgeons, remarks most often founded upon lack of knowledge of the object of their criticism. It is not my purpose to defend an organization which requires no defence but merely to indicate the commonly heard criticisms and attempt to show their fallaciousness. Before doing so, however, it is but right to say that there are requirements to be fulfilled by the candidate for Fellowship to which not all applicants by any means begin to measure up. One of these is a reputation for honesty in one's professional relationships, and judgement in this regard is passed by the man's confreres. It matters not how good a surgeon he may be, if he is not a "square dealer" it is thumbs down. From time to time Fellows of the College fall from grace in this regard and upon adequate proof being submitted are expelled forthwith. It is not an expected thing, therefore, that all surgeons should be enthusiastic supporters of the American College of Surgeons.

Three common criticisms are as follows in the order of their frequency: First: "The F. A. C. S. degree is not worth the paper it is written on." Second: "The American College of Surgeons is just a money grabbing proposition." Third: "It is a United States' proposition and not for us Canadians."

It is always a source of criticism in a general way that the F. A. C. S. degree is granted without the candidate writing a set examination. The reasons for

so doing will be gone into later, but because it is done academic critics have raised their hands in holy horror. They are willing to join with their Alma Mater in honoring those of her children who have distinguished themselves in various walks of life with L.L.D.'s and other Doctorates; they pay tribute with hosts of others to the soldier who wins the Victoria Cross, but to accord a surgeon any honor who shows himself by *acts* rather than words to be proficient in his art is not to be thought of at all. Such glorious inconsistency is not only amusing but instructive. It indicates the practical surgical ability of the critics. The hall mark of surgical erudition is undoubtedly the Fellowship in the Royal College of Surgeons of England, and yet one at times hears of those who bear this degree who have never performed a dozen major operations on the living subject. The reason why it remains the most coveted degree in the world is not because a certain man secured it who never practiced surgery but because it was won by those who did and distinguished themselves in a practical way. It secured its prestige by being centered in a small country densely populated by a people whose ideals had been uniform in character for hundreds of years. Had it been founded in America, the melting pot, of enormous area and ideals as diversified as the original nationalities represented, it would have remained with about the same status as the several smaller groups of surgeons in existence when the American College of Surgeons was founded.

Let us now go back twenty years to the city of Washington. Four hundred and fifty prominent surgeons of the United States and Canada had assembled at the invitation of an organization committee which had been appointed at a meeting of the Clinical Congress of Surgeons of North America held the previous year. This meeting considering the surgical field on the continent and recognized a number of factors which may be briefly enumerated.

1. That in the words of Abraham Flexner uttered the previous year, "our medical education includes something of what is best and all of what is worst to be found among civilized nations."

2. That with such diversity of medical teaching there must exist an equal diversity of medical and surgical standards.

3. That this state of affairs constituted a serious menace to the safety and health of the people which must be corrected.

To create out of the then existing chaos a degree conferring body, the prototype of the Royal College of Surgeons of England, would have spelt failure to the enterprise at the start, the object of which was to rapidly raise the standard of surgery on this Continent. Doubtless this group of men reasoned thus: We have in this country thousands of mending surgery. Each is pursuing his own way largely independent of the other. Many are poorly trained, many are working under the most adverse conditions, but *all* are doing surgery and will continue to do surgery regardless of whether this College is founded or not. If we can erect a simple structure which will tend to unite them and raise their ideals, thereby making them better surgeons, we are going a long way. Let us take as our foundation, graduation from an approved medical school. To this add several years of practice of surgery and the evidence of this in the form of case records of actual patients treated in hospital and certified by the hospital. Further, as far as possible determine whether in general he is a capable surgeon, sincere in his outlook, and honest in his dealings with the profession and the public; and let this be passed upon

by men who know him personally and have worked with him. Concisely enunciated they expressed these ideals in Article II of the Bye-Laws as follows:

"The object of the College shall be to elevate the standard of Surgery, to establish a standard of competency and of character for practitioners of surgery, to provide a method of granting Fellowship in the organization, and to educate the public and the profession to understand that the practice of surgery calls for special training and that the surgeon elected to Fellowship in this College has had such training and is properly qualified to practice surgery."

The new college must have an initial membership and the Founders, enrolled as such, include the leaders in Surgery in the United States and Canada of that day and many of our own. The first President was John M. T. Finney of Baltimore; First Vice-President, W. W. Chipman, Montreal; Second Vice-President, Rudolph Matas, New Orleans; with Franklin Martin and Albert J. Ochsner of Chicago, Director General, and Treasurer respectively. To this group were added recognized surgeons from all over the continent who appeared to fill the requirements. Not all of these justified the ideals of the founders. And it was only after the College became a real power and organization was complete that Fellowships were conferred on those who satisfied all the original requirements. No doubt every similar group will have reproaches cast at it for accepting misfits in the beginning. The Royal College of Surgeons of Canada has had the same problem. Suffice it to say that time is the great healer.

From the very beginning it was felt that the surgeon in order to do good work must have an adequate workshop. The hospitals of this continent at that time were in almost as great a state of turmoil as the medical profession and largely due to the professional work of the latter. The management was continually subjected to the petty quarrels, misunderstandings and grumbling of the medical staffs, each member or clique having its own ideas of how patients should be treated and what was the proper equipment and organization to effect it. The hospital managers either linked up with one camp and enjoyed the hatred of the rest, or as frequently happened pursued the policy of "laissez faire" and did nothing. Those were the days when even to smile at another doctor's patient was to brook his hearty disapproval. To interfere when a surgeon was doing his first cholecystectomy unaided, having previously only read of it in a text book was unthought of. The doctor owned the patient body, soul and pocket, and he must not be disturbed. It really did not matter if you made a diagnosis on which a patient's life depended without consultation and exhausting all means to determine the truth. With many the diagnosis really didn't matter much.

The American College of Surgeons soon changed this state of affairs. They said "We are working for the welfare of the public, and we shall see that the public gets a square deal if it will aid us." The result was the development of a minimum standard for hospitals which guaranteed adequate equipment and facilities to treat the sick and a medical staff keeping records of their cases and working together to solve their mutual clinical problems. With this simple standard the United States and Canada was reviewed and less than one hundred hospitals were able to show that they met it. The Hospital Standardization Programme was initiated and after it had gotten underway the man chosen to lead it was Dr. Malcolm T. MacEachern, a Canadian, graduate of McGill University and before this appointment Superintendent of the Montreal Maternity and the Vancouver General Hospitals. He chose his team and

went to work. To-day the one hundred has in round numbers become three thousand: three thousand hospitals safe for the public in Canada and the United States! The minimum standard has remained unchanged. Like the Ten Commandments it was short but it required a lot of hard work to live up to it. Many hospitals of twenty-five beds have fulfilled it adequately as well as those many times larger. It requires the hospital to supply adequate diagnostic facilities; the medical staff to organize, meet at regular intervals to discuss the clinical and scientific problems of the hospital, and to keep satisfactory records of their patients in hospital. The hospitals have benefited enormously but not to the same extent as have the medical profession. Times without number I have heard men say: "Fifteen years ago we were different men. We suspected each other, we did not work together, the spirit was bad in every way. Now all is changed. We know each other, respect our mutual qualities and are aware of our limitations. We discuss our patients frankly and freely one with the other and the patients and the hospital get the benefit. If a new man comes along and wants to do surgery we watch him, gauge his ability, help him along, letting him work with the more experienced until he is quite capable of doing his cases alone." Who has not heard similar expressions? Is this not worthwhile?

But the College has approached the matter from another angle. There must be research and the advancement of the science of surgery. Each year a clinical congress is held which presents one of the finest clinical and scientific programmes in the world. At the same time is held a similar institute for hospital executives. In continuous service are five committees, 1. On Bone Sarcoma. 2. On treatment of malignant disease. 3. On Archives of Malignant Disease. 4. On Fractures. 5. On Standardization of Clinical Laboratories. Besides there is the Board on Industrial Medicine and Traumatic Surgery. All have done work of untold value. Amongst a multitude of tasks the College undertook successfully the standardization of Surgical Dressings which has resulted in a great saving to hospitals of time and money. The Department of Literary Research in connection with the College Library gives a free service to all qualified practitioners regardless of whether they are connected with the College or not who wish to study the current literature on any subject. One could labor this subject at great length but suffice it to say that the object of the founders has been accomplished and will continue to be progressive. In brief the College has

1. Raised the standards of general medical and in particular surgical education to an unbelievable degree in twenty years.
2. Developed a new spirit in the medical profession of co-operation and fraternity.
3. Made hospitals places for the scientific treatment of disease as well as its prevention.
4. Because of these it has given the people of this continent safe hospitals and safe surgeons, and has renewed the faith of the public in the medical profession as a group working progressively towards its welfare.

Now, is Fellowship in this organization "not worth the paper it is written upon?" I leave the verdict to your own judgment.

Is it a "money grabbing proposition." Just in the same way the savings bank is. The College never forced a dollar out of a doctor. If he gave he reaped a

hundred fold. He got a good place, well equipped, in which to treat his patients (The hospital is no longer looked upon as a last resort). He benefitted by the improved educational atmosphere in that hospital which made him progressive and hence more appreciated by his patients for whom he obtained better results. It helped and is helping him earn his bread and butter. But why reproach him for ingratitude? As long as there are parents and children the same sort of thing will be observed.

Is the American College of Surgeons "for the United States alone and not for us Canadians?" Not if we have any reason left. Our men shared in its foundation and have helped to bring to it its present standing. Are we to let their labor be wasted? There are too many benefits to be derived, speaking selfishly, to withdraw our support in the slightest degree. It gives us in Canada all that it gives the United States, and we need this help. It is a common heritage and should remain common property.

To you who tread the stately halls of the College home in Chicago this month will come a variety of emotions. As you walk along the corridor to the convocation hall you will gaze at the portraits of the College Presidents, Finney, Crile, Deaver, William Mayo, Cushing, Armstrong, Ochsner, Charles Mayo, Matas, Chipman, Stewart, than whom no worthier names appear in our history of surgical achievement on this continent. In passing you will pay them silent tribute. You will think of Ochsner who wished in death to be robed in the gown of the American College of Surgeons. You will sit in Convocation Hall at one of the most impressive ceremonies you will ever witness, and listen to the Fellows, your fellows, expound their knowledge of the present and their faith in the future. And you will come away proud as you have never been before that you belong to a College that has set a mark upon you and honored you by recognizing you as a disciple of a living, vital Aesculapius.

Mead's 10 D Cod Liver Oil.
is made from Newfoundland oil.

Professors Drummond and Hilditch have recently confirmed that for high vitamins A and D potency, Newfoundland Cod Liver Oil is markedly superior to Norwegian, Scottish and Icelandic Oils.

They have also shown that vitamin A suffers considerable deterioration when stored in white glass bottles.

For years, Mead's Cod Liver Oil has been made from Newfoundland Oil. For years, it has been stored in brown bottles and light-proof cartons.

Mead's 10 D Cod Liver Oil also enjoys these advantages, plus the additional value of fortification with Mead's Viosterol to a 10 D potency. This ideal agent gives your patients both vitamins A and D without dosage directions to interfere with your personal instructions. For samples write Mead Johnson & Company, Evansville, Ind., U. S. A. Pioneers in Vitamin Research.

Minutes of the Annual Business Meeting

(Continued from September Issue).

TUESDAY, SEPTEMBER 5th, 1933, 8 P. M.

The meeting called to order by the President and reading of reports was proceeded with:—

Report of the V. O. N.

Read by Dr. C. J. W. Beckwith in the absence of Dr. C. S. Morton.

The President and Executive,

The Medical Society of Nova Scotia.

Gentlemen:

Re: Victorian Order of Nurses.

This order has been carrying on as usual—and has accomplished a lot of work—for the past year—With 14 centers and 36 nurses in Nova Scotia they have attended over 10,000 miscellaneous cases including 2,103 obstetrical cases—making in all some 47,000 visits.

One Nova Scotian nurse qualified and was awarded one of the four scholarships for post-graduate work.

Respectfully submitted,

C. S. MORTON.

Halifax, N. S.,

Aug. 21st, 1933.

Moved by Dr. G. W. T. Farish, seconded by Dr. D. A. MacLeod,
“that this report be adopted.”

W. H. Hattie Memorial Fund.

Report read by Dr. H. K. MacDonald.

The Report of the Hattie Memorial Scholarship Committee.

At a meeting of the Committee appointed by the Halifax Medical Society to make recommendations to the Executive Committee of the Nova Scotia Medical Society the following recommendations were made:

- (1) That the scholarship mentioned in the letter previously forwarded be named “The W. H. Hattie Memorial Scholarship”.
- (2) That the amount to be raised by the Nova Scotia Medical Society be not less than \$5,000.00, and that this amount be raised by the physicians of Nova Scotia.
- (3) That in the awarding of this scholarship due consideration be given to the financial as well as the scholastic status of the applicants.
- (4) That the scholarship be awarded by the Committee on Admissions of the Faculty of Medicine of Dalhousie University sitting with the President and Secretary of the Nova Scotia Medical Society, for the year in which the scholarship is awarded.

- (5) That the scholarship be given to help the student with the expenses of his first year in medicine.
- (6) That the Secretary of the Nova Scotia Medical Society confer with this Committee regarding the method of raising the money.

These recommendations were incorporated in a letter to Dr. Walker, the Secretary of the Nova Scotia Medical Society.

After receipt of this letter, to test out the feeling of the various branch societies, Dr. Walker wrote letters to every branch society in Nova Scotia. Many of the answers received were favorable to the project, consequently your Committee recommends that an attempt be made to raise the amount or part of the amount, and that the matter receive discussion this evening, and be voted on by the Society. In the meantime the Dr. Hattie prize has been carried on by subscriptions from the different members of the Faculty of Medicine of Dalhousie University.

(Signed) H. K. MACDONALD, Chairman,
H. B. ATLEE,
H. G. GRANT.

September 5th, 1933.

Dr. M. A. B. Smith. "I would ask that the Committee, the President and Secretary, do all they possibly can to further the fund. I am in favor of the memorial fund and will support it. The money need not be raised immediately. It would be a worthy cause to help some boy procure a medical education. What we have in mind is that probably in the Maritimes there are many sons of very worthy people who cannot get an education. Should the money be raised by the doctors? I do not know if it is quite clear whether the doctors have to raise it themselves or if they may ask some of their wealthy patients to contribute to this worthy cause. In this way a start might be made—perhaps a couple of thousand."

Dr. Herbin. "Awarding it every year to a different student might not be the best thing to do. If he has no money to start his education he would not have enough after the first year to finish. Would it not be better to take one worthy student and see him through his course? If a sufficient amount were raised the interest on the money should, at least, see one worthy student through his course of study."

Dr. Thomas. "We should be guided a good deal by which the outcome of our efforts for a scheme to honor the work of Dr. John Stewart by creating a Professorship in Surgery, which petered out. I think that it would be a good idea to get some experiences from that previous effort. In any case, we ought to look into it. Then there are other men too—the late Dr. E. V. Hogan who did a great deal of work for the College. What was the cause of the previous failure?" Dr. H. K. MacDonald said that the widow of the late Dr. Hogan had provided a fund. Dr. Grant had received some word of this.

The President asked if the Dr. John Stewart Chair of Surgery was a Society matter.

Dr. Murphy then gave a few remarks as he recalled the matter. There was a resolution passed by The Medical Society of Nova Scotia calling upon the medical profession of the province to provide some \$50,000 to establish a permanent Chair of Surgery to be known as "The John Stewart Chair of

Surgery." The resolution was one of those that went through in a moment of very thoughtless enthusiasm. Afterwards a presentation of silver plate was made to Dr. John Stewart.. The previous resolution was never put into effect and no effort was made to carry it out.

Dr. LeBlanc then gave his views on the subject, "I am very much in sympathy with the scheme, of the Hattie Memorial Fund. For myself personally young men come asking for assistance—good brilliant men—come asking where they can procure the money to pay for their medical education. How can this scheme be worked out? It might be well to study the methods of other Associations in similar endeavours. Perhaps a method of taxing the members so much a month could be adopted. This would not amount to very much, 25 or 50 cents. It is only a suggestion but I am very strongly in favor of assisting young men to procure a medical education. I am confident that the Western Medical Association from Yarmouth, Digby and Shelburne will support this movement most heartily."

The President asked the wish of the Society re this report.

Dr. O. B. Keddy spoke briefly and said that every member of the Society would like to honor the memory of Dr. Hattie. He did not doubt that it could be raised and he would be glad to contribute.

Dr. M. A. B. Smith remarked—"I am afraid that if so much a month is asked of the doctors it will fall through. I think that a letter should be written to every member of the Medical Society of Nova Scotia asking them to contribute to this fund.

Moved by Dr. G. W. T. Farish, seconded by Dr. C. Herbin,
"that the matter be put in the hands of the in-coming Executive."
Carried.

Moved by Dr. O. B. Keddy, seconded by Dr. M. A. B. Smith,
"that this report be adopted and acted upon." Carried.

Report of Cogswell Library.

To the President,
Medical Society of Nova Scotia.

Your Committee notes that the somewhat full report submitted by it last year was not dealt with by the Society, so far as is shown in the published minutes (nor was the Committee, as far as these minutes state, reappointed).

In the face of such discouragements, and in the absence of any outstanding event in the affairs of the Library during the past year, your Committee now confines itself to the brief and general statement that the proceeds of the Cogswell bequest have, as usual, been applied as a part of the expenditure on the Medical Library at Dalhousie University.

Your Committee would respectfully urge the more general use of this library by the members of the Society, in accordance with the regulations laid down in the apparently overlooked report of last year.

Respectfully submitted,

J. R. CORSTON, Chairman

Moved by Dr. A. R. Campbell, seconded by Dr. E. K. Maclellan,
"that the report be adopted." Carried.

The President made some comments re the Secretary's Report which was in his hands. He stated that it was incomplete and suggested that it be revised and published. He proposed however, to read the section of the report dealing with obituaries and asked the members to stand while the names were being read.

Obituaries.

Patrick Alphonso McGarry, M.D.,C.M., Dalhousie 1903, Canso, N. S.
Murdock Daniel McKenzie, M.D.,C.M., Dalhousie University, 1898,
Parrsboro, N. S.

John Alexander Munro, M.D., McGill University, 1905, Amherst, N. S.
Dugald Stewart, M.D., University of New York, 1892, Bridgewater.

James Douglas Densmore, M.D.,C.M., Halifax Medical College, 1877,
Manchester N. J., Honorary Member of The Medical Society of N. S.

William Northup Cochran, M.D.,C.M., Dalhousie 1901, Mahone.

Stella-Messenger-Pearson, M.D.,C.M., Dalhousie 1904, Yarmouth.

Edward Vincent Hogan, M.D.,C.M., McGill University 1896, F.A.C.S.,
F.R.C.S.,C.B.E., Halifax.

Alexander Simeon Smith, M.D., Bellevue Hospital Medical College, 1890,
New Glasgow.

Aubrey Fulton Tuttle, Pugwash, N. S., (Medical Student).

Thomas Henry Smith, M.D.,C.M., McGill University, North Sydney.

George David Stewart, M.D., Bellevue Hospital Medical College 1882,
Sydney, N. S.

Alexander S. McNeil, New Waterford, N. S.

Edmund James Johnstone, M.D., Bellevue Hospital Medical College,
1882, Sydney, N. S.

Clyde Strangan Hennigar, M.D.,C.M., Dalhousie 1909, Liverpool.

Editorial Board Report.

The following report was read by Dr. Gosse:

Report of the Editor-in-Chief of the Bulletin, 1932-33.

Mr. President:

It is again my duty to report upon the doings of the BULLETIN during the past year having respect to its editorial activities.

The conditions under which we have had to work during the year have not been by any means pleasant. However, in view of the action of this Society since this meeting convened we regard it as a kindness to gloss the matter over as further unpleasant details can serve no useful purpose.

We are happy to report that in spite of much extra work and annoyance the journal still maintains its existence. Last year it was our pleasure to report a new Section—that of Case Reports. This year we would submit another for your approval—The Cancer Section. In this we believe you will rejoice with us in that in this matter we are in advance of other journals, and in advance of the Canadian Medical Association, Cancer Committee who this year recommended, that space be provided in the Canadian Medical Association Journal for the dissemination of Cancer knowledge. The practice had been adopted by us months before they had suggested it.

While these various features and the collecting and editing of all material has entailed a very considerable amount of work on the part of those directly

responsible one is happy to acknowledge a debt of gratitude to the many who have contributed and for the kindly courtesy which has uniformly been met with, the real factors which make the BULLETIN possible.

Special mention should be made of my associates on the BULLETIN Board. To Dr. J. K. MacLeod and Dr. Benvie for their contributions, and for their readiness to consider dispassionately and helpfully any problem of policy submitted to them. Our greatest debt however, is to our city confreres Doctors Morrison and Atlee. They are the ones who have made life endurable in the atmosphere of the BULLETIN during the past year. They are interested in the journal and have held themselves always ready to contribute of their time and of their most excellent talents to its service.

So much difficulty was experienced in exercising that prerogative which enabled us to clean up the journal and to keep it clean that the several other matters referred to us by this Society a year ago were not attempted. It is to be hoped that they will find easier solution in the coming year. It is also hoped that a generally improved atmosphere will admit of the introduction of those other improvements in the journal which to us seem desirable.

Approved by the Board and respectfully submitted.

N. H. GOSSE.

Moved by Dr. G. W. T. Farish, seconded by Dr. W. R. Dunbar,
"that this report be adopted." Carried.

Dr. Herbin here took exception to the fact that the report of the Secretary, Dr. S. L. Walker had not been read and asked that it be read and adopted.

Moved by Dr. W. R. Dunbar, seconded by Dr. A. I. Mader,
"that the report of Dr. S. L. Walker be revised and published in the BULLETIN." Carried.

Report of Committee on Narcotic Drugs, (Special Committee).

Your Committee having examined the Report on Narcotic Drugs and in particular the recommendation of the Geneva Conference in 1931 are of the opinion that the abolition of the medicinal use of Heroin would be an extreme measure and that the recently increased restrictions imposed by the Government at Ottawa are adequate to our purpose in Nova Scotia. We therefore recommend that no action be taken by this Society in this matter.

A. B. CAMPBELL,
J. R. CORSTON.

Moved by O. G. Keddy, seconded by H. G. Grant,
"that the report be adopted." Carried.

Special Committee re Secretary.

Read by Dr. W. R. Dunbar.

We, your Committee, appointed to look into the matter of a Secretary as successor to Dr. S. L. Walker, resigned, beg to report that after the consideration to submit to this Society the name of Dr. H. G. Grant, to act as Secretary of the Nova Scotia Medical Society and Business Manager of the BULLETIN.

Respectfully submitted,

W. R. DUNBAR,
J. C. MORRISON.

Moved by Dr. Sutherland, seconded by Dr. H. B. Atlee,
"that this report be adopted." Carried.

Nominating Committee.

Report of the Nominating Committee was as follows:—

Place of meeting in 1934—Yarmouth.

President—Dr. T. A. Lebbetter, Yarmouth.

Ist Vice-President—Dr. J. C. Morrison, New Waterford.

2nd Vice-President—Dr. R. M. Benvie, Stellarton.

Secretary and Business Manager—Dr. H. G. Grant, Halifax.

Treasurer—Dr. W. L. Muir, Halifax.

Executive of The Medical Society of Nova Scotia.

Colchester-East Hants Medical Society:

Dr. W. R. Dunbar, Truro N. S.

Dr. R. A. MacLellan, Rawdon, N. S.

Cumberland County Medical Society:

Dr. A. E. Mackintosh, Amherst; Dr. M. J. Wardrope, Springhill.

Halifax Medical Society:

Dr. M. G. Burris, Dartmouth; Dr. H. W. Schwartz, Halifax; Dr.

E. K. Maclellan, Halifax; Dr. A. E. Murray, Halifax; Dr. H. B.

Atlee, Halifax; Dr. C. W. Holland, Halifax.

Lunenburg-Queens Medical Society:

Dr. D. A. Campbell, Bridgewater.

Pictou County Medical Society:

Dr. J. Stewart Murray, River John; Dr. V. H. T. Parker, Stellarton.

Eastern Counties Medical Society:

Dr. M. G. MacLeod, Whycocomagh; Dr. J. L. McIsaac, Antigonish.

Valley Medical Society:

Dr. R. O. Bethune, Berwick; Dr. W. R. Dickie, Digby.

Cape Breton Medical Society:

Dr. D. M. McNeil, Glace Bay; Dr. Freeman O'Neil, Sydney; Dr.

D. W. Archibald, Sydney.

Western Nova Scotia Medical Association:

Dr. W. C. O'Brien, Wedgeport; Dr. L. M. Morton, Yarmouth.

Public Health: Deputy Minister of Health, Dr. H. G. Grant, Dr. R. L. Blackadar, Yarmouth; Dr. J. K. MacLeod, Sydney; Dr. W. F. MacKinnon, Antigonish; Dr. W. N. Rehfuss, Bridgewater; Dr. H. V. Kent, Truro.

Health Publicity: Deputy Minister of Health, Drs. N. H. Gosse, Halifax; R. M. Benvie, Stellarton; S. R. Johnston, Halifax; G. R. Burns, Halifax; J. L. MacIsaac, Antigonish.

Advisory Committee to Public Health: Drs. G. W. T. Farish, Yarmouth; J. J. Roy, Sydney; A. S. Burns, Kentville; G. R. Burns, Halifax; F. R. Little, Halifax; H. K. MacDonald, Halifax; J. L. MacIsaac, Antigonish.

Board of Management for N. S. Society for Cripple Children: Drs. L. R. Morse, Lawrencetown; Dr. Murray, Tatamagouche; J. F. Macauley, Sydney.

Historical Medicine: Drs. H. L. Scammel, Halifax; M. D. Morrison, Halifax; G. H. Murphy, Halifax; M. E. McGarry, Margaree Forks; W. J. Egan, Sydney; H. B. Atlee, Halifax; J. A. Sponagle, Middleton.

Workmen's Compensation Board: Drs. J. R. Corston, Halifax; D. A. MacLeod, Sydney; M. G. Burris, Dartmouth; P. A. Macdonald, Halifax.

Council C. M. A.: Dr. S. W. Williamson, Yarmouth; A. B. Campbell, Bear River; D. McNeil, Glace Bay; D. Murray, Tatamagouche.

Narcotic Drugs: Drs. D. W. Archibald, Sydney Mines; G. H. Murphy, Halifax; Allan Morton, Halifax.

Legislative: Drs. C. E. Kinley, Halifax; J. G. MacDougall, Halifax.

Editorial Board: Dr. N. H. Gosse, Editor-in-chief; Halifax; Dr. H. B. Atlee, Halifax; M. D. Morrison, Halifax; and the Secretaries of all Branch Societies.

Provincial Medical Board: Drs. J. G. MacDougall, Halifax; H. K. Macdonald, Halifax; M. G. Tompkins, Dominion; M. G. MacLeod, Whycocomagh; A. B. Campbell, Bear River; A. E. MacKintosh, Amherst.

Cogswell Library Committee:

Drs. J. R. Corston, John Stewart, N. H. Gosse, Dr. C. W. Holland, and W. L. Muir.

Moved by Dr. W. R. Dunbar, seconded by Dr. L. M. Morton,
"that this report be adopted as it stands." Carried.

Report of the Treasurer:

FINANCIAL STATEMENT NOVA SCOTIA MEDICAL SOCIETY YEAR 1932-33

RECEIPTS

July 1, 1932.		
Balance cash on hand Savings Bank.....	\$660.82	
Current Acct.....	616.81	
		\$1,277.63
Fees collected during year.....		1,955.53
Receipts from Medical Bulletin.....		2,008.85
Interest on Savings Bank.....		19.66
		\$5,261.67

DISBURSEMENTS

Cost of Medical Bulletin.....	\$2,271.51
Salaries.....	1,200.00
Travelling Expenses.....	104.75
Sundry Expenses, Postage, Telegrams, Stenographer, Telephone, etc..	492.80
Rent of Office.....	330.00
Cash on hand, June 30, 1933	
Savings Bank.....	\$680.48
Current Account.....	182.13
	862.61
	\$5,261.67

PROFIT AND LOSS STATEMENT

Fees collected.....		\$1,955.53
Interest on Savings Bank.....		19.66
		<hr/>
		\$1,975.19
Less Costs		
Medical Bulletin.....	\$ 262.66	
Travelling Expenses.....	104.75	
Salaries.....	1,200.00	
Sundry Expenses.....	492.80	
Rent of Office.....	330.00	
		<hr/>
		2,390.21
Net loss for year.....		\$ 415.02
		<hr/>

NOTE: The deficit which we have is due to the falling off in the payment of fees.

Cogswell Library.

COGSWELL LIBRARY FUND
NOVA SCOTIA MEDICAL SOCIETY
YEAR 1932-33

RECEIPTS

Balance Cash on hand July 1, 1932.....	\$ 90.88
Interest from Bank.....	2.88
Income from Bonds.....	172.27
	<hr/>
	\$266.03

DISBURSEMENTS

Dalhousie University.....	\$265.00
Balance Cash on hand June 30, 1933.....	1.03
	<hr/>
	\$266.03

Re-investment of \$5,000. Dr. Muir had asked some individual members what could be done but they could not suggest any course to adopt. The \$5,000 was invested as followed:—

Sold Province of New Brunswick 3½% \$5,000.	
Bought Eastern Canada Savings & Loan.....	\$2,500 5¼% 5 yrs.
Bought Mortgage Corporation of N. S.....	2,500 5 % 5 yrs.

The general fund shows a falling off. There will probably be \$250 per year to be handed over to the Dalhousie University.

Dr. Corston pointed out that the investment did not confirm to the will and quoted the exact Clause of Dr. Cogswell's will dated May 15th, 1890, which reads as follows:—

"I give to the said Medical Society a further sum of one thousand pounds to be invested by them in British or Colonial Government inscribed stock or securities and I declare the interest dividends and annual income thereof shall be applied at their absolute discretion."

A discussion followed. The opinion was that the debentures could be disposed of should the Society see fit.

Moved by Dr. Thomas.

"that Dr. Cogswell's bequest be carried out as soon as convenient."

Moved in amendment, by Dr. J. R. Corston, seconded by Dr. Thomas

"that the matter of investment be referred to the Cogswell Library Committee who, with the Treasurer, would look further into this matter."

Carried.

Auditor's Report.

Report read by J. C. Morrison.

Your Auditors have examined carefully all bills, accounts and receipts of the Society and beg to report that apart from a few irregularities which occurred in handing over monies received to the Treasurer but which have now been satisfactorily adjusted, we find all the said bills, accounts and receipts to be in order and correct.

Respectfully submitted,

J. C. MORRISON.

RALPH P. SMITH.

(To be continued)

OBITUARY

The BULLETIN extends its sincere sympathy to Dr. J. L. MacMillan of Westville on the death of his mother, Mrs. Margaret MacMillan, which occurred on September 26th at Lake Ainslie, C. B.

The BULLETIN also extends its sincere sympathy to Dr. F. S. Finlay of Halifax, on the death of his mother, Mrs. Mary Finlay, widow of James Finlay, for many years a well-known grocer in the South End.

The BULLETIN has received a letter from Mrs. J. H. Wasson, President of the Women's Institute, Mangerville, R. R. No. 1, Sunbury County, N. B., asking if we could help her in getting in touch with a physician who would go there to practise.

Report on Tissues sent for examination to the Pathological Laboratory, from September 16th, 1933 to October 15th, 1933, inclusive.

The total number of tissues sections is 132. In addition to this, 11 tissues were sectioned from 5 autopsies, making 143 tissues in all.

Tumours, malignant.....	25
Tumours, simple.....	3
Other conditions.....	91
Awaiting section.....	13—132

Unfortunately the giving of an accurate Diagnosis is hindered by many of the specimens arriving at the Laboratory unaccompanied by any history whatever. Often the source of the growth is omitted. A short note of the sex and age of patient, duration of tumour and any other relevant points in the history of the case would be much appreciated and would be of considerable help in the giving of a fuller report on Diagnosis and Prognosis.

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ALTHOUGH many members of the Medical Society are well acquainted with our recently elected President, it is fitting that, at this time, he be introduced to them all.

My first recollections of Dr. Thomas A. Lebbetter, or "Tommy" as we called him then, go back to the last few years of the Halifax Medical College. He came here from St. Francis Xavier University, a slim, well-groomed, black haired youth; cheerful in appearance, but with a distinct alertness or keenness of mind which stamped him, even then, as one concerned with the more important things of life. At the Medical College and, in his last years of training, at the University, he took an active interest, not only in the work which was fitting him for the vocation he had chosen, but also in those activities which appealed to a person of culture and refinement. His oratory and logic were heard on many an occasion when he represented Medicine in debate against the well trained men of Law and Arts, and at least one "Theatre night" was enlivened by his presence. Although he did not devote much of his time to athletics, he was always ready when Medicine was called upon to defend herself on the football field against the denizens of the Forrest Building.

Since graduation our ways have parted but I have followed his career with interest. When the great call to Arms came, he responded gladly and served overseas with the St. Francis Xavier Stationary Unit. On his return he established himself in practice at Yarmouth, where he has been most successful in his life's work. Although a busy practitioner he has always found time to concern himself with the activities of his local Medical Society, and also that of the Province.

It is twenty years since Dr. Lebbetter graduated from Dalhousie; not a long period as time is reckoned, but sufficient to effect changes in most of us. Time has dealt kindly with him; mentally and physically he is in the prime of life. The same gentleness and cheerfulness of disposition persists as in his College days, and his keen mind has not been dulled by responsibility. He is typical of the higher type younger practitioner and is worthy of the great honour bestowed upon him by our Society.

H. G. G.

CASE REPORTS

LUMBAR SYMPHETECTOMY.

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INTRODUCTION

THE rationale of operations on the Sympathetic System is explained by Physiology. The Lumbar Ganglia supply Vaso-Constrictor fibres to the arteries of the lower extremity. Excision of these causes a vaso-dilatation which may be sufficient to ward off threatened gangrene. An increase of skin temperature follows from 4 to 8 degrees C. The Sympathetic fibres to the intestine inhibit peristalsis. Removal of the lumbar ganglion is thus indicated in Hirschsprung's Disease in that the inhibitory action of the Sympathetic is removed and allows the vagus free play in stimulating the peristalsis. Rene Leriche of France and two Australians, Royer and Hunter, did pioneer work in this branch of surgery. It is a comparatively new development in surgery. We must not be too optimistic and carefully select our cases.

Case I. Boy—age 14.

Complaints. (1) Constipation.
(2) Lack of control of bowels.

Present Illness. Has been obstinately constipated since birth. Bowels would only move once a week and then only after taking large and increasing doses of purgative. During the last year he has had incontinence of faeces on laughing or sneezing. He has avoided his boy friends on this account and was forced to give up games. The abdomen has been increasing in size.

Examination. Abdomen very much increased in size. Large masses of faeces could be felt in region of pelvic colon. Rectal examination showed the sphincters to be dilated and patulous. There was a large mass of faeces in the rectum.

The incontinence of faeces was a false one, not due to paralysis of the sphincters, but to dilatation from the hardened faeces. Barium enema was given, which showed a very much dilated and redundant pelvic colon.

Diagnosis. Megacolon or Hirschsprung's Disease.

Treatment. After spending several days in clearing out the rectum and colon, manually and by enemas, a lumbar Sympathetectomy was performed by the extraperitoneal route on the left side. The second, third and fourth ganglia with the sympathetic cord were removed.

Result. Six months after the operation he has natural bowel movements without any laxatives. He has perfect control of his sphincters and can mix freely with his school friends and play games.

Case II. Male—age 38. Race—English.

Complaints. (1) Cramps in muscles of legs.
(2) Severe pain in legs.
(3) Toes blanch at times, followed by cyanosis.

Present Illness. Dates the cramps in legs to October, 1932. Could only walk about 200 yards when the severe cramps in calf muscles forced him to rest. He smokes cigarettes moderately.

Examination. There was an absence of pulsation in anterior and posterior tibial vessels at the left ankle. They could be palpated on the right side. No ulceration or trophic changes in the skin. The femoral pulse could be felt on both sides. His heart was normal. B. P. 120/80. Kahn test negative. Urine normal.

Diagnosis. Anterior Sclerosis was ruled out on account of the normal feeling vessels, age and normal blood pressure. Raynaud's Disease is much commoner in women. The absence of pulsation indicated a Thrombosis in the Femoral or Popliteal Artery. The diagnosis of Thrombo-Angitis Obliterans was made.

Treatment. February, 1933, a bilateral Lumbar Sympathectomy was done by the transperitoneal route.

Result. Patient was seen seven months after the operation. His pain has been very much relieved. Feet are warm. He still suffers from cramps in the muscles of his legs but can walk further than he formerly could.

Case III. Female—age 34.

Complaints. (1) Very painful ulcers on dorsum of left foot.
(2) Toes blanching and then becoming cyanosed.
(3) Inability to walk any distance on account of the painful ulcers.

Present Illness. When about twenty years of age suffered from fingers blanching and becoming cyanosed. Ulceration and necrosis of terminal phalanges eventually resulted. Six years ago began to have the same trouble with her feet. Left foot became very sensitive to cold. About eighteen months ago developed several ulcers on dorsum of left foot. There have never healed, and she has scarcely walked on account of the pain. She states that her fingers bother her very little.

Examination. Showed a normal pulsation in anterior and posterior tibial arteries. There were several small chronic ulcers at base of toes and on the dorsum of foot. Feet were cold to touch and would readily blanch and then become cyanosed. Her finger tips were deformed due to old

Osteitis of Phalanges. Physical examination of the Circulatory system was negative. B. P. 124/75. Urine normal. Kahn test negative.

Diagnosis. Raynaud's Disease.

Treatment. On May 12, 1932, a bilateral Lumbar Sympathectomy was performed by the transperitoneal route.

Result. Patient was seen during September, 1932. Her feet have been notably warm ever since her operation. She has had complete relief from pain. The ulcers are all healed except for one in region of external malleolus of fibula.

CARCINOMA OF THE MOUTH

N. H. GOSSE, M.D., C.M. (Dal.).

Demonstrator in Surgery, Dalhousie University.

Mr. J. W. Age 75.

Fourteen years ago had a little sore "like a cold sore" on his lip, it wouldn't heal. So he went to a Chiropractor. Mr. Chiropractor treated it—every day for six months—an hour a day. The treatment consisted in his lying down on his back and holding two rods in his hands—one each side of his mouth, so that the magical emanation passing from one rod to the other would exert their beneficent influence upon the sore and heal it. It cost him \$300.00 for that, but the dogs which licked Lazarus would have done him more good and cost him less.

Next he went to a man who used X-rays. They were genuine X-rays, I have no doubt of that, but I fear there were not very many of them. He received *thirty* treatments over a period of ten years, and there was no change.

He then came to this city and saw a medical man who advised him to see a well known physical therapist. From him he received some twenty "spark treatments. I'm afraid that they too, were of the kind that "shall not hurt nor destroy."

Still unchanged he returned home, when he heard of a woman who cured cancers, which he believed his lesion to be. So he entrained and went to her. She began the use of plasters. This was very painful but it nearly healed it *nearly but not quite*—perhaps she was too gentle—and it soon broke down again. Further treatment produced similar result only it broke down more quickly after each treatment, and finally it came to be quite a size.

It was now obvious that the hope of the race has also let him down. So he returns to the true fold again, commending his spirit into the hands of a surgeon. There, of course, it was safe, and the good man painlessly and kindly cut it all out, or nearly all. That was just about a year ago. By September 15th it was quite healed. By October 1st *there was recurrence*

Early in November, his Doctor phoned me describing the case and speaking of its rapidity of growth and asking me to look after it. I advised him to hurry him along, but the patient was in no hurry for he didn't arrive till two weeks later.

At the time of my first seeing him which was just about two months after the operation, the growth occupied a position from the angle of the mouth extending along the inner side of the cheek almost to the angle of the jaw. It measured $4\frac{1}{2} \times 2 \times 1$ cm. It was a fungating vascular squamous carcinoma.

Treatment. My idea of treatment was that it should have the maximum of radium irradiation that the tissues would stand, *in one dose*. Our radium supply did not admit of that then, so I implanted in his tumor all I could get—10 gold seeds—and a week later was able to secure and implant another 15 seeds to make a total of 3,452 Millicurie hours, interstitial radiation. In addition he received a dose of H. V. x-radiation. (This combined irradiation left his face hairless for upwards of four months).

The reaction was quite a good one but subsided in the usual time. He stayed around Halifax for a while, and has been reporting himself back at regular intervals since for examination. For nearly a year now there has been no evidence of disease, and no further treatment has been given. Constitutionally there is great improvement.

Points of interest here are:

1. The length of time a pre-cancerous lesion can carry on before taking on malignant qualities—in this case more than twelve years, during which time it might have been very easily cured.
2. The effect of irritation upon a lesion. One is reminded of the way in which Ewing damns the person who would use caustics upon any lesion about the mouth. There is no doubt that the malignant transformation was finally effected by the arsenic plasters or at least that its malignancy was speeded up.
3. The extremely rapid recurrence after loosening cell restraint by excision. Certainly the cutting into such tumors speeds them up.
4. The marvellous effect of irradiation—in adequate dose. However there are of course, many much more resistant than this that will not do so well.

No suggestion of a cure is made. The patient is made to realize that the final result for him depends upon his prompt reporting of any change that might occur, and, in any event upon his periodic return for examination.

CARCINOMA OF THE SIGMOID.

C. E. KINLEY, M.D., C.M. (Dal.).

Lecturer in Surgery, Dalhousie University.

Mr J. T., age 38. Carpenter.

Admitted Oct. 30th, 1932, complaining of abdominal pain and distension of the abdomen.

The family history was negative as was his personal history except that when 8 years old the wheel of a truck passed over his abdomen.

Last February he had an attack of moderate lower abdominal pain associated with much gurgling in his abdomen. The attack lasted four days. Since that time until admission to hospital he has been well except that he noticed occasionally a small amount of blood and mucus in the stool.

On October 21st he began to have pain around the navel, cramp like in character and very severe. This was associated with gurgling noises in the

abdomen and fullness of the abdomen. He worked until the 27th, when he began to vomit.

Examination. on admission Oct. 30th..

Pale, fair nutrition, seems fairly comfortable. Complains of moderate abdominal pain, not vomiting. Temperature and pulse normal. The abdomen slightly distended, with no masses palpable. Moderate tenderness in right upper quadrant.

Rectal examination negative.

On observation for several hours in hospital it was noticed that during the spasms of pain a swelling would appear in the lower left quadrant associated with gurgling sounds. It was a soft mass and disappeared on pressure.

His general physical examination revealed nothing of note. W. B. C. 7,000.

As his pain became more severe a laparotomy was decided upon immediately. The diagnosis was intestinal obstruction,—volvulus of the Sigmoid or malignant stricture. The operation revealed an annular carcinoma of the sigmoid. The bowel above was not oedemateous or much distended. The mesentery was stiff with inflammatory oedema. Resection of the growth followed by a lateral anastomosis was done, also an ileostomy, through a stab wound in the right iliac region.

His postoperative course was rather stormy. He developed B. Coli Infection in his incision which responded readily to treatment. The ileostomy functioned well and closed after 15 days. The bowels began to move normally on the sixth day.

On Nov. 14th he developed another obstruction which was relieved by a left ileostomy. A tube was sewn into a distended loop of bowel. This obstruction was shown to be due to an inflammatory band in the pelvis. He rapidly recovered from the secondary obstruction.

He was discharged on Dec. 21st, 1932 with all incisions well healed, ileostomies healed and bowels functioning normally. Subsequent follow up shows him to be working and to be quite well.

I present the case as a case of carcinoma of the sigmoid in a young adult, which would have probably gone on for some time, had not acute obstruction developed.

DIVERTICULUM OF DUODENUM.

V. O. MADER, M.D., C.M., (McGill).

Demonstrator in Clinical Surgery, Dalhousie University.

W. B. age 52, lineman, was admitted to the Victorial General Hospital on August 8th, 1933, complaining of:

- (1) Pain in the Abdomen.
- (2) Belching of gas.
- (3) Loss of weight.
- (4) Melena.
- (5) Haemorrhoids.
- (6) Constipation.

There is nothing in the personal or family history relevant to the present condition except that during childhood he suffered from frequent attacks of severe abdominal pain which disappeared at adolescence. The present illness began about eight months ago, although he has been suffering from constipation and haemorrhoids for several years. He states that although he has had several bright red haemorrhages in the stool he has also had several tarry black loose movements, one of which was particularly large and foul smelling and followed an attack of weakness so severe that he had to be taken home, and remained in bed for one week.

During the last eight months he has been suffering from abdominal pain and belching almost continuously, and especially after meals, these symptoms being much more severe during the last two weeks.

Physical examination reveals—tenderness in the epigastric just below the costal margins, most marked slightly to the left of the mid-line.

The blood Kahn is negative—blood picture shows a mild secondary anaemia—gastric analysis revealed a low free acidity. Examination of stools on several occasion for occult blood was positive, but not constantly. X-ray examination of the gastro-intestinal tract showed that the stomach emptied freely. The first part of the duodenum is slightly irregular and there is marked delay in the passage of barium through the second part of the duodenum with evidence of sacculation or diverticulum. All plates taken show this diverticulum still filled with barium after the remainder of the meal has passed to the colon.

Operation was performed August 28, 1933. On the Antero-mesial aspect of the second portion of the duodenum a diverticulum the size of a hen's egg was found filled with a firm doughy material. This was evacuated into the bowel proper without difficulty. The diverticulum was then invaginated with a Lambert and purse string suture.

Following uneventful recovery re-examination by X-ray revealed no evidence of the diverticulum, the stomach and duodenum both emptying normally. On Discharge, September 22, 1933, the patient has no complaints.

Traumatic Perforation of Ileum, Cerebral Embolism, Faecal Fistula with External Intussusception.

K. McK.

A white male child, aged 5 yrs., was admitted to the Victoria General Hospital on November 28, 1932, with a history of having struck a telephone pole while coasting.

He complained of Abdominal Pain—Vomiting—Excessive Thirst.

On examination there was *no* signs of external violence; the abdomen was rigid, and tender throughout, his temperature was 100.3, his pulse was 148 per minute, and respirations 22 per minute. His leucocyte count was 10,200 and on taken several hours later was 18,000.

Operation was performed seventeen hours after the accident. Upon opening the abdomen the peritoneal cavity was found to be filled with a black, watery fluid which was carefully mopped out. About 1½ feet proximal to the ilio caecal valve a perforation of the gut, large enough to admit the finger was found. This opening was partially closed and an ileostomy was performed

using the perforation for the purpose. The abdominal cavity was drained with four cigarette drains and one rubber tube; the wound was partially closed with "through and through" silk-worm gut sutures.

During the following three days the patient's condition was critical and on December 3rd, the child became very restless with twitching of the left side of the face. Respirations became very laboured—12 per minute, the pulse rate was 120 per minute, cyanosis marked. Fifteen minutes after the beginning of the attack the child's head and eyes began to turn to the right, the pupillary light reactions became sluggish, and nystagmus (right) was noted. The left arm and leg became flaccid. Knee jerks and cremasteric reflexes were found to be present on the right and absent on the left. A left Babinski was elicited. These signs gradually disappeared within 12 hours, and after recovery the general condition of the patient seemed better than before these signs and symptoms appeared.

Ten days post-operative during a fit of crying the wound broke open and the bowel tore almost completely across at the point of the original perforation. At operation the wound was partially closed leaving a faecal fistula. General improvement occurred rapidly but there remained this faecal fistula through which the small intestine would intussuscept both from above and below. This external intussusception gradually became larger and larger so that on several occasions six to eight inches of small intestine had to be reduced under anaesthesia. In order to prevent this occurrence and with a view to re-establish the continuity of the intestinal canal, a side to-side anastomosis between the proximal and the distal loop of the intestine adjacent to the fistula, was performed through a transverse incision above the fistula on March 6, 1933. This procedure was effective in preventing the intussusception occurring but did not influence the amount of intestinal contents discharging through the fistula.

On June 15, 1933 the fistula was dissected out and examination showed that the stoma made at previous operation was patent. The two limbs of bowel forming the fistula were then cut off and invaginated in the usual manner, and the abdomen closed without drainage.

Patient made an uneventful recovery and was discharged on July 29, 1933.

All in a day's work—The following well illustrates the hardships which a country Doctor so often is called upon to endure. Dr. H. H. Banks of Barrington Passage was called for by a fisherman one dark, stormy night in late September to make a perilous trip in a small fishing boat to aid a dying seaman on the U. S. revenue cutter "Aurora." He answered the call of duty as a matter of course, and after being buffeted by heavy seas through the inky darkness Dr. Banks finally boarded the "Aurora" only to find that the unfortunate seaman had already died.

The Secretary has received letters from the Rev. A. S. McLean, Presbyterian Minister at Ingonish and Dr. H. A. Grant of Big Bras d'Or, asking if any Doctor would be interested in practising in northern Victoria, Cape Breton. Further information may be obtained through the Secretary or directly by communication with Rev. Mr. McLean or Dr. H. A. Grant.

CANCER

THE DOCTOR'S PRACTICAL RELATION TO THE CANCER PROBLEM*

WILLIAM CARPENTER MACCARTY, M.D.

THE cancer problem has many phases, such as histogenesis, etiology, immunity, and heredity, which are being studied in institutions for pure research. But aside from these subjects, still open to investigation, there are three immediate and practical phases about which much is already known: the frequency of the disease, the necessity of and means of early diagnosis, and the good results of present methods of treatment. With the general acceptance of this knowledge cancer can easily be materially reduced in seriousness. In so far as medical students and practitioners are concerned, the immediate and tangible problem rests in effectual utilization of this knowledge for practical purposes.

Statistics reveal that there are approximately 150,000 deaths from cancer yearly in the United States. The more important problem is to reduce this number and to care for those victims who are still alive. By calculation I have decided that there are at least 2,000,000, and possibly more, cancer patients in our midst who are waiting to be recognized. Statistics reveal that 75 per cent. of the cancers of the stomach are inoperable when the patients are first seen in consultation by the surgeon (Balfour). This leaves only 25 per cent. to whom some possibility of help can be offered. Even this 25 per cent. does not represent the early stages of cancer; by actual measurement it is found that the resected gastric cancers average 6 cm. in diameter, 50 per cent. of these being palpable through the abdominal wall (MacCarty). With increasing knowledge, and more general use of the roentgen rays, we are, however, seeing an increasing number of smaller lesions but no more than are required to show that there is much room for improvement. What has been said of gastric cancer is also true of cancers in other regions. Thus, 30 to 50 per cent. of the cancerous breasts and 25 per cent. of the large intestinal cancers are inoperable, according to Harrington and Rankin. The average size of the operable lesions is 3 cm. for the breast and 6.5 cm. for the large intestine (MacCarty). There must be reasons why these cancers are so large. Certainly all of them have not been symptomless and many of the patients have been seen by physicians, or by venders of various medicines for temporary relief of symptoms. Possibly there are six reasons:

1. The patient with cancer does not always know that he or she is even sick. This certainly happens, but rarely.
2. The patient suspecting cancer fears an examination. This happens, but probably less frequently than ten years ago.

*From *The Bulletin* of The American Society for the Control of Cancer, and published by permission.

3. The patient does not submit to complete examination. This happens frequently because not 25 per cent. of the patients with cancer of the stomach, encountered in Kirklin's experience, have been previously subjected to roentgenologic examination.
4. The patient goes to a physician and it is actually impossible for him to recognize the condition. This occurs.
5. The patient refuses to take the physician's advice. This occurs, but not as frequently as in past years.
6. Early cancer does not give the text-book signs and symptoms of cancer but rather those of chronic inflammation, obstruction of some kind, anemia, hemorrhage, or weakness.

In my opinion the medical profession is suffering from a confusion of knowledge largely the result of a confusion of nomenclature, premature theoretical explanations, some stubbornness, and impractical conservatism. There are more than 950 terms used to name neoplastic conditions. As a matter of fact there are only three great groups of neoplasms in so far as their cytology and clinical behavior are concerned (MacCarty):

1. Those composed of adult cells with normal tissue arrangement: the *cytomas*.
2. Those composed of cells normally or nearly normally arranged, but having the morphology of malignant regenerative cells: the *blastomas*.
3. Those composed of cells of the malignant regenerative type, not arranged in any fashion approaching that of any normal tissue: the *problastomas*.

It may be said that the first two groups have their subdivisions but these are only of academic interest and have the same diagnostic and prognostic significance as their respective main groups.

Clinical experience has taught us that the neoplasms of the first group are relatively benign, in that they are not invasive, grow by expansion, and do not metastasize. They sometimes kill by impinging on or interfering with vital structures. The second and third groups are clinically malignant, in that they invade surrounding tissues and form regional and distant metastatic growths. The general popular term "cancer" embraces the second and third groups but not the first.

For each group there are many synonyms. Such a superfluity of names is naturally the result of that great period of observation and collection of material which has always necessarily been the forerunner of scientific generalizations.

Although each of the three main groups (the *cytomas*, *blastomas*, and *problastomas*) has its own general and variable prognosis, there are still other factors which alter or control the prognosis in individual cases. Each of these and there may be more, has been studied, and there are enough facts to aid us materially in handling our problem.

Factors Governing Prognosis.

Judging from my own clinical and pathological experience there are at least fifteen factors governing prognosis in cancer. I shall describe them briefly in the approximate order of their clinical importance

1. *The presence or absence of nodal involvement and distant metastasis.* It may be stated that length of life is inversely proportional to the

amount of nodal involvement and distant metastasis. To this principal there is the corollary that the proximity of death depends also on the vital anatomic situation of both primary growth and metastasis. In support of this first principle many figures might be given. I shall, however, confine myself to a few of the statistics from The Mayo Clinic.

TABLE 1
NODAL INVOLVEMENT

Organ	Cases studied	Length of post-operative life, years	With nodal involvement, per cent.	Without nodal involvement, per cent.
Breast	962	3	39.25	74.6
Stomach	1,000	3	19.00	52.0
Breast	962	5	24.2	63.5
Lip	136	5	18.1	90.3
Breast	218	5 to 8	18.9	63.9
Breast	962	10	13.3	44.0

2. *Fixation of growth.* The greater the fixation of a cancer to surrounding structures, the greater the difficulty of surgical removal, the greater the immediate operative risk, the greater the chance of local recurrence, and the less the chance of complete recovery. I have no figures to substantiate this principle, but practical experience shows that surgeons will not attempt removal of a fixed growth. Such patients are referred to radiologists.
3. *Situation.* Cancers situated in organs that are easily accessible at physical examination, especially when the patient is forced to an examination by the presence of a tumor, hemorrhage, pain, or obstruction, usually receive early treatment and this is conceded universally by all to give the best prognosis. It may be stated, therefore, that malignant, or benign tumors so situated as to produce early pain, hemorrhage, mechanical obstruction, or an easily recognizable mass, are more favorable. The relation of organic situation to size and favorability of early recognition may be seen in Table 2 which represents a study of 3,778 cancers of the large bowel, breast, and stomach (MacCarty).

TABLE 2
RELATION OF SITUATION TO SIZE

Situation	Average size, cm.	Largest, cm.	Smallest, cm.
Hepatic flexure	8.94	14	4.0
Cecum	7.8	15	3.0
Ascending colon	7.26	14	4.0
Transverse colon	7.22	14	2.0
Stomach	6.16	19	0.5
Descending colon	6.07	13	2.0
Rectosigmoid and sigmoid	5.94	15	1.0
Splenic flexure	5.9	8	2.0
Rectum	5.8	18	1.5
Breast	3.2	13	0.2

In general it may be stated that the greater the diagnostic and therapeutic accessibility of a growth and the earlier it produces incapacitating signs and symptoms, the better the prognosis.

- 4 and 5. *Renal and cardiac efficiency.* The part which the heart and kidneys play in cancer is similar to that which they play in general health. The lower the cardiac and renal efficiency, the poorer the prognosis, and especially the greater the immediate therapeutic risk.
6. *Anemia.* This condition is associated apparently with two different conditions: reduction of diet and single hemorrhage or constant or repeated oozing from the growth. Perhaps a third condition exists, although it is difficult to prove that it is not one of the two. By this I mean anemia due to a theoretically existent toxic condition arising from the cancer itself, or associated with its disintegration. In general, it may be said that, the greater the anemia, the greater the immediate therapeutic risk and the shorter the life. If, however, the anemia is the result of a single or of recent repeated hemorrhages from the growth, this may not necessarily alter the ultimate prognosis after the growth is removed.
7. *Size of growth.* In my experience, a long enough period has not elapsed since accurate measurements have been made to allow definite conclusions. Information, therefore, must be indirect. It has been established that there is a definite relationship between size of growth and the presence of nodal involvement which in turn has prognostic value. In Table 3 the relationship of size of growth to the presence of nodal involvement may be seen.

TABLE 3
RELATIONSHIP OF SIZE OF GROWTH TO NODAL INVOLVEMENT

Organ	Cases	With nodal involvement, cm.	Without nodal involvement, cm.
Hepatic flexure.....	16	8.55	9.34
Cecum.....	118	7.8	7.8
Transverse colon.....	61	6.85	7.6
Stomach.....	1,002	6.74	5.58
Splenic flexure.....	10	6.4	5.4
Rectosigmoid and sigmoid.....	469	6.04	5.84
Rectum.....	601	5.98	5.63
Descending colon.....	30	5.88	6.27
Ascending colon.....	28	5.6	8.92
Breast.....	1,443	3.92	2.53
Total.....	3,778		

In the first five organs or portions of organs, cancers are usually very large. There is no apparent relationship between size of growth and lymph nodal involvement in these, but in such organs as the rectosigmoid, splenic flexure, rectum, stomach and breast, where symptoms and signs appear early and are more easily recognized, there is a definite relationship. It is fair to state that the larger the primary growth, the greater the possibility of nodal involvement, and hence the worse the prognosis.

8. *Age.* It is the general clinical impression that age has some bearing on the prognosis. Thus, clinical experience reveals that cancer is usually more rapidly fatal to a young person than to an older person. It is very difficult, however, to study this problem statistically because many other factors are involved. If age alone is taken into consideration, there may be still a difference of size, situation, fixation, duration, character of growth and nodal involvement, to say nothing of general factors such as pulmonary, cardiac

and renal efficiency. In a series of 218 patients with cancer of the breast who died of recurrence, Sistrunk and I reported that 41.7 per cent. of those who were more than fifty years of age were alive from five to eight years after operation and that 31.8 per cent. of those who were less than fifty were alive for the same period. These figures confirm the general opinion. On the other hand, in studying the same series in decades we found many variations.

TABLE 4
AGE

Decade of life, years	Units	Postoperative length of life					
		Patients without nodal involvement			Patients with nodal involvement		
		Average	Longest	Shortest	Average	Longest	Shortest
30 to 40	Years	3	4	3	2	4	0
	Months	5	5	0	3	9	5
	Days	19	2	22	16	3	18
60 to 70	Years	2	3	1	2	7	0
	Months	7	9	8	3	1	8
	Days	23	20	22	10	0	5

It appears that no great generalizations should be drawn as to any constant differences in the different decades in this series. I believe that generalizations regarding age alone, when applied to clinical practice, might sometimes be very misleading. I have seen patients less than thirty years of age with cancer of the breast, rectum and ovary, all live more than twenty years after radical treatment. Despite the fairly common exceptions, it is perhaps correct to say that the younger the patient the worse the prognosis, keeping always in mind that all other factors have an influence regardless of age.

9. *Direction of Growth.* By this expression it is meant to denote whether the bulk of the cancerous mass is toward the lumen or surface of the organ or whether it is infiltrating the wall and growing toward adjacent organs or cavities, such as the peritoneal cavity in the case of intestinal cancers or the thoracic cavity in the case of cancer of the breast. Some cancers, especially of the colon and stomach, grow massively toward the lumen, with little or no invasion of the wall. Others do not grow toward the lumen but invade the wall, the serosa, and the neighboring structures. Of the two types, the latter has the worse prognosis. It is more likely to be accompanied by nodal involvement, and may be much smaller than those which grow toward the lumen.
10. *Loss of weight.* There are probably several reasons for loss of weight in association with cancer: quality and quantity of food, mechanical obstruction, pain, worry, and possibly infection and absorption of disintegrating tissues. As a single prognostic factor it is probably of little significance, but taken in association with other factors it adds gravity to any prognosis. It must be kept in mind always that persons who are underweight are usually better surgical risks than those who are overweight.

11, 12, 13, and 14. *Cellular differentiation, lymphocytic infiltration, fibrosis and hyalinization.* Differentiation is undoubtedly important, but not as important as some clinicians have thought. It is of great scientific interest, but in considering its immediate clinical value, one must not forget that there are some exceptions to the general rule that favorability of prognosis is proportional to the degree of differentiation. There can be no doubt that there is some relation between the degree of differentiation of tumor cells and their

rate of growth, but rate of growth is variable even in the same tumor. Size, situation, infiltration, nodal involvement, fixation, lymphocytic infiltration, fibrosis and hyalinization must all be taken into consideration.

TABLE 5
RELATIONSHIP OF PRESENCE OF NODAL INVOLVEMENT AND SIZE

Organ	Cases	Size, cm.			Percentage with nodal involvement
		Largest	Smallest	Average	
Grade 4					
Stomach	55	15	3.0	7.8	85.0
Breast	72	13	1.0	5.4	75.0
Colon and rectum	10	9	5.0	4.4	80.0
Grade 3					
Stomach	67	15	2.5	5.8	62.0
Breast	53	7	1.0	3.25	58.0
Colon and rectum	58	15	3.0	6.1	77.0
Grade 2					
Stomach	25	16	1.8	6.7	12.0
Breast	32	12	0.8	3.4	18.7
Colon and rectum	138	13	1.0	5.6	35.0
Grade 1					
Stomach	1	7	7.0	7.0	0.0
Breast	0	0	0.0	0.0	0.0
Colon and rectum	21	11	1.5	4.9	9.5

A study of Table 6 reveals the value of differentiation, lymphocytic infiltration, fibrosis and hyalinization, all of which cannot be determined without detailed microscopic study.

TABLE 6
VALUE OF DIFFERENTIATION, LYMPHOCYTIC INFILTRATION, FIBROSIS AND HYALINIZATION

Factor	Average length of postoperative life, years		
	Stomach	Breast	Rectum
With lymphocytic infiltration	2.73	2.51	1.57
Without lymphocytic infiltration	2.7	2.48	1.31
With differentiation	2.73	3.65	1.54
Without differentiation	2.56	2.37	1.08
With fibrosis		2.72	1.53
Without fibrosis		1.87	1.29
With hyalinization		2.81	2.33
Without hyalinization		2.21	1.44
With lymphocytic infiltration and differentiation	2.8	3.78	1.59
Without lymphocytic infiltration and differentiation	1.55	2.45	0.71
With differentiation and fibrosis		3.87	1.58
Without differentiation and fibrosis		1.96	1.15
With differentiation and hyalinization		4.0	2.33
Without differentiation and hyalinization		2.04	0.61
With fibrosis and lymphocytic infiltration		2.69	1.65
Without fibrosis and lymphocytic infiltration		1.4	1.17
With lymphocytic infiltration and hyalinization		2.76	2.25
Without lymphocytic infiltration and hyalinization		1.68	1.27
With fibrosis and hyalinization		2.89	2.33
Without fibrosis and hyalinization		2.05	1.28
With lymphocytic infiltration, differentiation, fibrosis and hyalinization		4.4	2.25
Without lymphocytic infiltration, differentiation, fibrosis and hyalinization		1.52	0.76

15. *Duration of disease.* Nothing is more inaccurate and unreliable than the recorded duration of disease in most written histories of cancer. Duration is more important when applied to individual signs and

symptoms, which unfortunately have nothing to do with the type or grade of cancer itself. Signs and symptoms in cancer have to do with size, anatomic situation, mechanical obstruction and hemorrhage. Even pain is usually insignificant unless associated with mechanical obstruction. None of these is diagnostic of cancer, or even prognostic, if treatment can be instituted. Many benign conditions present such signs and symptoms, and may have been present long before cancer has arisen. In other words, it is often impossible to decide or determine the duration of the actual malignant growth in the great majority of instances. As a single prognostic sign it has little value. Inoperable cancers, especially of the stomach and colon, frequently have very short recognizable histories. In general, the duration of the disease is mainly of value taken in conjunction with other factors.

Now before concluding, something practical relative to the frequently used term "biopsy" should be stated:

The term is used ordinarily to mean microscopic visualization of tissue removed during life. Four functions are served by the procedure: differential clinical diagnosis, research, prognosis and the direction of treatment. Of these the first and last are at present of greatest practical importance. Since there are no reliable clinical or serologic tests for the recognition of cancer in its early stages, and since cancer is frequently associated with chronic inflammatory conditions which give signs and symptoms, experience has taught that biopsy is the only means of making a differential diagnosis in many instances. The situation has been made simpler by perfection of surgical technic and by the utilization of pathologists as necessary clinical adjuncts to the practice of medicine and surgery. The risk of removing tissues is almost nothing when it is done by well trained and experienced surgeons. In clinical practice, dealing with attempts to treat cancer in its early stages, the following rules have been of value:

1. Every chronic sore or lump, especially if recently acquired, which does not disappear, or become smaller, or show signs of disappearance after two or three weeks of local treatment (rest, local antiseptic care and general hygienic care) should be subjected to biopsy. It should be excised if possible rather than incised.
2. Tissue for biopsy should not be removed unless the one who removes is capable of performing the radical operation in case a malignant condition is found, or unless he is in close proximity to some one capable of completing the operation.
3. The biopsy should not be performed, as a rule, on small, doubtful lesions situated near epiphyseal lines in children. There are, perhaps, rare exceptions to this rule.
4. Biopsy should not be undertaken if the immediate and ultimate operative risks are greater than the possibility of cancer.
5. Tissue may be removed by incision of the sore or lump, if it is large and if it is thought to constitute a hopeless condition in which there is only a small chance that the lesion is not malignant. Immediate radical operation should follow the diagnosis if experience shows that radical operation will prolong useful life or that it will make even a short life free from lingering suffering; otherwise it is unnecessary.

6. Biopsy may be done by means of surgical exploration of body cavities in which some unrecognizable but incapacitating pathologic condition is known to exist. Differential clinical diagnosis of conditions of the abdomen, bones and central nervous system is becoming more difficult, and experience with surgical exploration shows that many small cancers are being found. In the hands of well trained surgeons, risks of exploration are relatively small. The conservative surgeon is likely to refrain from exploration unless the patient is at least partially incapacitated, unless roentgenologic studies reveal a definite lesion in one of the systems, or unless, even though roentgenologic signs are absent, the patient's incapacity is increasing despite ordinary non-surgical treatment.

Material removed for biopsy is studied best at the time of operation, and in a fresh, unfixed condition. It may be fixed, cut by the frozen tissue method, and stained, or it may be embedded in paraffin or celloidin, cut and stained in the usual manner. The first of these (fresh and unfixed) is the best in the hands of those especially trained in living cytology; fine details of cellular morphology are lost after fixation and embedding, leaving only histologic criteria by which the nature of the specimen can be judged. I feel, after long experience with all methods, that the fresh tissue method gives about 10 per cent. greater chance of recognition of early cancer.

In conclusion, may it be said that progress in handling the cancer problem rests for the present at least on more complete examinations (especially with roentgen rays and biopsy), the recognition of the fact that early cancers do not give symptoms of cancer as described in text books, the general acceptance of the relationship of chronic inflammation to cancer, and the elimination of much if not all of our confused and not universally accepted terminology. If these simple and established facts form an intimate part of the practitioner's system of dealing with all patients, then he will surely discover many early cancers and properly care for the 2,000,000 or 3,000,000 which are now waiting to be recognized. There is no use talking about "early diagnosis" and then expecting to make diagnosis in this stage by signs and symptoms of cancer. The various organizations for the dissemination of knowledge to laymen have done their work well.

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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.

Communicable Diseases Reported by the Medical Health Officers for
the Period Commencing August 21st, to September 21st, 1933

County	Chicken Pox	Diphtheria	Infantile Paralysis	Influenza	Measles	Paratyphoid	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. (Other Forms)	V. D. G.	V. D. S.	Whooping Cough	TOTAL
Annapolis											1			1
Antigonish								2						2
Cape Breton		5	1				2	2				12		22
Colchester								1						1
Cumberland									1					1
Digby								4						4
Guysboro											2			2
Halifax City	7	6			1			19					25	58
Halifax								2						2
Hants					1						3			4
Inverness						4	1				2			7
Kings				5				1		1	2	1		10
Lunenburg														
Pictou														
Queens														
Richmond														
Shelburne													5	5
Victoria														
Yarmouth														
TOTAL	7	11	1	5	2	4	3	31	1	1	10	13	30	119

RETURNS VITAL STATISTICS FOR AUGUST, 1933.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis	17	11	14	6	7	2
Antigonish	8	13	6	4	2	0
Cape Breton	85	73	54	41	24	12
Colchester	26	14	28	7	7	1
Cumberland	34	32	40	13	10	6
Digby	21	10	12	7	7	2
Guysboro	19	10	5	7	2	0
Halifax	109	95	57	76	46	6
Hants	13	17	18	9	6	0
Inverness	19	16	8	8	6	3
Kings	16	14	25	7	5	1
Lunenburg	19	18	21	4	7	2
Pictou	18	33	19	25	17	2
Queens	7	10	7	0	0	0
Richmond	19	11	3	3	6	1
Shelburne	11	9	2	4	4	1
Victoria	8	3	2	1	3	2
Yarmouth	25	32	20	15	22	2
TOTAL	474	421	341	237	181	43

Correspondence

THE following correspondence and the results of an interview with Mr. Bennett, the Prime Minister, by delegates of the Canadian Medical Association are given below.

184 College Street,
Toronto 2, March 21, 1933

The Right Honourable R. B. Bennett, K.C.,
Prime Minister of Canada,
Ottawa, Canada.

Dear Sir:—The Canadian Medical Association is a voluntary federation of the nine Provincial Medical Associations of Canada. In matters of national health interest, the Association endeavours to interpret and reflect the judgment of the medical profession of Canada as expressed in and through the Provincial Associations. At this time, I am desired by the Association to direct your attention to the following points:—

(1) During the present economic crisis, the Government of Canada of which you are the Prime Minister, has recognized its humanitarian responsibilities in providing relief for unemployed workers and their dependents.

(2) In the distribution of relief funds to the provinces, money is available for the provision of food, fuel, shelter, and clothing.

(3) If we are properly informed, the provision of medical care as a charge against federal relief funds, is not admitted.

(4) In our opinion, medical care of those unfortunate citizens who are unable to provide care for themselves, is just as essential as any other provision which has been made.

(5) We recognize that the care of the indigent has long been considered in Canada as a provincial responsibility, but the Government of Canada has recognized, in the present crisis that the provision of such care is a national obligation. This leads us to say that there appears to us to be no good reason why medical care should not be grouped with the other essentials and made available to all the needy of Canada as a proper charge against national funds.

(6) It is not overstating the fact when we say that the present economic situation tends to undermine the health of a very large number of our people, which fact must be construed as possessing the possibilities of a national menace. This is the time when every effort should be put forth to protect and preserve the national health. One very important step in this programme of protection should be the provision of medical care to all the people who need it.

(7) It is our understanding that, at the recent Dominion-Provincial Conference, it was recommended that medical care should be included under the Act providing national relief, which clearly indicates that the provinces have gone on record as approving of federal intervention into this phase of provincial health activities.

(8) Broadly speaking, hospitalization of the indigent at the expense of the province, or the municipality, or both, is apparently working out with reasonable satisfaction. It is, therefore, not suggested that this should be altered, or that additional federal funds should be provided for this service.

(9) One of the crying needs of the moment throughout Canada is the provision of adequate medical and nursing care to be carried out as far as possible in the homes of the unemployed, thus preventing, to a great extent, (1) human suffering; (2) human wastage; and (3) subsequent hospitalization at very much higher costs.

These are days when every self-respecting, self-sustaining citizen realizes his responsibility to the full amount, and there never was a time in the history

of the nation, when it was more evident that the strong must bear a larger share of the burdens of the weak. The medical profession of Canada desires to go on record that it is endeavouring to the best of its ability to live up to the ideals and traditions of the profession in doing its share towards alleviating distress. There is a limit, however, to the giving powers of any individual, and the medical profession should not be expected to carry more than its reasonable share of the load of health protection. Most respectfully, Sir, do we urge that your Government should make provision at the earliest possible date, for the inclusion of medical care as a part of relief expenditures which are being provided for the several provinces of Canada.

All of which is respectfully submitted,

(Sgd.) T. C. ROUTLEY,
General Secretary.

OFFICE OF THE PRIME MINISTER, CANADA

Ottawa, 24th March, 1933.

Dr. T. C. Routley,
General Secretary,
Canadian Medical Association,
184 College Street,
Toronto 2, Canada.

Dear Sir:—I have your letter of the 21st, with respect to medical attention being provided for the needy during the period of depression.

I am bringing your communication to the attention of the Minister of Labour.

As you are, of course, aware, the actual administration is carried on by the Provincial authorities, and the Federal Government makes contributions to enable the Provinces to fittingly discharge their obligations.

You will be further advised in due course.

Yours faithfully,

(Sgd.) R. B. BENNETT.

184 College Street,
Toronto 2, October 5th, 1933.

The Right Honourable R. B. Bennett, K.C.
Prime Minister of Canada,
Ottawa, Canada.

Dear Sir:—Acting upon instructions of the Canadian Medical Association, which body represents the organized medical profession of Canada, we appear before you to-day.

Most respectfully, Sir, do we desire to direct your attention to the following:—

(1) The Government of Canada is recognizing and discharging an honourable and humane obligation in providing funds out of the national treasury, to the Provincial Governments of Canada, to extend relief to unemployed citizens and their dependents who are in need.

(2) If we are properly informed, relief expenditures have been set out by your Government to include food, fuel, shelter, and clothing, but do not include medical care.

(3) On March 21st, we wrote you, urging that medical care be included in unemployment relief. (A copy of the letter is attached to this memorandum).

(4) On March 24th, you replied stating in part that "The Federal Government makes contributions to enable the Provinces to fittingly discharge their obligations." (A copy of the letter is attached to this memorandum).

(5) The Provincial Governments of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Prince Edward Island have advised the Canadian Medical Association that, in their opinion, medical care is an obligation which should be included in unemployment relief.

(6) The above mentioned Provincial Governments have further advised the Canadian Medical Association, that if permission were granted them by the Federal Government, to include medical care in the list of relief provisions to which the Federal Government is contributing a portion of the cost, such care would be provided.

(7) The medical profession always has given freely of its services to those unable to pay for such services. But there comes a limit, beyond which any citizen, doctor or layman, finds himself powerless to proceed in giving of his time or money.

(8) At the present time, the medical profession, in some parts of Canada, have reached the point where they cannot further supply medical care gratuitously to persons on relief. The profession, however, adhering to its ideals and traditions, and having in mind that its first duty is the protection of the public health, will gladly undertake to contribute, by way of service, one half of the cost of such care during the present emergency; and would respectfully suggest that the other half of the cost of their professional services be assumed by the State.

May we summarize:—

- (1) The Federal Government is providing relief funds to the provinces.
- (2) Such relief funds are intended to assist each province to fittingly discharge its obligations.
- (3) The provinces have stated that medical care is an obligation and that the Doctors should not be asked to contribute their services gratuitously, thus carrying the entire cost.
- (4) The Doctors are willing to contribute one-half of the cost during the present emergency by accepting as their fee, half the established tariff rate for their Province.
- (5) The Provinces are willing to pay one-half the cost of medical care if the Federal Government will permit national funds to be used for the purpose on the same basis as such national funds are being used to pay for food, fuel, shelter, and clothing.
- (6) Most respectfully, Sir, do we ask that your Government approve the addition of medical care to relief provisions and that the Provinces be so advised at the earliest possible date.

All of which is most respectfully submitted on behalf of the Association by,

G. A. B. ADDY.
E. S. MOOREHEAD.
D. S. JOHNSTONE.
F. C. NEAL.
L. GERIN-LAJORIE.
T. C. ROUTLEY.

CANADIAN MEDICAL ASSOCIATION CONFERENCE WITH PREMIER BENNETT OTTAWA, FRIDAY, OCTOBER 6, 1933

The following constituted the delegation from the C. M. A.:

DR. G. A. B. ADDY.....	Saint John.....	President, C. M. A.
DR. L. GERIN-LAJORIE.....	Montreal.....	Repres. Quebec.
DR. F. C. NEAL.....	Peterboro.....	Pres. Ont. Med. Assoc.
DR. E. S. MOORHEAD.....	Winnipeg.....	Repres. Manitoba Med. Assoc.
DR. D. S. JOHNSTON.....	Regina.....	Repres. Sask. Med. Assoc.
DR. T. C. ROUTLEY.....	Toronto.....	Gen. Sec. C. M. A.

The delegation presented to the Prime Minister a document setting forth their position (see copy attached). Each member of the delegation spoke to the petition. The Prime Minister replying made the following observations and statements.

1. While I have every sympathy with the point of view you have expressed, you really have no contact with me; the matters you have presented are strictly the business of the provinces.
2. I am fully aware of the necessity of proper medical care being provided all people on relief but must insist that this is an obligation resting upon each Provincial Government.
3. I am in entire accord with the argument that the medical profession should not be asked to carry the load of providing the necessary medical relief.
4. I shall advise each province that it should undertake to provide medical care, to pay the cost of same and in the event of the province doing this and submitting its cost figures to the Federal Government, sympathetic consideration will be given by the Federal Government to sharing the cost of such medical care according to the merits of the case presented by the province.

In the opinion of some members of the delegation, Mr. Bennett implied that the Federal Government would pay part of the cost of medical care where it was shown by a Province that it couldn't afford to pay the cost.

Seeing that various provinces have different needs, he would not tie himself to assist by any percentage or proportion of the funds expended.

5. The Prime Minister advised the Committee that the position of the Federal Government in the matter would be made very clear to each Provincial Government and further that the Canadian Medical Association would be advised as to what was being said to the provinces.

6. It was pointed out to the Prime Minister that the delegation were under the impression, after conversations with some of the Provincial Governments, that the Federal Government had prohibited the utilization of Federal funds for medical care. The Prime Minister stated that the Federal Government had at no time forbidden the provinces to expend money for medical care but that the Federal Government had set out specifically that they were supplying funds and had stated that these funds could be utilized in providing food, fuel, shelter and clothing. On the foregoing items, the Federal Government has committed itself to a definite proportion of the total cost but the Federal Government is not prepared to commit itself to any proportion of the cost of medical care as a blanket policy covering the provinces as a whole. It should be repeated, however, that the Federal Government has no desire to see any province disregard its responsibility in respect to medical care but, on the contrary, looks to each province to provide such care and if the province needs financial aid in respect to medical care, the Federal Government will not expect any province to carry the burden in this respect beyond reasonable limitations.

7. The interview lasted one hour. It was the consensus of opinion of the delegation that the Prime Minister of Canada shared completely our point of view with respect to the care of the people and the necessity of the doctor being paid, at least in part, for the services which he must render but it is up to each province, through its constituted authorities, to discharge this obligation, both to the people and to the doctors and when this is done, to look to the Federal Government for such assistance as can be proven is needed by the area concerned.

184 College Street,
Toronto 2, Oct. 10th, 1933.

Doctor H. G. Grant,
Secretary,
Nova Scotia Medical Society,
Halifax, N. S.

Dear Doctor Grant:—

On Friday, October 6th, a delegation from the Canadian Medical Association was received by the Prime Minister of Canada, the purpose being to discuss the question of medical care of unemployed persons and their de-

pendents throughout Canada. Our representations were made in the form of a document, as per copy herewith enclosed. Each member of the delegation spoke briefly to the petition. At the close of the conference, the delegation jointly set out their understanding of it, as per copy herewith enclosed.

The position of the Prime Minister of Canada in the matter might be epitomized as follows:—

1. Medical relief to the unemployed and their dependents must be available.
2. The doctor must not be asked to carry the load.
3. It is strictly the obligation of the provincial government to provide the necessary care, and each province will be very specifically reminded of this by the Prime Minister.
4. Any province which pays for this care and then can prove to the Federal Government that the burden is too heavy to carry, may expect money in aid from the Federal Government.

In the opinion of your delegation, the conference was exceedingly worth while and we now feel that the air has been cleared and confusion in the matter can no longer be said to exist. It is strictly the business of each provincial government to get busy and do the correct thing under the circumstances.

If there is any further counsel or advice or information which you require please do not hesitate to write us. We are most anxious to assist in any way within our power. I shall be glad to be advised from time to time what progress is being made in your Province in working out any scheme which the Medical Association may think necessary and desirable.

Yours faithfully,

T. C. ROUTLEY,
General Secretary.



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Personal Interest Notes

DR. F. G. BANTING, Canadian Professor of Medical Research at the University of Toronto, will attend the Cancer Congress to be held in Madrid.

Dr. Owen Stanley Gibbs, British Medical scientist, who with his "Rubber heart" has successfully kept alive an animal from which the natural organ had been removed, for three and a half hours, has joined the faculty of the Georgetown University school of medicine, and will, with his transfer from the University of Georgia, continue his experiments in Washington. Dr. Gibbs was formerly Professor of Pharmacology at Dalhousie University.

The wedding took place at St. Thomas Aquinas Church, Halifax, of Mary Barbara, daughter of Mr. and Mrs. Norman A. Currie, and Dr. Bernard F. Miller, son of Dr. and Mrs. Alexander W. Miller of New Waterford. Dr. Cyril Miller of the staff of St. Francis Xavier University, and a brother of the groom, officiated at the marriage. Dr. Arthur Lister Murphy attended as best man, and Mr. Clive Currie and Dr. Clarence Bethune attended as ushers. Dr. and Mrs. Miller will take up residence in New Waterford where Dr. Miller is practising.

Dr. J. G. Fitzgerald, Dean of the Faculty of Medicine, University of Toronto, leaves Toronto on October 15th to attend the meetings of the International Health Board in Geneva.

Dr. A. J. MacDonald who has been on the staff of the Halifax Infirmary will shortly open an office at New Germany.

Miss Frances MacLennan, daughter of Dr. S. J. MacLennan of Halifax, has been appointed to the staff of the Halifax Ladies' College. Last winter Miss MacLennan taught in New Brunswick, and there is gratification at the fact that she has accepted a position in her "home" city.

At the annual meeting of the Medical Council of Canada held at Ottawa September 6th, Dr. R. H. Arthur of Sudbury, Ontario, was elected President, succeeding Dr. W. A. Thomson of Regina, and Dr. H. B. Atlee and Dr. C. S. Morton of Halifax, members of the Governing Board.

Dr. Gordon A. Winfield, a graduate of Dalhousie, has returned to Halifax, and established an office on Barrington Street. Dr. Winfield has just completed post-graduate work at Akron and Cleveland, Ohio; also at Montreal.

Miss Evelyn Burns, daughter of Dr. and Mrs. A. S. Burns of Kentville, has left for New York where she will take a four-year post-graduate course at Teachers' College, Columbia University.



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Dr. A. F. Miller, Medical Superintendent of the Nova Scotia Sanatorium, accompanied by Mrs. Miller recently visited Pictou and Sydney, where he addressed the Medical Societies on Tuberculosis.

Victoria, B. C.—Payment of \$10.00 per month to doctors as nominal remuneration for treatment of relief patients, effective August 1, has been approved by city council.

Miss Shirley Bruce, daughter of Dr. and Mrs. James Bruce of Sydney has left for Montreal to enter the Royal Victoria Hospital as a student nurse.

Dr. A. L. McLean, a former graduate of Dalhousie University, who afterwards took the C. P. H. from Johns Hopkins University and has spent the last four years as Director of the Henrico County Health Department, Virginia, is here as assistant in Preventive Medicine, and also Epidemiologist to the Provincial Health Department.

Dr. Frank Hebb of Liverpool has been appointed Medical Health Officer for the town.

Dr. and Mrs. R. M. Benvie of Stellarton recently visited Wolfville accompanied by their son, Robert, who entered Acadia University.

Dr. and Mrs. A. Fraser McGregor of New Glasgow were recent guests at St. Andrews-by-the-Sea, to attend the wedding of Mrs. MacGregor's brother, Mr. Anderson of Montreal.

Dr. Catherine Whittier, returned Missionary from India, and her sister, Dr. Jean Whittier of Toronto, have recently visited our Province. Dr. Catherine after five years in India was home on her first furlough while Dr. Jean is taking a preparatory course in Toronto for missionary work in a Foreign Field.

Dr. and Mrs. Bernard Chaisson of Eel Brook, Digby Co., were recent visitors in Cape Breton.

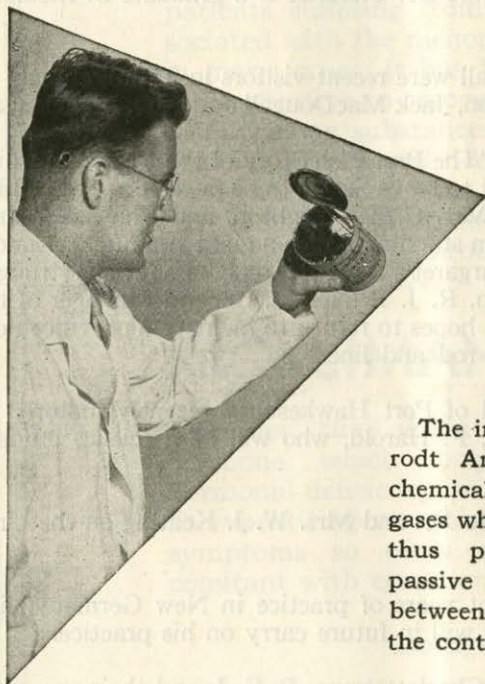
Dr. N. H. Gosse of Halifax recently addressed the Women's Institute of East Hants on the subject of Cancer Control.

Dr. J. Arnold Noble, F.R.C.S. (E.), has opened office at Coburg Road, Halifax. Dr. Noble is a son of D. A. Noble, formerly of Sydney, and now of Moncton, N. B.

Dr. Laura Ward of Frederick, Maryland, recently visited her mother and sister at Halifax.

The wedding took place on September 21st at eight o'clock at the United Church, Imperial, of Miss Elsie Irene, daughter of Mr. and Mrs. Albert Swimimar of Woodside, and John Alexander MacKay, son of Dr. M. H. MacKay and the late Mrs. MacKay of West Bay, Cape Breton.

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Clarence Gosse, son of Dr. N. H. Gosse, Spring Garden Road, Halifax, left recently for Saint John, N. B. Mr. Gosse has for the past six months been an inspector for the Retail Credit Company, and through his ability won promotion to the Company's office at Saint John.

Three well-known young people of Halifax left recently on the "Westernland" to pursue their studies in London, England. They were the Misses Mabel and Frances Morrison and Dr. Clarence Morrison, children of Dr. and Mrs. M. D. Morrison, Robie Street. Miss Mabel is a Ph.D. of the University of Toronto as well as an M.A. of Dalhousie; Miss Frances is a Bachelor of Music of Dalhousie University; while Dr. Clarence is a graduate in Medicine from the same institution.

Dr. and Mrs. J. G. MacDougall were recent visitors in Truro, enroute to Wallace, where they visited their son, Jack MacDougall and Mrs. MacDougall.

Mayfair publishes a picture—"The Best Fish Story of the Year," in which Dr. T. M. Creighton, who came out to Nova Scotia to be present at the Golden Wedding of his parents, Mr. and Mrs. C. E. Creighton, and who has a large practice in London, England, is seen standing beside a giant tuna (600 pounds) caught with hook and line in St. Margaret's Bay after an hour's furious struggle. Seated beside him is his companion, R. J. R. Nelson, General Manager of the Halifax Shipyards. Dr. Creighton hopes to return to his native province next year and try his luck again with rod and line.

Dr. and Mrs. J. R. MacLeod of Port Hawkesbury recently motored to Halifax accompanied by their son, F. Harold, who will be a science student at Dalhousie this term.

Congratulations are extended to Dr. and Mrs. W. J. Keating on the birth of a daughter on August 21st.

Dr. Samuel Marcus after eight years of practice in New Germany, has removed to Bridgewater, where he will in future carry on his practice.

Dr. and Mrs. W. H. Soper of Charlottetown, P. E. I. and their son, were recent visitors in Halifax.

Rev. Father Stone recently officiated at the marriage in the Presbytery of St. Thomas Aquinas Church, Halifax, of Gertrude Elizabeth, daughter of Mr. and Mrs. R. A. Wood and D'Arcy, son of Mrs. Sullivan, Rosebank Avenue and the late Dr. M. T. Sullivan, of Glace Bay, the wedding being a very quiet one, and bride and groom unattended.

L. D. Currie, M.L.A.-elect, Glace Bay, and the Rev. H. G. Wright, Inverness, attended the second biennial convention of the Canadian Hospital Council at Winnipeg, September 7th. Mr. Currie addressed the Convention on Hospital Legislation, and the Rev. Wright discussed Nova Scotia's Experience with Tuberculosis.

It is true, indeed, that excellent results have been reported following the use of **SISTOMENSIN**, "CIBA" in patients suffering from disturbances associated with the menopause. However, in many cases, it has been found much more effective to associate with the ovarian hormone substances capable of suppressing immediately certain of the more distressing symptoms, thus rendering the patient comfortable until permanent relief is afforded through the influence of **SISTOMENSIN**.

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Miss Ruth Macaulay, daughter of Dr. and Mrs. M. A. Macaulay, of Halifax, will spend the winter at Sorbonne in France.

Dr. J. L. MacMillan of Westville, accompanied by friends recently spent the week-end at Lake Ainslie, C. B.

Dr. and Mrs. A. F. Weir of Freeport were recent visitors in New Glasgow and Westville.

Mr. John Lynch, son of Dr. and Mrs. J. G. B. Lynch of Sydney, has left for Montreal to resume his studies in Medicine at McGill University.

Dr. Hugh Alexander Stuart of Sydney, Fellow in Surgery at the Mayo Institute, Rochester, Minnesota, has been appointed in charge of sixteen Fellows at the Mayo exhibit in the World Fair at Chicago. Dr. Stuart and his comrades were chosen for this work from a field of one hundred and sixty Fellows engaged at the Minnesota Institute.

Dr. A. A. MacDonald, a native of Heatherton, Antigonish County, who has successfully practised his profession for years at Dorchester, Mass., retired from active work recently, and is now at St. Martha's Hospital, Antigonish.

That Bird, The Frog.—The following extract is taken from a boy immigrant essay on frogs: "What a wonderful bird the frog are. When he stand he sit, almost. When he hop he fly, almost. He ain't got no sense, hardly. He ain't got no tail either; when he sit, he sit on what he ain't got, almost."



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