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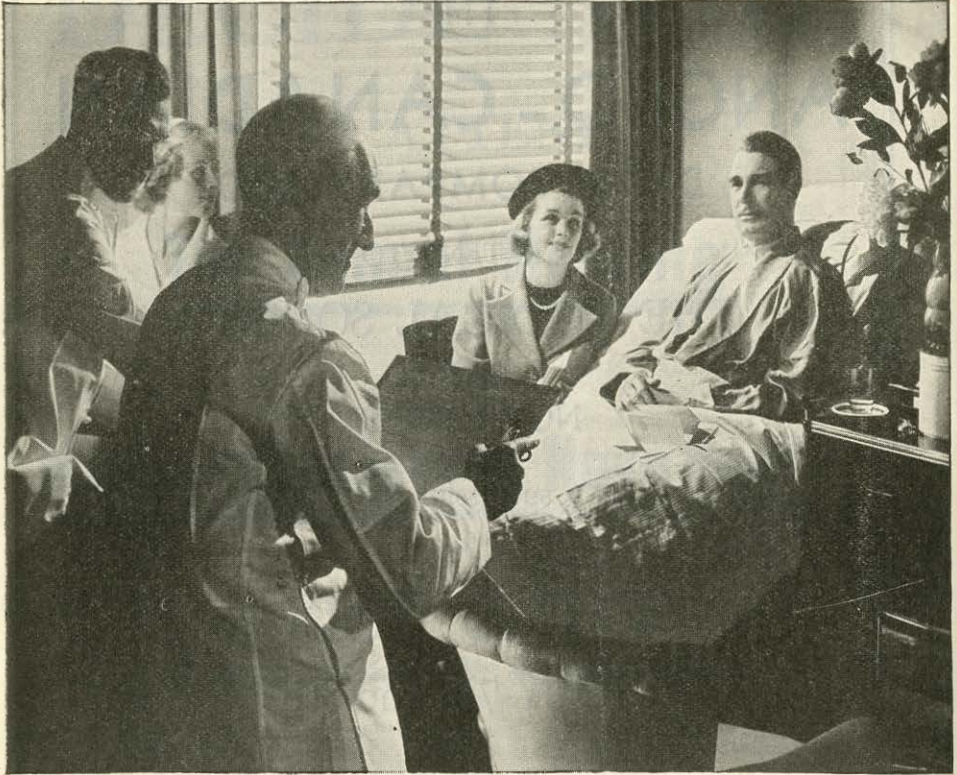
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The Physician in the Modern World

CLARENCE G. CAMPBELL

IN this age the tempo of change is quickened beyond measure. Time ever corrosive etches new patterns into human institutions dissolving old landmarks which we had thought to be permanent, at least for our day. The consequent blurring of outline and apparent flux and confusion confronts us with paradox on every hand; crying need when productive capacity is almost unlimited, recurring threats of war when peace may be a condition of survival, regimentation of thought when we are prepared as rarely in the past to profit by leisure, the gift of political stability and economic liberty.

Whatever may be the pathology at the root of the current sickness of human society, it remains hidden. The catch-words of contemporary leaders may stir our emotions but their facile generalizations too often confuse when they do not betray us. One may point to immoral finance capitalists, or teach that the middle classes are strongest in a society built on a Jeffersonian base and in this connection speak of the increasing monopoly of land, or blame industrialism which grew out of a demand for luxuries and has resulted in a shift in emphasis from property which should be qualitative and sessile to money which is fluid and unstable and can only be expressed quantitatively. But the symptoms are many and the wide variety of apparently irrelevant data further confuses the clinical world picture. We have no technique that will probe and illuminate the Dadaism of modern times and we may remind the extremists that when diagnosis is obscure palliation may be the wisest treatment.

An increasing orientation toward the economic side of life may be observed. At least in democratic countries legislation is formulated with especial consideration to the interests of business men and the executive must serve, though perhaps not too openly, the profit motive. So when we consider the background of the medical profession it is not surprising that the doctor in a business man's civilisation should stand in a position of peculiar difficulty. In a sense he stands apart from the industrial movement. He has contributed few of its key machines. He serves none of them. He knows as few men are privileged to know that in serving the modern passion for comfort industrialism has failed to safeguard health or provide security for the majority. He has seen centripetal tendencies in industry create appalling sanitary conditions. He watches the pace of living speed up until urgency and tension wear out the body make thinking difficult and spiritual invulnerability impossible. The doctor knows how poor in human values modern institutions may be, but he also may hope. His biological outlook permits him to concede that unrest and violence may arise not from the opposition of civilisation to nature but rather that through civilisation the real capacities of nature have as yet found but partial and inadequate expression. The physician has deeper roots in the past than the bourgeoisie. In the chaotic medley of sounds and voices the blind rushing to and fro he may preserve a measure of detachment and remember that he has known quieter and more spacious days. But he is not

unaware, as the commercial man may be, of social injustice. He has seen that inequality of opportunity and privilege is inextricable from the tissue of the past and he will not be surprised by the misery and madness of things to come.

All this the doctor knows and more. He is acutely conscious of his economic weakness. His peculiar training, because time is considered in terms of money, is a capital investment on which he may never secure an adequate return. He must be a business man, particularly vulnerable to the attrition of competition since unethical competitors lack unbusinesslike scruples, a merchant who cannot advertise or otherwise stimulate his market a salesman of goods which are sometimes unmarketable but which may on occasion be of inestimable value. There is no equation to correlate medical services and money. When the physician is able to change the direction of a disease process which would otherwise be irreversible his services are beyond valuation. On the other hand when he may only stand aside in the presence of pathology, reversible or irreversible, what can one say of price? One modern cliché "Time is money" expresses tendencies that impinge with great force on the physician. He is not found giving even lip service to its barbaric complement "Life is cheap". He is a worker who may not know the bargaining power of the closed shop yet must maintain upper middle class standards of living, he is a child in the jungles of finance (with some notable exceptions), an overcapitalised business man with no organisation to regulate competition and make it profitable and above all one who is constantly striving to diminish his own market. Can there be any doubt that the doctor is one of the most insecure of men?

The medical man is the meeting place of opposing influences. The essentially personal nature of his services are with difficulty considered in their physical aspect alone. The merchant may pass on goods unchanged, the banker may collect interest for the exploitation of time, the soldier may sell his blood to the highest bidder or pour it out freely for an ideal but the physician is none of these. Like the priest he is in a sense a man apart. Like the churchman he is woven with particular intimacy into the fabric of human suffering and lacking the ideological direction and practical backing of a great organisation his outlook is consequently sharply individualistic. And this may be at once a source of weakness and of strength. On the one hand it makes for independence of judgment, enhances the richness of his human contacts and makes him value his humane and liberal traditions. On the other hand individualism is a source of economic weakness, it clashes with the trends of the times, it may be impossible when the political forms now in embryo are delivered from the womb of the next world war.

It is plain that many adjustments may be necessary before the medical profession will be in harmony with a changing world; and these new relationships can only be worked out in the forum of the medical society. And here is a model for the state itself. Free from the pressure policies of lobbyists, from the sectional interests that paralyse parliaments, a school for the free expression of opinion, a unit closely knit by bonds of fellowship that are forged by common ideals the medical society is a unique and powerful focus for the doctor's efforts as a group. What shall be his position when the dominant collectivism of today becomes the tyranny of tomorrow, from Left or Right? Will he find strength in union and be heard, or remain divided and inarticulate then as now, to be dictated to or liquidated as more realistic powers may dispose? Only in his society can the doctor hope to find an answer. Again his position

although tactically weak is strategically strong. For although there may be an especial stringency to economic facts, as long as pain remains king of the body there will be work for him to do.

In this grim century the voice of youth is speaking with great insistence; and the destiny of the medical profession must be shaped to a large extent by those about to enter the field. Since one may regard the doctor as a commentary on the medical school let us examine some of the influences to which he is subjected in the formative period when he approaches the problems of the body without prejudice, eager to understand.

From the application in the monasteries of quantitative methods to the measurement of time, from the establishment by Copernicus of space as a system of magnitudes, and from the union and co-ordination of these categories with motion arose the world picture of modern science. Mechanism now appeared to fulfil the need for a new definition of reality. Combine with this the rationalisation of anatomy and the utilisation of experimental methods that were to clarify the new theories of function and the stage is set for that brain child of a materialistic age, the body as a machine and its corollary, the physician as an engineer to see that it runs efficiently. It is no coincidence that this early age which knew the iatromathematical medicine of Borelli and Sanctorius saw also foreshadowed, though not always in practical use, the steam engine, the threshing machine, the power loom and dredge, the air pump, barometer and pendulum clock. This triumph of the dehumanising power of applied mathematics was made somewhat conditional by the biological discoveries of the latter half of the 19th century which restated with convincing emphasis the evidence that links man to the rest of the organic world.

It is inevitable therefore that medical education should be heavily charged with the scientific atmosphere. A mere brush with the humanities is followed by long hours with dial readings and equations with graphs and formulae and when this data is imperfectly co-ordinated it cannot be assimilated and much of it is but remotely related to the problems of the doctor. True, fascination lies here and discipline too, but the physician is not one who must read the galaxy or seek its microcosm in the atom. He is primarily a biologist, a student of man and the pattern of his relations to other creatures in the web of life. Habits of careful observation determine clinical method not abstract calculation. Consider the naturalists in medical history—Withering, Hunter, Sydenham, Charcot, MacKenzie—the list is long and distinguished.

Soon the student is found in another laboratory, the great city hospital. The young surgeon learns more about vivisection and the young physician reads another chapter in the book of experimental method. He watches the specialists piece together a patch-work quilt of data and wonders what he may be able to accomplish alone and away from all this. He acquires practical technique and learns that the pathologist has the last word in questions of diagnosis. He takes the final hurdle of examinations, a rather unscientific scientist, his lore a pot-pourri of modern instances seasoned by the wise, and is ready for a career. His art he has yet to learn, and it is to his credit that he succeeds so often and so well.

All might be well were we unchallenged. But for the laity it is only a step from questioning the intellectual powers of medical men to doubting their ability to give good service. Hence the growth of the cults and the demand for specialists. For is not the need for the specialist and the success of the cult

a confession of weakness? Of course some forces operate that are beyond the doctor's control. As the pioneer linkage to the land of an earlier day becomes more tenuous and increasing industrialisation tends to shatter the unity of the middle classes and fuse its elements with the capitalist and working groups the family itself is weakened as the base of communal life, and from this disintegrating influence the family physician cannot escape.

Again the acquisition of especial techniques requires time and careful training. The master craftsman in wood or metal might call this overemphasis, but the fact remains that there will continue to be an irreducible field that is the province of the specialist for technical reasons.

Other arguments that attempt to justify the trend toward specialisation are more specious. One hears much about the magnitude of the field. If we include the experimental techniques, the confused interpretations and the many statistical studies based too often on a poverty of instances: if we mean by the field all the medical fashions of the moment then indeed it may be difficult to assimilate. But the amount of wheat in all this chaff is unfortunately small indeed.

Some are enthusiastic about the efficiency of the group approach to disease problems and speak of the need for rationalisation in medicine as in industry. But here we have no blue-print for the organisation of medical services. The analogy must be inexact. Rationalisation in industry is efficient because each contributor to a process is assigned a clearly defined task with which he is familiar and the relationship of which to the whole is obvious; moreover the end result is well known from the beginning and is under the control of expert management. Nothing like this is possible in medicine since we are not dealing with distinct and sharply defined diseases but with people who are ill, an entirely different matter. A group of specialists resembles a department store well stocked with varied and excellent wares, but the patient a prospective buyer does not know what he wants nor does he know whether it is to be found in the store at all or not; and there is no one to tell him. Should anyone presume to believe that the internist could direct the patient with certainty and endeavor to co-ordinate the separate functions of a group of specialists let him compare over a period of time the diagnoses on hospital records with the corresponding necropsy reports.

Narrowing and strict delimitation of experience may result in wiser judgment and in better appreciation of the problems of a restricted segment of the medical field as long as medicine remains so largely empirical. But this is true only if such peculiar knowledge is superimposed on a base of wide familiarity with general pathology.

The trend however is obvious, the laity demands and the schools conform, the rank and file of the profession gives encouragement and the specialists themselves are not heard in protest. Specialism has economic implications, it becomes the goal of the enterprising, it becomes a criterion of aptitude for teaching and leads to the curious spectacle of a sort of hierarchy in which those with the narrowest interests command the greatest prestige. If the growth of specialism has its roots in the incapacity of general practitioners and this inadequacy can be traced back to an education moulded and determined by specialists have we not a wheel that may yet come full circle?

But the past cannot be recalled, the present is elusive and what shall we say of the future? It may be that a fuller sense of our limitations would not be amiss. To one of inquiring frame of mind how marred with artifacts the

most familiar of our conceptions turns out to be if we probe deeply. Can anyone maintain that our management of eclampsia or hypertension is rational therapy or may be until we are permitted to see these conditions more clearly? Perhaps we should realise that an inherent reversibility in most disease processes allows a large part of our therapeutic efforts to be fruitful. Again, despite notable triumphs we must recognise the strange sterility of mass attacks on disease problems, despite expensive equipment and selectively trained personnel. It may be that the energy consumed in organisation and executive detail is largely wasted or it may be too much to expect of the research worker assigned to days of patient fact finding in a limited field that he should have that larger outlook and illuminating insight which has been indispensable in the past. When we consider the use of ox liver in night-blindness by Hippocrates we are reminded that many of our values have not so much been created in our day as that they have been rediscovered and adapted to the pattern of the present. Consider the complex and kaleidoscopic pathology of disease in the individual and the emergence of a varying element of this background into consciousness as symptom, or to clinical accessibility as physical sign. When we realise that it is usually impossible to predict the static necropsy picture from the dynamic formula of active pathology; when the morphological matrix of so many syndromes is as yet entirely unknown, should we wonder that our exquisite diagnostic techniques are so strangely blind? Or that functional tests are sometimes misleading when the true inwardness of function itself remains hidden? We have perhaps too often in the past mistaken co-incident or successive phenomena for cause and effect and may be in need as seldom in the past for more than patient fact finders.

We hear much of preventative medicine and gratefully acknowledge priceless victories. But it may be that our efforts along these lines will be more fruitful when we are permitted to see more clearly the physiognomy of disease itself. It might be wiser to postpone commitment to issues that are cloudy. The clamor for eugenic sterilisation when geneticists are uncertain; the certainty that control of the environment will eradicate tuberculosis; the temerity of those who venture to add death itself to the sensory appeasement and merciful short circuits of the morbid state. We should be aware that the systems of the day do not necessarily sum up the wisdom of the ages. The endocrine complex, the question of avitaminosis, the current orthodoxy in infant feeding, the light from Vienna—all this and much more we are so sure of, the evidence appears to be so cogent; yet who may predict the terminology of tomorrow.

The future of preventative medicine may depend to some extent on progress in the theory and practise of the social sciences, and many things outside the daily round touch the doctor intimately. The need for a safer motor car (I think the door handles would be a good place to start reform) and for a highway adapted to the motor age, the abatement of industrial hazards, slum clearance and the growing necessity for mental hygiene are but a few things about which it is difficult to keep silent.

One may discern amid the uncertainties of the present an increasing trend toward government interference in the affairs of the citizen and this paternalism has been seen to culminate in the befuddlement and savagery of the so called totalitarian state, it's color incidental. The factors which are producing this change are impinging heavily upon the present status of the medical profession. The economic weakness of the doctor is becoming more acute and a great proportion of the public are deprived of the privilege of choosing

the quality of service that they desire. From this dilemma there may be no escape except in surrender to the state; and to many it would seem than an alliance can be worked out that would be of benefit to all. But let us remember that the good doctor will still be revered long after society has ceased to revolve around the axis of the money making question. And let us be certain that as a body the medical fraternity shall have a large measure of influence in shaping the details of such an arrangement so that our splendid heritage shall not be wasted and that in the future as in the past our name shall be honored for integrity and loved for unselfish service.

NOTICE

Those who plan to attend the annual meeting are advised to make reservation immediately as the Lobster Carnival at Pictou Lodge is being held at practically the same time. This may be done through the Secretary or by writing Mr. John O'Dowd, Care of the Nova Scotian Hotel, Halifax.

Vomiting of Pregnancy

T. W. MACLEAN, M.D.,
Scotsburn, N. S.

EIGHT or ten years ago the writer had some interesting experiences with cases of vomiting of pregnancy, which responded surprisingly to sedative treatment. Some of these cases had been quite serious and alarming, others were very mild but almost all of them, even the ordinary nausea of pregnancy, were relieved gratifyingly.

The treatment used was simply a mixture of Bromides, Chloral, Hyoscyamus and Cannabis Indica. The series of cases was small and no very definite conclusions could be drawn, but the results were so pleasing that I ventured to report the matter at the Pictou meeting seven or eight years ago and published a little account of it in the BULLETIN.

Afterwards I was told, by those who had had much more experience, that I was on the right track, but that it would not work in toxic cases. This seemed to be a reasonable way of looking at the matter, and although some good reports came in from various other sources, gradually my enthusiasm waned.

A couple of years later Dr. Goodal of Montreal was giving us a lecture on things of that nature ending his paper with these words, "I can interrupt *any* case of vomiting of pregnancy by blocking the para-sympathetic nervous system with phenobarbital, sodium amytal or a variety of other drugs." To me these were brave words and contained just the reassurance I had been looking for, so I hied me home looking for the world's most toxic case of vomiting, wishing to try my prentice hand on same.

The case was a surprisingly long time turning up and I had almost forgotten about it when, after a year or two, I was called one morning and there was just the case I had been looking for, right before my eyes! She was naturally a poor, shabby, little scrap of a woman with a muddy complexion, scarcely able to keep going herself without trying to support another life. She had vomited practically everything she had swallowed for three weeks and now was a most wretched looking wisp, with a rapid pulse, dirty, dry, brown tongue, sick looking colour and a herpes broken out over the side of her face.

In hospital, instead of relying on intravenous or any other method we thought it would be a good opportunity to try sedative treatment. The sedative used was that preparation of Parke, Davis and Company, called compound cerebral sedative, containing bromides, chloral, hyoscyamus, cannabis indica, and a little morphine. She was, of course, not able to retain the medicine by mouth so four times the usual dose was given by bowel in a little saline and repeated every four hours. In the afternoon the nurse asked me to see her again as she was worried about her strange appearance, thinking something serious was going to happen. Her appearance was strange, but she was just thoroughly and completely "doped". She would open her "dopey" dreamy eyes and answer in such a slow, sleepy way when roused, but she would always answer in some kind of a way, and every time we roused

her we gave her something to drink and everything she drank stayed down. The nurse was instructed to adjust the dose of medicine, and the interval of administration so that she would stay in that sleepy, dreamy state for a couple of days, and to rouse her frequently for nourishment. She must have had a great time doing nothing but sleeping and drinking after her three weeks vomiting.

She was then allowed to waken up and for a few days was given small doses by mouth. There was no more vomiting so she went home, with instructions to take small doses if nausea should recur.

Things went along all right for three weeks, when the vomiting recurred about as violently as before. I gave her one dose by bowel and told the old lady who was looking after her to give her another in the evening. She had another big sleep and was feeling better when she awakened.

For the rest of her pregnancy she got along with an occasional dose by mouth when the warning nausea would appear. That was all there was to it and next spring she had a fine fat baby half as big as herself.

You know how things happen in this life. You spend months or years looking for a certain rarity and having found it, shortly a group of similar ones appear. This was true here. Enough cases turned up to bring back the old confidence in this method of treatment.

While busy and interested in these things a number of tubercle bacilli sneaked up on me and playfully excavated portions of my lungs, so there won't be any more adventures with vomiting women, but there is plenty of time now to think and write about them.

This story is told to illustrate the fact that vomiting of pregnancy is a condition which is very easily treated and can be interrupted effectively and almost immediately. This does not seem to be very well known for recently I have had the opportunity of questioning a number of students and graduates and none of them seemed to have any knowledge of the use of sedatives in this condition.

The particular drug which is used is probably not important, the one to use being whichever you find does the work best; I have become accustomed to the bromide mixture and find it safe and effective. The dose to be used is—q.s.—that is enough to do the work, remembering that our object is to block those irritating impulses which are set up by the beginnings of a new life in the maternal organism, are transmitted through the nervous system and made manifest by that spokesman, the stomach. Yes, the dose is q.s.; in some cases a small dose being enough to check ordinary nausea, in other cases a larger dose such as seemed to be required in the above case. It is important to give the first dose or two by such a route that it will be retained.

There is another type of vomiting which comes on late in pregnancy, caused by partial failure of the excretory functions and a backing up in the blood stream of the waste products of metabolism, and is part of a general toxæmia. This type does not respond at all to the use of sedatives. This would seem to be an interesting proof that the ordinary type of vomiting is due to an irritation of the nervous system for in the toxic type of vomiting there is no response to sedatives while in the other the response is dramatic.

Of other methods of treatment:—The use of nutrient intravenous salines is an excellent way of getting over an emergency and represents a nice advance in our methods of treatment. That method of taking the basin away and not giving the patient anything to vomit in never seemed to give me any results.

I have told this little story of what it is worth hoping that the information may be as useful to some of the readers as it has been to me. I think I can confirm those brave words of Dr. Goodal—"I can interrupt any case of vomiting of pregnancy by blocking the para-sympathetic nervous system" or to state the case in ultra scientific language—all that is necessary in treating vomiting of pregnancy is to thoroughly "dope" the patient.

Dr. William P. Murphy of the Peter Bent Brigham Hospital, Boston, will give a paper on "Problems of Diseases of the Blood in General Practice."

THE Staff of the Children's Memorial Hospital, Montreal will repeat the post-graduate course in the Medical and Surgical aspects of the Diseases of Children during the week of September 13th next. The course which was given last year met with unusual success. Many more applications were received than could be accepted. It is expected that this year applications will again far exceed the limited accommodation available. Those desiring to apply for the course are urged to do so without delay. The registration fee is \$15.00. This will include daily lunches at the Hospital for the duration of the course as well as other entertainment including a dinner at the Faculty Club when a prominent speaker will be the guest.

Historical Section

Historical Background of the Nova Scotia Hospital, Dartmouth and the Victoria General Hospital, Halifax

MARGUERITE H. L. GRANT

(Continued from May Edition.)

The Development of the Nova Scotia Hospital, Dartmouth

THE Provincial Hospital for the Insane was established at Dartmouth in 1858 and was followed by the City Hospital at Halifax in 1859, also the new Poor House which was erected between the years 1868 and 1869. As the Hospital for the Insane was the first to be decided upon a resumé of its origin will recall that it was as far back as 1759 when the first regulations were made for the care of idiots and lunatic persons, an Act having been passed in that year, "for regulating and maintaining a House of Correction or Work-House within the Town of Halifax" . . . "and be it further enacted, that if any person or persons committed to the said house of correction be idiots, or lunatics, or sick and weak and unable to work, they shall be taken care of by the master or keeper of the said house, who shall keep an exact account of what charges he shall necessarily be at therein, to be rendered to the said overseers, upon oath, if demanded." The building was a small one and a wing was added for the insane in 1812 at a cost of £229. 11s. 10½d. As late as 1813 there were practically no organized agencies for looking after the insane, the old idea had not completely died out that these hapless creatures were the special objects of God's wrath and hence were treated with very little kindness. However, in 1841 after the incorporation of the City of Halifax, definite steps were taken to provide an asylum for them. Reports show that at the Poor House at this time there was an alarming increase of persons suffering from mental derangement—"that there were from forty to fifty persons labouring under different degrees of insanity", and that they were kept employed in making hats and in other forms of light work. They had the comforts which the institution could afford but not the proper accommodation, and no open space essential to proper treatment.

Though petitions had been presented to the House of Assembly in 1832 and 1840 for a public hospital, there were requests from those who preferred a separate hospital for the insane, and on March 10th, 1842, a select committee was appointed to inquire into the practicability of founding an insane asylum and of the propriety and expediency of appropriating temporarily for that purpose some portion of the new bridewell or penitentiary which had recently been completed on the North West Arm.

In 1843 the Commissioners of the Poor petitioned for a grant to erect another wing on the main building of the Poor House in addition to the one which had been built in 1812, to allow them to accommodate the insane and other inmates who were confined to the same wards. They stated that, "there was also a building (the wing) appropriated for the insane but it was partly occupied by some paupers for want of other suitable accommodation, and although the present lunatic house was enlarged a few years ago at the expense of the town, yet from the increasing number of unfortunate inmates, it was becoming too confined for their comfortable accommodation, . . . that there were from two to three hundred persons throughout the province, who needed a proper place as many persons were unwilling to look after them they had to be placed in jails." However, no further additions were made to the Poor House as it was decided to build a new one in the west end of the town. The promoters for a general or united hospital had now become divided as is seen in a petition which was presented on February 22nd. 1845, when the majority of subscribers requested an asylum for the insane, while a few favoured a general hospital for which large subscriptions had already been made. This petition was presented by the Mayor, H. Bell Esq., the Alderman and Common Council to the House of Assembly and is as follows:

"To the Honourable
House of Assembly for the
Province of Nova Scotia,
now in Sessions convened.

"The Memorial of the Mayor, Aldermen and Common Council
of the City of Halifax
Respectfully sheweth

"That there are now in the Poor's Asylum in the City forty Insane persons, and that according to the general rule which inquiry and observation has established on the subject, which shows that there are one in a thousand of the population subject to this calamity—there are probably two hundred and fifty such cases in the Province.

That until very recently such cases have been considered and treated as hopeless, and the unhappy subjects have been viewed as outcasts from Society, and only like inferior animals to be caged and chained and whipped into submission, as if entitled no longer to the characteristics which distinguish from the 'beasts that perish' and as if the link which unites them to the human family were entirely dissolved. The advance of intelligence, of civilization and science have dissipated these gross and misanthropic ideas—have made ashamed of these barbarous practices and have stimulated to efforts in behalf of this class of our suffering fellow beings. In almost every Country in Europe and America, and nearly in every town, Asylums are now provided for their especial benefit and by a system of kindness and sympathy treating them as still of our own species and as intellectual beings,—exciting their love instead of their fear,—many are restored and it has been demonstrated that if taken in time with proper treatment, the disease is as susceptible of cure as any other disorder. The Reports on this Subject show that eighty per centum on an average may be restored, and that those who are beyond recovery need not be degraded below the rank of human beings, but are capable of a great degree of enjoyment, worthy of their intellectual nature, or at least of a great alleviation of their sorrows.

To enter largely on this subject would seem more than superfluous—the cause itself is the strongest argument.

It has therefore not been deemed necessary to obtain a list of names. The City Council as the Representatives of their fellow citizens beg leave to submit the subject to the consideration of the Legislature—not because it is a municipal concern, but to bring the subject in the shortest and most condensed form to the notice of your Honourable House. A large portion of those in the Poor's Asylum are from other parts of the Province, there being only ten of the present number who belong to Halifax. It will therefore be in its benefits and should in justice be in its support, a Provincial Establishment.

It is the opinion of some that a general Hospital is as much required as a Lunatic Asylum, or that both objects may be attained in one Establishment—this point your Memorialists leave entirely to the judgment and decision of your Honourable House.

A subscription amounting to £871 has been raised and a further amount perhaps to the extent of \$500 is expected. Hoping that your Honourable House will aid this effort and make such provision as the case requires,

Your Memorialists as in duty bound will ever pray,

H. Bell, Mayor

William Story, Jr.	Henry Pryor	}	Alderman
Andrew Mackinlay	William Caldwell		
John Edward Starr	Jos. Jennings		
Chas. M. Cleary	C. D. Hunter	}	Common Councilmen
Wm. G. Anderson	Henry Mignowitz		
Henry Spike	John Rhind		
William B. Fairbanks	A. Hemmeon		
B. E. Mack	David Rugg		
Andrew Sinclair	John Winters		

"We, the undersigned, agree to pay the sums attached to our name for the purpose of establishing an Adylum for the Insane on condition that the Legislature make a permanent provision for its support."

The petition was signed by sixty-one citizens headed by the Mayor, who donated his year's salary of £300, the other donations varied from £1 to £50. The list included four business firms and one Society, that of the Youth's Philanthropic Society which donated £1.

The petition further stated:

"We, the undersigned, agree to pay the sums attached to our names for the purpose of establishing a General Hospital embracing an Asylum for the Insane on condition that the Legislature make a permanent provision for its support."

This was signed by twelve citizens donating from £1 to £5 for a general hospital.

The petition was referred to a committee including Messrs. Fairbanks, A. M. Uniacke, DeWolfe, Spearwater, McNab, Huntington and Desbarres.

Note: See petitions 1845 at Archives.

The House was disposed to favour the proposition for a united hospital, if the same could be established with advantage to the lower colonies and recommended that His Excellency the Governor be requested to issue a "com-

pointed out that gentlemen in charge of the Boston and Worcester Institutions had both stated it was always desirable that the site for an asylum for the insane should be surrounded by scenes of a lively and cheerful character—"That Dartmouth presents an extensive view of the harbour, its islands, shipping, etc., and also the beautiful chain of lakes by which it is bounded on the south and east side and the rising ground in front, fast yielding to cultivation."

Another property offered was one near the Cove, known as "Prince's Lodge", containing four hundred acres and valued at fifteen hundred pounds, but it was not superior to "Birch Cove".

In 1849 complaints were again made when a memorial was read from the Commissioners of the Poor suggesting the necessity of providing a suitable asylum for the insane as the apartments in the Poor House occupied by them were the only places in the Province where pauper insane persons could be taken care of, there being then fifty-five individuals. They also stated that the apartments were not suited for the purpose either as regards the comforts or security of the inmates; that the expense of these persons, as they were generally destructive in their habits, was much greater than for the paupers; that they could not meet the needs and constant applications for others and that the charge of the insane or lunatic persons did not properly belong to them as Commissioners of the Poor Asylum and was not contemplated under the sanction of which they exercised their functions. However, in the meantime steps were being taken to erect the hospital and an act was to be passed for establishing the same. In 1852 the Honourable Mr. Bell called the attention of the Council to a suggestion made by persons who were interested in the asylum for the insane—that the Governor should proceed to appoint commissioners before the subscriptions contemplated by the Legislature were raised, £5,000 to be collected before this Act could be passed. In that year the Act for the founding of the insane asylum was passed, but in 1853 three sections of it were repealed also three commissioners were to be appointed as "Commissioners of the Lunatic Asylum as a body corporate." The attention of the Government was also called to the Act and His Excellency the Governor advised to direct the Board of Works to proceed forthwith to select a site and erect necessary buildings for the institution. The whole cost of the work and grounds was limited to £20,000 and in July the Honourable Messrs. Uniacke, Tobin and Howe were appointed a committee to examine the sites proposed.

Finally, the site about two miles from Dartmouth, selected by the universally esteemed philanthropist Miss D. L. Dix, was decided upon, "as in the neighbourhood of a rapidly increasing village, where many mechanics have their residences, the facilities for crossing the harbour could be speedily extended and an arrangement would be entered into with the Steam Boat Company for a reduction in the cost of crossing."

After further investigations and reports it was recommended that the building be constructed for one hundred and twenty patients and to allow for additions—to be of brick and substantially built except the ornamental parts, which should be of hewn granite or freestone with a frontage of three hundred feet. Washington Hospital plans were copied and the cornerstone was laid on the 8th of June, 1856. In May 1857, James Ratchford DeWolfe, Esq., M.D., was appointed medical superintendent.

In February 1858, the estimates for the building then constructed were given as £14,204. Ninety patients were to be admitted and a detached

building was to be erected in addition, also a southern wing for violent patients, as there was no place for them in the present building.

The building was a brick structure of three stories, six wards to each floor and each ward complete with a parlour, dining-room, clothes room, bath room and water closet. Fifteen patients could be accommodated in each ward comfortably. Eleven pounds were allowed for each person for furniture. The water was to be supplied from Lake Maynard, the building was to be lighted by gas and cooking to be done by steam.

In December 1858, the Chairman of the Board of Works was authorized to effect insurance to the extent of £1,000 on the furniture then in the hospital for the insane; ten Commissioners were appointed among whom was Daniel McNeil Parker, M.D. and bye-laws of the hospital were drawn up and approved.

In a local paper of January 1859 it was reported that several insane patients were removed from the Poor House, Halifax to this new asylum.

The first report of the hospital was made by James R. DeWolfe, M.D. on February 16th. 1859, just thirteen years after a commission appointed by Lord Falkland, including Hugh Bell, Samuel O. Fairbanks, Esq. and the late A. F. Sawyer, M.D., went to the States on a visit of inquiry in reference to the construction and management of a hospital for the insane. In the report it was shown that the hospital was efficiently managed by the medical superintendent, the steward and matron, that seventy patients from six to seventy-five years of age were admitted (thirteen of whom were supported by friends, twenty-six by townships, and the remainder classed as transient paupers and maintained by the province). It was stated that fifteen were discharged, eight of whom were cured—a high percentage. A vote of thanks was offered Miss Dix for her interest in the welfare and prosperity of the institution. Amendments were made in the management of the hospital and orders given for the erection of a portion for unruly patients. The following quotation in the Acadian Recorder, June 1858, probably refers to this wing—"The contract for the erection of the building in connection with the Lunatic Asylum has been taken by Messrs. Evans, Gilland and Baine for the sum of £5,000".

Today after seventy years this hospital, though changes have taken place, still stands and the following words written in the past pay just tribute to the gentleman who was the leader in establishing this institution—"The inception of this hospital, formerly known as Mount Hope, was largely credited to Hugh Bell, and it was mainly owing to his persistent energy and own personal liberality that the Legislature was induced to project that institution on a scale which many at the time deemed extravagant, but which subsequent experience has proved to be not more than adequate to the wants of the province".

to be continued.

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It is to be distinctly understood that the Editors of this Journal do not necessarily subscribe to the views of its contributors, except those which may be expressed in this section.

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No. 6

IT is always a pleasure to read THE BULLETIN, and this is particularly true of the last few issues. It is interesting to know what problems the men in other parts of the province meet and how they meet them.

The present issue is sponsored by the Pictou County Medical Association and a word of explanation, perhaps of apology, may be needed. Owing to a slight misunderstanding we were given a very short time to get the material together and as our members are widely scattered, it was impossible to have a full meeting. Again most of our members are Scotch and they have a natural antipathy to boasting of their "cures" or admitting their "kills". And as most of our cases fall into one or other category our choice of subject is limited.

Possibly, in the near future, we may have an article on the History of the Medical Men of Pictou County which may emulate the splendid article of Dr. G. A. Webster.

We hope to see every member of the Nova Scotia Medical Society at Pictou. The Pictou Lodge is a beautiful spot and you will have a good holiday as well as a profitable meeting. We assure you a true Highland welcome.

J. C. B.

THE meeting of the Maritime Division of the American College of Surgeons in Halifax, May 20th and 21st, was judged to have been very successful by those qualified by experience to express an opinion. The clinical material was ample and well selected for purposes of instruction. Those without as well as those within the College acted as a unit and co-operation bore its natural fruit. We have heard many pleasing remarks regarding the work of the local committee responsible for arrangements and it gives us pleasure to make that fact more widely known.

One of the happiest elements connected with this gathering was the bringing together of men from the three Maritime Provinces. Would it not be an agreeable and profitable thing—not so much from a medical as from a social standpoint—for the three provincial societies to meet together at stated intervals in Saint John, Charlottetown or Halifax.

All in attendance were particularly pleased with the group of men sent to this sectional meeting to represent the College. Gentlemen of the highest professional attainments as charming as they were learned.

The Community Health Meeting was an amazing affair. The Dalhousie Gymnasium was crowded and the overflow filled one of our largest churches to the very doors. The reasons for attending probably varied from pure curiosity to that of a free consultation, but it demonstrated that the public at large and ourselves are intensely interested in something in common. Next to the spiritual we are all interested in the physical well being of ourselves and those dear to us. When Dr. Malcolm MacEachern addressed these great audiences on "Doctors, Hospitals and Patients" and Dr. George Crile on "The American College of Surgeons—Its Aims and Objects" the gatherings were introduced to the realm of medical ideals. In this somewhat conservative and cautious community—as befits New Scotland—some of our colleagues question the entertaining the public with talks on medical subjects. Although attending in a somewhat critical frame of mind one cannot help but feel that on the whole the good outweighs any theoretical ill effects.

It is not our purpose to review the history of its inception nor enlarge upon the achievements of this College during the last twenty-five years in the field of professional work and hospital improvement. One would like to say, however, that if the American College of Surgeons had accomplished nothing else than the bringing into being of the Staff Conference it should have our unbounded gratitude, respect and support. In my student days a doctor would be in extremis as well as the patient before the opinion of a colleague was asked for in consultation. It seemed to be considered a humiliating acknowledgment of ignorance to seek another opinion. The procedure itself became in technique and dignity something of a diplomatic encounter. What a change! Today we gladly share our experiences, acknowledge our sins of omission or commission—seek the opinion of others—criticize and question. The Hospital Staff Conference makes and keeps us students and the community we serve reap the benefits.

H. W. S.

FAITH vs. WORKS

"As a man thinketh in his heart, so is he!"

THIS remark of Solomon's applies in many cases to one's physical, as well as one's mental health. The mind has a very marked influence over matter. A number of years ago, a woman who had a large fibro myoma of the uterus was admitted to the Aberdeen Hospital. Her general condition was good and there was no reason to expect other than a happy result from a subtotal hysterectomy.

However, before she left home, she made complete arrangements for her funeral, giving explicit directions, choosing hymns, pall bearers, etc. When she came to the hospital she had with her the outfit in which she wished to be "laid out." The result was that she died and her death was largely due to her desire to die.

A young man was a Bank Clerk in London, England. He found that in "the underground" or crowds his heart palpitated violently. He became convinced that he was suffering from "heart disease." He spent his salary consulting specialists. Each assured him that his heart was sound; yet his

symptoms persisted. The South African War was in progress at the time and there were many recruiting stations in the City. He conceived the idea of enlisting so that the examining doctor would discover his malady and finally he would know his condition. Accordingly, he signed on. He was given his examination and much to his horror the decision was "Fit as a fiddle." No amount of explanations was of any avail and he embarked for South Africa. Long before reaching there he was in the best of health, which continued and he came through the war unscathed.

A large percentage of those consulting doctors is suffering from mental rather than physical symptoms, but as a rule the mental is left untreated. This gives the opportunity for the exploiting of these patients by the charlatan and the patent medicine vendor, and incidentally pays to keep the ether polluted by very intensive advertising of strange nostrums.

Faith curing by means of strange machines formerly had its vogue. The Electric Belt and Oxygenator can easily be remembered. I had one experience with the Oxygenator—an appliance which was attached to the patient's limb and did wonderful things to his metabolism.

A middle-aged man was very ill with measles and broncho-pneumonia. His wife was induced by an Oxygenator agent to experiment with the contrivance. It was applied in the evening and the temperature was to be normal in the morning. Much to the agent's dismay, the patient became worse, so that he was greatly relieved when the doctor arrived. The cash register was marked "No Sale."

Christian Science teaches that disease does not exist but is only a state of mind. It was founded by a neurotic old lady known as Mrs. Eddy. In her youth she was subject to hysterical spasms and grew up to be a confirmed neurotic. She got relief from her imaginary ills from the suggestions of a travelling faith healer by the name of Quimby, and it was from his teachings she evolved her doctrine of "Christian Science."

Although she taught that there was no such thing as pain she was glad to consult a doctor and use morphine for the relief of biliary colic. Her pains, she stated, were due to "malignant animal magnetism" sent through the ether by her enemies.

The late Dr. Norrie of West Branch was called to see a patient dying from erysipelas of the face. He had been ill for some time. When Dr. Norrie inquired what treatment had been used he was told "Faith." His reply was, "God bless me! Faith without works is dead. Your husband will soon be dead too. Good day." Although she saw her husband die because he had not had medical attention, it did not prevent her "praying" two of her daughters into premature graves. They died from measles.

"Faith Healers" are not all outside the medical profession. We have our own Dr. Locke.

Many so-called "rheumatic cases" are pure neuroses. By our search for focal infection we may unwittingly confirm them in their "neurosis."

An East River farmer lost some sheep. In his search he found the carcass of one in the wood by the pasture and it was partially devoured. All signs suggested that it had been killed by a bear. So he visited a neighbour, in order to have him accompany him that night to watch for the slayer. He found his friend so crippled by lumbago that he was unable to move without severe pain. However, when evening came he saw his friend, slowly and labouriously, using his rifle as a support, coming across the fields. They repaired to the wood stationed themselves where they could see the dead sheep

and themselves not be seen. Shortly two bear cubs were seen tearing at the bait. After waiting some time, one fired a shot at the cubs. They immediately began to whimper and scurried up a tree. In an instant they heard the mother bear coming—rushing through the brushwood.

The crippled farmer was cured instantly and Phil Edwards could not have followed him through that rough going to open country.

Under proper setting he could have been cured "by the laying on of hands" and this is practically what is done by Dr. Locke. He twists the patient's toes. Motion pictures of the Doctor in action have been made and nothing could be detected that would have any effect on disease.

The Doctor is not a quack. When actual pathology is present the patient is taken to his office and proper advice is given. I have had two patients consult him, but apart from new shoes they were the same before and after treatment.

The remote situation, the crowds, the small fee and then the "toe twisting" all have a very definite effect on the neurotic. Should Dr. Locke move to a city, have a fine suite of offices, and charge large fees, his power would soon wane.

The only "faith healer" in our midst is the chiropractor. He cures by "laying on of hands" but very violently. All his diseases are due to sublocation of the spine and pressure on the nerves as they pass through the vertebral foramina. These foramina are much larger than the nerve trunks. The nerve is protected by a large pad of fat and areolar tissue. A contortionist can twist his vertebral column in very strange positions, yet not impinge on a nerve. In Pott's disease, very acute angulation may be present and yet no nerve pressure, but a chiropractor always finds it! Our learned operator even has an X-Ray machine to demonstrate just where the pressure takes place. He has never been known to show a patient what changes have been brought about by his treatments. One treatment never cures and the full payment has to be given in advance. He treats every patient the same, high pressure, low pressure, venereal diseases, etc. They are a very definite menace to the public health (and purse).

A patient suffering from an incurable cancer of the bowel paid one of these gentry the sum of three hundred dollars before he realized his mistake. He could get no redress.

Another paid thirty dollars in advance to be cured of a cough. Fortunately for him, he became suspicious and was examined by a doctor, who found pulmonary tuberculosis and the quack had to disgorge.

A young man of 32 developed manic-depressive insanity. His mother was keen on faith cures, so had the chiropractor called in. He found marked pressure on his lumbar nerves, so proceeded to reduce the dislocation. Three days later a doctor was called. The patient was dying. He had acute retention and on catheterizing the urine was very bloody. The violence used on the back had ruptured his kidney (one or both) and death was the result. Autopsy was refused.

A number of years ago, a bill was introduced into the local house, curtailing the activities of these charlatans. During the debate it was found that a goodly number of the members had been treated by the chiropractors and they were in their favour, so the bill was dropped. "What fools we mortals be!"

So the merry-go-round whirls on. The public enjoys being fooled, so all the profession can do is to slowly but surely spread the truth. "Virtue hath its own reward."

CASE REPORTS

A Case of Splenic Leukaemia

DOING general practice in a small mining town one contacts, in time, many varieties of illnesses.

Occasionally, rather rare types are discovered, recognized and treatment instituted with phenomenal results. On the other hand, lesser and more common maladies for which routine text-book treatment should give good results, often fail to respond to treatment.

In May, 1936, I was consulted by a lady of approximately fifty-five years of age, complaining of not feeling well; "draggy", discomfort almost to the degree of pain in upper left abdomen; found it very difficult to do her household duties, tired easily, etc. This condition had been gradually coming on for over a year; had considered and talked about calling a doctor for long but delayed.

In appearance, this lady was sallow, presenting almost the Addison's type.

Examination showed the patient to have a subnormal temperature, pulse 76, regular; blood pressure approximately normal; heart apparently normal. A large mass was easily felt in upper left quadrant of abdomen, extending down to below the umbilicus, not tender. My impression was either an enlarged kidney, spleen or pancreas. However, I advised hospitalization, telling her husband that the case had an appearance of cancer of some of the abdominal organs (this due to colour, history, etc.).

The patient entered hospital May 5th (the following day from my first visit). In consultation with Dr. Blackett a complete blood examination was made. The red cells were normal, haemoglobin down somewhat but the white cells showed 650,000, approximately 80% of which were lymphocytes.

From this blood picture we decided that the mass in left abdomen was an enlarged spleen, diagnosis splenic leukemia. No other glands were involved, only possibly a few enlarged neck glands, but very slight.

Dr. Blackett recommended deep X-ray therapy, which I was only too glad to accept, as it presented a serious appearance to me. Dr. Blackett divided the abdomen into nine zones as for anatomical study. These zones were numbered and the strong ray (120 K. V. 5 M.A.) was thrown on two or three of these zones at one sitting, but the skin of the patient was prevented from burning by filtering the ray through a thick aluminum screen; length of treatment three minutes.

On May 7th zones one and two were treated; four days later the white cell count had dropped from 650,000 to 310,000. The other zones were progressively treated throughout May and three treatments in June. On June 22nd, 1936, the white blood count was 6,250.

In November, 1936, a check-up showed that the white blood count had again increased to 19,000. Two treatments reduced this to 9,000, and incidentally the spleen had reduced in size to practically normal. In April, 1937, a recheck showed 17,000 white blood cells. One treatment reduced this to 11,000.

Today the patient seems in good average health and is doing her own work.

V. H. T. PARKER, Stellarton and
A. E. BLACKETT, New Glasgow.

A Case of Peculiar Abscess Development following Lobar Pneumonia

Patient, a man of fifty-six years of age, with nothing relevant in past history except a marked tendency to boils, developed lobar pneumonia on March 15th, 1937, following an attack of influenza. The pneumonia ran a normal course except for temperature range which never exceeded 102°F and which fell by lysis.

At about twelfth day, when the patient was considered to be making a good recovery and physical examination otherwise negative, the right parotid region of face became markedly swollen and tense, followed two days later by a similar swelling on the left side of the face, the appearance being that of mumps. The temperature was elevated to 100°F. but did not go higher, and the pulse rate was normal. There was no chill. Pain and tenderness were only moderate but fluctuation was noticed and thick grayish pus was at first aspirated and then evacuated by incision, first from the swelling on the right, three days after it appeared, and then from the swelling on the left side. Soon both ears began to discharge pus profusely, with the patient becoming quite deaf.

These were the first of a large number of abscesses which appeared in the next two weeks, and which were unaccompanied by any chills or rigor, and no further elevation of temperature or of pulse rate. The white blood count varied between 12,000 and 16,000. Eight separate abscesses were incised in the neck, varying in size from a plum to an orange, and one the size of a half grape fruit was incised on the left chest wall just below the axilla.

Urine examined on three occasions was negative. Elrod Kahn was negative, a blood culture was not done. In an examination of the pus by the pathologist a pure growth of staphylococcus aureus was obtained from cultures. No tubercle bacilli were found.

A staphylococcus vaccine was given along with supportive treatment, but his condition became progressively worse. Pus collected in high quantity deep in the thigh muscles of the left leg, but as before there was no systemic reaction, and the patient was almost unaware of its occurrence.

Emaciation became extreme and the gravity of his condition was aggravated by extremely severe haemorrhages which began to occur from a deep incision in the neck. The wound was opened wide and explored but it was impossible to locate the bleeding point because of the profuse discharge and slough. The haemorrhages were peculiar in that they occurred with no apparent exciting cause—bleeding freely for a few minutes in spite of pressure and stopping as suddenly as they had started. The severity of the haemorrhage was uninfluenced by packing, or the administration of calcium and haemoplastic serum, and, although still a foul pus-filled cavity, final resort was made to closing the wound tightly with deep sutures. Following this there was much oozing, but no severe bleeding.

At this time two blood transfusions were given, following which the patient began to show improvement. There was no further abscess development, and no bleeding from the neck wound although it opened wide again after a few days. By May 13th, 1937, all wounds had ceased to discharge and were appearing clean. The patient was gaining rapidly with full recovery hoped for.

J. A. F. YOUNG,
Cotswold, N. S.

Two Interesting and Unusual Cases of Intestinal Obstruction

The following interesting cases and rather unusual causes of intestinal obstruction indicate that one scarcely knows the exact condition he is going to encounter when operating on the abdomen. The first case demonstrates that sometimes it is impossible to remove the appendix without grave danger to the patient. A young lady twenty-one years of age is referred for operation on May 27th, 1933. Diagnosis—acute appendicitis. The history given is that she has been vomiting intermittently for twenty-four hours with acute pain in the right iliac region. Examination on entering hospital reveals rigidity and swelling over the right iliac region with marked tenderness on pressure. Temperature 100.4; pulse 82, respiration 18. An alert, observant nurse noticed that the vomitus a few moments before patient was taken to the operating room was somewhat fecal. Under gas oxygen ether anaesthesia, one could feel a large hard mass in the right iliac region. An oblique incision was made over this, the external and oblique muscles being incised in the gridiron fashion. On entering abdomen, a thickened mass of omentum was found somewhat adhered to the caecum. Resecting this off the caecum, the lateral walls of which were hypertrophied, one could feel a very large retro-caecal appendix approximately a good five inches long gradually tapering down from its base at which site its diameter was at least five-eighths inch to its apex which was the size of that of a fair sized appendix. We were dealing with an inflamed hypertrophied appendix fixed in the posterior wall of the caecum, raising this wall sufficiently, together with the pericaecal infiltration, to cause a mechanical obstruction at the ileo-caecal valve. The whole mass appendix and caecum was fixed and immobile. There was no evidence of tuberculosis; the age of the patient and previous healthy history rather off-set a diagnosis of carcinoma; no evidence of actinomycosis and the conclusion was that this was a purely inflammatory condition of long standing. An end to side anastomosis was performed between the ileum and ascending colon. The patient made an uneventful recovery; the mass in the right iliac fossa gradually disappearing from day to day, she left the hospital on June 22nd and at present time of writing, although she no doubt has her appendix greatly reduced in size, snugly confined retrocaecally, is enjoying excellent health.

The second case is that of a young farmer 30 years of age who had been suffering from symptoms of obstruction of the bowel 48 hours before admission to the hospital. There had been no evacuation of the bowels for three days. On admission, Jan. 7th, 1927, his t. was 99.2; p. 58; r. 20. He was suffering with colicky pains in the abdomen, slight distention was present and although we succeeded in obtaining some evacuation from large bowel with enemas, there was absolutely no flatus and he vomited a large amount of brownish fluid. Laparotomy was performed. Usual paramedial incision was made below umbilicus. On entering the abdomen, a perfect round smooth mass was felt about the size of an orange. On attempting to extricate it, it was fixed with the point of fixation above the umbilicus and we found that we were dealing with a cystic condition, the results of a true Meckels diverticulum, which had been closed at both ends with an entero-cystoma formed at the junction of its middle and outer third. The obliterated portion of the Meckels diverticulum attached to the umbilicus was about five inches long and that which was attached to the ileum, about two and a half feet from the ileo-caecal valve, was one inch long.

This was undoubtedly a true Meckels diverticulum as opposed to those more frequent false ones which usually occur in the duodenum and lower colon. This Meckels diverticulum had knuckled the bowel under it causing small bowel obstruction. It was easily relieved and the cord and cyst removed. The patient did well for 36 hours after operation, abundance of flatus being expelled. Unfortunately, however, he then developed acute dilatation of the stomach with marked vasomotor collapse and acute delirium and despite postural treatment, gastric lavage and intravenous saline with glucose, he died four days after the operation. Possibly, if he had consulted a doctor earlier result might have been different and whether or not the present day use of intestinal decompression with the administration of gas gangrene serum would have saved him, it is difficult to say.

CLARENCE MILLER, M.D.

Two Cases of Congenital Talipes Equino-Varus

Baby T. Male born Dec. 19th 1936.

Baby McK. Male born Jan 30th 1937.

Although this deformity is common, yet seldom do two cases occur in one general practice within six weeks of each other.

Baby T. the 6th birth, four children now living. No deformity in parents nor other children, except eldest boy does not speak plainly. First birth; difficult, baby died from trauma. Birth, six years ago, directly preceding present, produced a large full term still born foetus, possibly hydrocephalic.

Present birth, labor began at 9 p. m. Vertex presentation, foetal head floating above pelvic brim. After fourteen hours fairly active labor no progress made, child had to be delivered by moderately difficult version and extraction. Practically no liquor amnii.

Second case, Baby McK. also sixth child, five other children normal and healthy. No deformity in parents. Birth normal except scant liquor amnii.

Both children being males, and scant liquor amnii, bears out the fact that this deformity appears twice as frequently in males as in females and strengthens the theory that lack of liquor amnii is an etiological factor in this malformation.

In each case one foot, being worse than its fellow, was so rigid that it was impossible to mold it into normal position, but became easily molded and flexible after a months' treatment.

The appliance used consisted of a piece of pine 1/16" thick shaped to fit the sole of foot. A strip of Elastoplast adhesive 1½" wide about 8" long; to the middle of which was applied a double thickness of Sterilastic rubber bandage, to give the Elastoplast greater elasticity. The Elastoplast was started at the outer margin of foot, carried across instep to the inner margin of pine sole. As the Elastoplast was carried across this it was pulled firmly to flatten the foot, and continued up the lateral side of leg with as much tension as possible, while the foot was held in the corrected position. A narrow strip of Elastoplast was then applied over the instep on top of first layer; another narrow strip was applied circularly above knee, to prevent slipping. Applied thus the Elastoplast was only in contact with the skin over dorsum of foot

and lateral aspect of thigh. The Sterielastic extending from external malleolus to the head of the fibula kept the Elastoplast from adhering to skin here as the piece of pine protected sole of foot. Thus the peronaei muscles could be massaged and foot moulded into corrected position by the mother, as instructed, for twenty minutes twice a day. She also changed the dressing, at weekly intervals. After a month of this treatment, a light plaster of paris splint was applied to medial side of leg. To do this, similar pine soles were shaped to fit over first soles. A Cellona plaster of paris slab $1\frac{1}{2}$ " by 8" long was applied from lateral margin of foot across sole, up medial side of leg to knee. As soon as hardened, this was removed and reinforced with a piece of heavy copper wire flattened and shaped to fit the plaster. Over this another slab of Cellona bandage was applied. One 3" by 3 yd bandage made two splints. These were bandaged in place, removed twice daily for massage and molding. At monthly intervals new ones are made to correspond with growth of feet.

After four and three months treatment respectively the feet are now in normal position, it only remains to keep them thus until child walks.

In cases not perfectly corrected by the above treatment, where foot is badly turned inward due to medial rotation of the lower third of the tibia on its vertical axis; the following additional appliance may be used, when the child is asleep, to keep the legs in the everted position.

Bore two holes in pine soles, (one at heel the other at toe) insert a shoe lace through each of these holes, knotting end of each so it will not pull through. Bore two holes $2\frac{1}{2}$ " apart near long edge of a piece of ply wood 4" x 9". Insert laces which pass through heels into these holes, and circumscribe two arcs by rotating soles outwards. Along the arc of each quadrant bore a series of holes, by inserting laces at the toes through these holes the desired degree of eversion may be obtained. When lace at toe is tied to lace at heel the foot will be kept stationary at the greatest degree of eversion possible at the moment.

Case 2

Ammonium Mandelate in B. Coli Pyelitis.

Miss M. Age 12.

Feb. 20th 1937 complained of lassitude, poor color, loss of appetite. H. P. I. Patient has not felt well for past three months, but has not had any attacks of chills and fever.

P. H. and F. H. negative.

Physical examination negative. Child is well developed and well nourished. Her color is pasty and she appears listless.

Examination of urine as follows. Opalescent straw colored, acid Sp. G. 1.030 Alb. and sugar neg. Microscopic examination shows many motile bacilli.

She was given the following prescription.

Hexaminae 3 III.

Ammon. Nit. 3 I.

F. E. Glycrrhizae 3 III.

Fermentol 3 IV.

Aquae ad 3 VIII. Sig. 311. . . ex aq. p. c. et h.d.

March 4th. No improvement in patient's condition or urine. She was given Pyridium Tablets, one three times a day, with restricted fluids.

March 23rd no improvement. Given the following prescription.

Pot Citratis	3 VIII.
Fermentol	3 II.
Aquae ad	3 VIII. Sig. 311. ex aq. t. i. d. a.c.

April 9th no improvement. She was then given six ounces Syr. Amdelate in a dose of one dram in water after meals and at bedtime.

April 22. Urine was normal, and patient was feeling much improved.

J. STEWART MURRAY

A Rare Injury.

On July 30, 1931, I received an emergency call to a farmer aged 38. I found him lying on a pile of hay on the barn floor, in a state of profound shock, and pulseless. About three feet of small bowel, covered with hay and hayseed, was protruding from the anal region. He had been levelling hay on the hay scaffold, and, being ready to descend, let his hay fork slide down to a pile of hay on the floor, sliding down himself immediately after. The handle of the fork evidently entered the abdominal cavity, starting at the left side of the anus. The handle was pulled clear by someone before I arrived.

I wrapped the bowel in a piece of sterile gauze, and had him taken to Sutherland Memorial Hospital; and with the assistance of Dr. T. W. MacLean, morphine and shock remedies were administered, the wound and adjoining area rendered aseptic, the bowel immersed in several warm, saline solutions, and care taken to remove every particle of seed. When several pairs of eyes could not detect anything foreign adhering to the bowel, the patient was placed well in the trendelenberg position and the bowel was slowly and with difficulty returned to the cavity, a light ether anaesthesia being given during the latter process; and while the sphincter, which had been lacerated, was repaired, and the wound closed. His hips were elevated in bed, and when he recovered from the shock he made a quiet recovery with no complications.

I report this case because such an injury is of necessity rare, and a good example of what bowel and peritoneum can sometimes put up with.

M. R. YOUNG.

An Atypical Case of Appendicitis.

J. W. Male, age 40, walked into my office on July 13, 1934, complaining of slight pain in the abdomen, and occasional indigestion. Three weeks previously the pain had been more severe for a few hours, but he "did not mind it much". He also thought that there was "a lump in the lower part of his stomach". There had been no vomiting, chills, etc. During this three weeks he had been doing most of his farm work as usual, and felt fairly well, excepting as noted.

Previous history was negative: he did not remember of ever having been ill before.

Examination—Tongue slightly furred, pulse 72, temp. 99°, B. P. 134-90, kidneys, heart, etc., normal, a large, tense tumor in lower abdomen, extending

to well above the umbilicus, more pronounced at right side. Per rectum, a uniform, fairly hard mass was detected.

Diagnosis—Abscess of appendix origin. Although he doubted my diagnosis because he was "not sick enough", I persuaded him to enter hospital, and after consultation and diagnosis were agreed upon, I opened the abdomen on July 14th, and evacuated at least a gallon of dark-coloured, foul-smelling material. No attempt was made to locate the appendix, as the patient's condition had become rather bad. A drainage tube was inserted, and the wound closed.

The patient was dangerously ill during the following ten days or two weeks,—large quantities of pus, and, I think, thin fecal matter, rapid, thready pulse, vomiting, hiccoughs, and alarming distension. However, he worried through. The discharge gradually lessened and stopped, and, so far as I know, he has been well ever since.

Although it is not unusual for a patient to walk about and even do some work, with an abscess in the appendix region, the case seemed peculiar to me because of the extremely mild preoperative and the extremely severe post-operative symptoms.

I believe that this patient had a bowel leak prior to and during most of the drainage period, and that it healed spontaneously. It is probable that he would have done better if he had been drained by the anal route—as I have seen done at different times some years ago, the patients making rapid and good recoveries with no recurrences.

M. R. YOUNG.

Cerebral Hernia

A child, age 6 years, while playing on the street was struck by an automobile. On my arrival she was unconscious, bleeding freely from a lacerated wound in the right fronto-parietal region, from which brain substance was oozing.

She was taken to the hospital, the wound cleansed and an open, depressed fracture of the skull was found. Spicules of bone and protruding brain tissue were removed and the wound closed. Nothing further was attempted as the child seemed in extremis.

A stormy period followed with high temperature, convulsions and delirium. Gradually a hernia of the frontal lobe developed, pushing open the wound and increasing to the size of an orange, with a free sero-purulent discharge. When the general symptoms had abated, about six weeks after the injury, the hernia was operated on. An incision was made around the base of the hernia and the mass, consisting of brain, meninges and inflammatory tissue was dissected off with the thermo-cautery. A slight depression of the bone was elevated and the wound closed without drainage.

The patient made a good recovery and now, about one year after the accident, there is only a small linear scar; no brain symptoms and she appears quite normal.

The interesting feature in this case is the amount of brain substance that can be removed in this area without apparently harmful results.

J. C. BALLEM.

Foreign Body in Vitreous.

Patient, Mr. L. M., age 40, stated that he had been struck on the left eye by a particle of steel, while at work in a local plant.

Examination of the cornea revealed no evidence of a foreign body. A small abrasion was noted however, about 2mm. from the temporal border, and directly behind this a small hole through the iris.

Ophthalmoscopic study showed no evidence of intra-ocular haemorrhage. The media were quite clear, but a small, greenish, bright object could be seen a few mm. in front of the optic disc.

The steel had penetrated the cornea and iris, had fortunately missed the lens, and entered the vitreous.

Under local anaesthesia (cocaine 5%), the blade of a cataract knife was passed through the eye into the vitreous, at a point as far back from the corneo-scleral junction as possible. The tip of a giant electric magnet was applied to the knife handle, and the blade slowly withdrawn. The particle of steel was found adhering to the tip of the blade. The piece of steel was about $1\frac{1}{2}$ sq. mm. in size.

Patient made an uneventful recovery with no complications.

Eye Injury involving Cornea, Iris and Lens

Patient, Mr. W. M., miner, age 28, received a blow on his left eye by a piece of coal.

Examination revealed a tear in the cornea about 4 mm. long with prolapse of a portion of the iris through the wound. The anterior chamber was deep and filled with blood.

Under local anaesthesia the protruding portion of the iris was excised, and the edges of the wound freed and cleansed. Atropine 1% was instilled, and general treatment instituted. When the blood had fully absorbed, an irregular grayish mass was noted lying behind the iris. The lenticular capsule had evidently been ruptured with dislocation of the lens. The lens itself was soft and cataractous. The corneal wound healed nicely leaving a very thin fine scar. The pupil was slightly irregular in shape.

At this time patient only had light perception, due to the cataract.

He came in to see me about four months later and I was surprised to find that the lens had absorbed almost completely, with only a fine, narrow band remaining. With the application of a +10 diopter lens he now had 8/10 vision.

R. S. SHLOSSBERG.

Carcinoma Jejunum

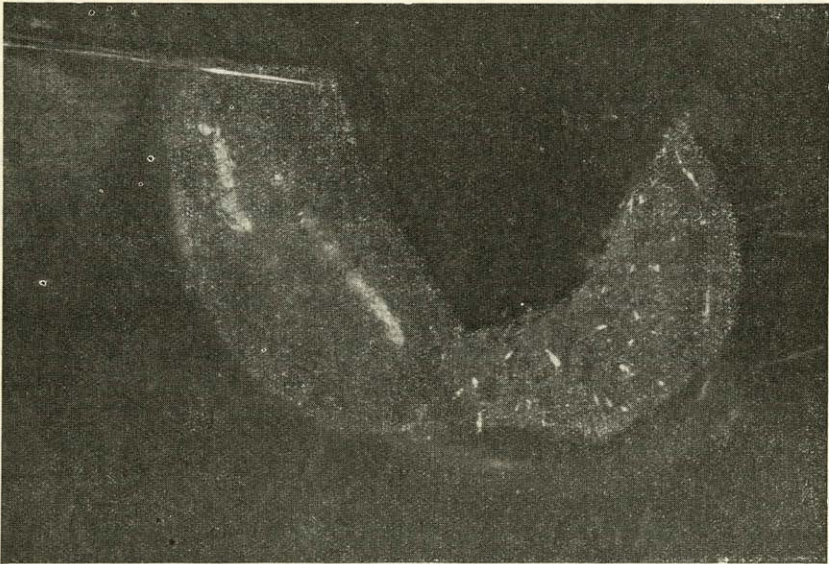
W. McK. Female—age 57.

A hospital patient seen in consultation April 19th, 1937, and gave the following History:

Married—5 children. Personal and family history negative. For the past year she noticed that she tired more easily and had lost about 20 lbs. in weight. On Christmas Day following her dinner she was seized with a severe

cramp-like pain, localized to the left upper quadrant of the abdomen and shortly afterwards she vomited a large amount of undigested food. Since that time pain and vomiting has persisted, except for short intervals, until for the past week when she vomited all fluids taken.

A small emaciated woman, looks older than stated age. Tongue dry and coated. Breath heavy. A few carious teeth in lower jaw. She has a loose cough with moist rales at both bases. Heart sounds are clear. Abdomen



rather prominent. Some tenderness on deep pressure under left costal margin, extending into the left flank. No masses could be palpated.

Blood count—whites 5,800, reds 2,300,000.

H. G. 65%.

Urine—negative. Stool—negative for occult blood.

Rectal examination—negative.

Chest K-Ray—negative.

G. I. Series—Stomach and duodenal cap fill well. Six hour, 24 hour, and 48 hour films show a small bowel obstruction near junction of duodenum and jejunum with marked dilatation of proximal bowel. The obstruction is probably due to a band or to malignancy.

Patient was given three days of intensive pre-operative treatment. Then under gas-oxygen the abdomen was explored. The stomach, liver and bile passages appeared normal. The jejunum was dilated to the size of a normal stomach and showed a ring carcinoma about 30 inches from the duodeno jejunal juncture. Several glands in the adjacent mesentery were enlarged. No secondary masses could be discovered. About two feet of Jujunum was excised and the usual end to end anastomosis done.

The hospital convalescence was quite uneventful. Patient out of bed on the 14th day and on full hospital diet.

Pathological Report. The gross appearance here reveals an annular carcinoma of bowel, of scirrhus type. The histological appearances reveal it to be an adeno carcinoma. One small gland in the vicinity was found but revealed no evidence of malignancy.

A. F. MCGREGOR.

The value of ultra short wave diathermy in traumatic plain is now well known and is well illustrated in the following case:

A.B., a rugged man, age 35, labourer, was brought to my office stooped and walking very slowly and could not straighten up. The injury was caused by slipping when engaged in a very heavy lift. He complained of pain in the chest and painful breathing.

My prescription was ultra short wave diathermy (6 meter) through the chest for 25 minutes, to be followed by deep massage of the muscles of the chest. He was placed on the couch and two large electrodes applied, one back and one in front of the chest, with 3 layers of white harness felt over each plate, between the electrode and the skin.

This electro-thermal current induced a sense of comfortable warmth of the body, rest and perspiration.

After six minutes the man looked up and said "The pain is gone". At the expiration of the prescribed 25 minutes, deep massage of the muscles of the back and sides was given for 10 minutes. At the conclusion of this treatment the patient got up and dressed in perfect comfort and could straighten up and sling his arms around and take deep breaths in ease. He went out walking straight and nimbly. He said he felt a little stiff but no pain.

I saw him at his work two weeks later. He said he went back to his work from my office, and has been working steadily ever since and has had no more pain, only a little stiffness for a day or two.

JOSEPH HAYES, D.S.O., M.D.

**The Annual Meeting of the Provincial Association of
Medical Health Officers**

will be held at

**PICTOU LODGE,
PICTOU,**

Tuesday, July 6th, 1937, at ten o'clock a.m.

There will be both morning and afternoon sessions.

An interesting programme is in course of preparation and a large attendance is anticipated.

Abstracts from Current Journals

SURGERY

Painful Shoulder, Ferguson.—*Archives of Surgery*, February, 1937.

The relatively high incidence of disabilities involving the shoulder gives to the above practical article a real value for the general practitioner. Only disabilities involving the soft parts are discussed but these are the ones that cause the surgeon the most serious difficulties. The lesions are classified:

- 1—Acute traumatic bursitis.
- 2—Acute bursitis with calcification.
- 3—Sub-acute bursitis with calcification.
- 4—Tendinitis or obliterative bursitis.

The consideration given to injury as a causative factor is full and thorough. Several X-Ray plates are shown in the cuts illustrating the process of calcification which occasionally occurs in the sub-deltoid bursae. Occasionally villi develop in the bursae which need to be exercised as also the calcified plaques which keep up some of the most painful lesions. Chronic bursitis patients are usually in the fourth and fifth decades of life, the condition being nearly always associated with direct or indirect trauma. Those patients with tendinitis or chronic obliterative bursitis are the most difficult to treat. Treatment consists of heat, usually as diathermy and moderate exercises within pain limits. A new line of treatment is suggested in the injection of 20-30 c.c. of novocain 1% into the bursal sac.

A series of exercises causing abduction and some rotary movements of the arm are given. These do not require special apparatus and can be easily carried out by a conscientious patient at home.

The etiological factor of toxic absorption either from the bowel or elsewhere is dismissed with the observation that "it has never been possible to trace any definite relationship between foci of infection and the painful disabilities described".

Umbilical Pain, Dodd.—*Medical Press and Circular*, March, 1937.

Under the general caption of "Pitfalls in Diagnosis" there has been appearing in the above worthy journal a series of intensely practical articles. The present issue is up to the high standard of its predecessors and carries the title of "umbilical pain". The article opens with the suggestion now generally accepted as to the causes of abdominal pain by localizing on the surface the corresponding area of spinal cord segment supplying the diseased abdominal viscera. In addition some reference is made to the other lesions above the diaphragm and retroperitoneal conditions which may cause abdominal pain. The intra-abdominal, mechanical and inflammatory, causes include all those conditions making up an acute abdomen. Of particular appeal seems the discussion of the "silent" acute appendicitis. When the appendix is retro-caecal, or is covered by the mesentery or is in the cavity of the pelvis the signs

in the right iliac fossae are greatly modified if not entirely absent. Differential diagnosis is assisted by dividing the abdominal wall into different zones and by using in these areas the forceps' pinch or flesh pinch as practised and recommended by Ligat, for eliciting hyperaesthesia. Considerable importance is attached to the palpable presence of the appendicular gland corresponding to the cervical gland of tonsillitis.

One does read with interest the reference to the newly recognized syndrome of fatigue and abdominal pain. The clinical picture suggests either ulcer or chronically inflamed appendix. Constipation is common. The persons most frequently affected are the so called middle class, solicitors, engineers, doctors, bank officers, newspaper workers and those whose habits constitute the fore-runners of so called maladjustments. The correction of habits and securing adequate rest will clear away the syndrome.

The article is well written and covers a great many of the pitfalls of diagnosis encountered while investigating abdominal disease. If the subject matter can be absorbed in the concise way in which it is written the article will well repay its careful study.

Dr. G. J. Wherrett, Executive Secretary of the Canadian Tuberculosis Association, will speak on the most important health problem we have in the province, "The Control of Tuberculosis."

The Summer-Time Use of Mead's Oloum Porcomorphum

During the hot weather, when fat toleranco is lowest, many physicians have found it a successful practice to transfer cod liver oil patients to Mead's Oleum Percomorphum.

Due to its negligible oil content and its small dosage, this product does not upset the digestion, so that even the most squeamish patient can "stomach" it without protest.

There are at least two facts that strongly indicate the reasonableness of the above suggestion: (1) In promatures, to whom cod liver oil cannot be given in sufficient dosage without serious digestive upset, Mead's Oloum Porcomorphum is the antiricketic agent of choice. (2) In Florida, Arizona and New Mexico, where an unusually high percentage of sunshine prevails at all seasons, Mead's Oloum Porcomorphum continues increasingly in demand, as physicians realize that sunshine alone does not always prevent or cure rickets.

Mead Johnson & Company, Evansville, Indiana, invite you to send for samples of Mead's Oloum Porcomorphum for clinical use during the summer months to replace cod liver oil.

Society Meetings

The Western Nova Scotia Medical Society held its regular Annual Meeting at the Grand Hotel, Yarmouth, on Tuesday afternoon, May 25th, at 3.00 p. m., with the President, Dr. C. K. Fuller, in the chair.

A very interesting paper entitled, "The Physical Diagnosis; Its Scientific, Clinical and Economic Implications" was given by Dr. LeRoy E. Parkins of Boston. Several important resolutions were passed on to the Executive of the Nova Scotia Medical Society for their consideration.

The following officers were elected for the coming year:

President: Dr. A. B. Campbell, Bear River.

Vice Presidents: } Dr. B. I. Chiasson, for Yarmouth Co.
 } Dr. L. F. Doiron for Digby Co.
 } Dr. H. H. Banks for Shelburne Co.

Sec'y-Treas: Dr. T. A. Lebbetter, Yarmouth, N. S.

Representatives to the Executive of the Nova Scotia Medical Society:
 Dr. A. H. Siddall, Pubnico Head.

Dr. L. M. Morton, Yarmouth.

T. A. LEBBETTER,

Sec'y-Treas. Western N. S. Medical Society.

HALIFAX MEDICAL SOCIETY

At the annual meeting of the Halifax Medical Society held recently the following officers were elected.

President, Dr. R. P. Smith; Vice-President, Dr. C. W. Holland; Secretary-Treasurer, Dr. C. M. Bethune; Executive, Dr. E. I. Glenister, Dr. R. H. Stoddard, Dr. D. J. MacKenzie and Dr. C. M. Jones.

The retiring president, Dr. E. K. Maclellan was in the chair.

PICTOU COUNTY MEDICAL SOCIETY

At the annual meeting of the Pictou County Medical Society held on May 27th the following officers were elected.

President, Dr. G. A. Dunn, Pictou; Vice-President, Dr. A. F. McGregor; Secretary-Treasurer, Dr. John Bell; Representatives to the Medical Society of Nova Scotia, Drs. H. B. Whitman and D. F. McLellan.

VALLEY MEDICAL SOCIETY

The thirtieth annual meeting of the Valley Medical Society was held at the Cornwallis Inn, Kentville, on May 27th. The following officers were elected for 1937-38. President, Dr. F. F. Chute; Vice-Presidents, Drs. H. R.

Corbett, E. A. Fergusson, Ira Sutherland; Secretary-Treasurer, Dr. H. E. Kelley; representatives to the Medical Society of Nova Scotia, Drs. G. R. Forbes and A. A. Giffin.

Dr. J. P. McGrath showed several cases which had been operated on to demonstrate post-operative results: (a) Resection of tongue for epithelioma; (b) Fibroma of the naso-pharynx; (c) Severance of nose with immediate suture; (d) Graft of nasal cartilages to repair result of an osteomyelitis.

Dr. K. A. MacKenzie read a very excellent paper on "The Mental Factor in Organic Disease"; and Dr. N. H. Gosse read a paper on "Some Errors in Abdominal Diagnosis".

COLCHESTER—EAST HANTS MEDICAL ASSOCIATION

The annual meeting of the Colchester-East Hants Medical Association was held May 20th following a banquet at the Scotia Hotel. Officers were elected and routine business dispensed with.

At the election of officers Dr. Dan Murray, of Tatamagouche, was the unanimous choice for re-election as president. The complete slate of officers is as follows:

President—Dr. Dan Murray, Tatamagouche (re-elected); Vice-President—Dr. T. R. Johnson, Great Village; Secretary-Treasurer—Dr. D. S. McCurdy, Truro. Representatives to the Medical Society of Nova Scotia:—Dr. F. D. Charman, Truro, Dr. D. F. McInnis, Shubenacadie.

The annual meeting of the association was held in conjunction with the regular monthly meeting of the Colchester County Hospital Medical Board. Four case reports were given by Drs. J. B. Reid, E. M. Curtis, F. D. Charman and D. S. McCurdy. Discussion of each report followed the presentation by the physician in charge of the case.

CORRESPONDENCE

The Editor:

I'd like you to stick this in some corner of the BULLETIN. To many, the subject of this letter may be a triviality but on me it has the same effect as the proverbial vivid-hued calico has on the male member of the bovine species.

I have before me a certificate of an Insurance Company to be filled out on the death of a policy-holder.

It asks such idiotic questions as "What College did you graduate from?" "How long have you been in practice?"—instead of simply asking—"Are you a qualified medical practitioner?"

Again they ask for a full history of the insured's previous illnesses—perhaps in the hope that they will find some discrepancy in his statements that would nullify the policy. But the "coup de grace" comes at the end when the physician is required to take an affidavit before a commissioner!

This is an insult, as well as a nuisance and we, as a body, should demand that it be deleted from all insurance forms. We do not have to take an affidavit when we are filling out examination papers, the inference being that they are more anxious to secure new business than to pay a claim.

(Sgd.) J. C. BALLEM.

Medical Library Dalhousie University

CURRENT MEDICAL LITERATURE

- British Medical Journal*, London, England - - - - - March 6, 1937.
- Nasopharyngeal Sepsis in 2,056 Cases of Mental Disorder: the Importance of Closed Sepsis by T. C. Graves, M.D.,F.R.C.S.
 - Zinc Protamine Insulin; a Clinical Trial of the New Preparation by R. D. Lawrence, M.D.,F.R.C.P. and Nora Archer, M.B.
 - The Nocifensor System of Nerves and its Reactions by Sir Thomas Lewis, M.D.,F.R.C.P.
 - Active Immunization Against Tetanus by Herbert H. Brown, O.B.E., M.D.,F.R.C.S.
 - Death Following Blood Transfusion: notes on two cases by F. Pygott, M.B.,D.P.H.
 - Psychology in Industry by May Smith, M.A.,D.Sc.
 - Endocrines in Theory and Practice; the Physiology of the Endometrium and Uterine Muscle, and of the Ovarian Cycle by J. M. Robson, M.D.,D.Sc.
 - Surgery of the Thyroid: lectures by Sir Thomas Dunhill.
- British Medical Journal*, London - - - - - March 13, 1937
- Protamine Insulin and Zinc Protamine Insulin in the Treatment of Diabetes Mellitus by H. P. Himsworth, M.D.,M.R.C.P.
 - Non-surgical Renal Emergencies (a post-graduate lecture) by James M. Stalker, M.D.
 - Treatment of Aspirin Poisoning by Intravenous Sodium Lactate Solution by Stanley W. Williams, M.D. and Rona M. Panting, M.B.,B.S.
 - Continuous Intravenous Saline Infusion by Hamilton Bailey, F.R.C.S., Wilfred I. B. Stringer, M.D.,M.C.P.S. and Kenneth D. Keele, M.D.,M.R.C.P.
 - Climato-Physiological Investigations at the Sea Shore by Otto Kestner, M.D.
 - Endocrines in Theory and Practice; the Physiology of the Endometrium and Uterine Muscle and of the Ovarian Cycle (ii) by J. M. Robson, M.D.,D.Sc.
- British Medical Journal*, London - - - - - March 20, 1937.
- Medicinal Kaolin in Food Poisoning: a Critical Survey by N. Mutch, M.D.,F.R.C.P.
 - Infectious Mononucleosis (Glandular Fever) and Monocytic Leukaemia by M. C. G. Israels, M.D.,M.Sc.
 - Terminal Caseating Tuberculous Bronchopneumonia, in which the Date of Onset was known by C. E. H. Turner, M.R.C.S.,L.R.C.P.
 - Carcinoma of the Bronchus in a Boy Aged Nineteen by J. Gordon Hailwood, M.D.
 - Industrial Aspect of Fractures of the Os Calcis by Bryan McFarland, M.D.,F.R.C.S.E.

Three Separate Causes of Antepartum Haemorrhage Occurring Simultaneously, by Philip J. Ganner, M.B.,B.S.,F.R.C.S.

Endocrines in Theory and Practice; Hormone Deficiencies in the Male by Kenneth M. Walker, F.R.C.S.

British Medical Journal - - - - - March 27, 1937.

Effect on the Eye of Radium Used for Treatment of Malignant Disease in the Neighborhood by Phillippa Martin, M.S.,F.R.C.S.

Isolation of the Influenza Virus and the Relation of Antibodies to Infection and Immunity: the Manchester Influenza Epidemic of 1937 by Leslie Hoyle, M.B.,Ch.B., and R. W. Fairbrother, D.Sc., M.D.,M.R.C.P.

Continuous Open Air for Pneumonia in Children by H. L. Wallace, M.B.,F.R.C.P.E.

Auditory Nerve Section in Meniere's Disease by R. Rutherford, F.R.C.S.

A Note on the Adrenal Cortex by L. R. Broster, D.M.,M.Ch.,F.R.C.S. and H.W.C. Vines.

The Evidence for the Compulsory Pasteurization of Milk by C. Fraser Brockington, M.D.

Endocrines in Theory and Practice: the Hormone Treatment of some Disorders of Pregnancy by T. N. A. Jeffcoate, M.D.,F.R.C.S.E.

Lancet, London, England - - - - - March 6, 1937.

Thrombo-angilitis Obliterans by E. D. Telford, F.R.C.S.

Medical Treatment of Non-malignant Pyloric Stenosis in Adults by T. Izod Bennett, F.R.C.P.

A Review of Gold Therapy by W. S. C. Copeman, M.R.C.P. and W. Tegner, M.R.C.P.

Striae Atrophicae Cutis by D. B. Rosenthal, M.R.C.P. (Illus.)

Tryptophane Reaction in Cerebro-spinal Fluid in Diagnosis of Tuberculosis Meningitis by J. Spillane, M.R.C.P.

Anaesthesia for Intracranial Operation by P. Ayre, M.R.C.S. (With charts).

Vitamin B and Diphtheria by B. A. Peters, M.D., and R. N. Cunningham, Ph.D.

Osteomyelitis by Walter Broadbent, F.R.C.P.

Leptospiral Jaundice Occurring Naturally in a Guinea Pig by Neil Mason, M.B.

Lancet, London - - - - - March 13, 1937.

Treatment of Acute Rheumatism in Childhood by R. Lightwood, F.R.C.P.
Nitrous Oxide Analgesia in Obstetrics; Machine for Self-administration of gas by Chassar Moir, M.D. (Illus.).

Turmeric (Curcumin) in Biliary Diseases by A. Oppenheimer, M.D.

Anti-curare Action of Substance 36, by Lady Briscoe, M.B. (Illus.).

Sporadic Salmonella Infections by J. H. Fisher, M.R.C.P.

Hernio-appendectomy by J. T. Morrison, F.R.C.S.

Sulphaemoglobinaemia Following Sulphanilamide Treatment by G. Discombe, B.Sc.

Coma as the First Symptom of Diabetes by E. F. Skinner, F.R.C.P. (With chart).

Eclamptic Hemiplegia by M. Hajkis, M.B.

- Lancet*, London - - - - - March 20, 1937
 Heart Disease with Normal Rhythm Complicating Pregnancy by K. Harris, F.R.C.P.
 The Chemotherapy of Typhoid and Some Other Non-streptococcal Infections in Mice by G. A. H. Buttle, M.R.C.S., H. J. Parrish, M.R.C.P., M. McLeod, B.Sc. and D. Stephenson, Ph.D.
 Effect of Compressed Air Baths upon the Vital Capacity in Emphysema by G. E. Beaumont, F.R.C.P. and J. F. Dow, M.B.
 The Phonostethograph; Records and Reproduces Sounds Heard on Auscultation by C. V. Henriques, M.R.C.S. (illus.).
 Encephalitis in Measles by G. A. E. Barnes, M.R.C.S., J. C. Blake, M.B., J. C. Hogarth, M.B., and M. Mitman, M.R.C.P.
 Tumour Growth in Hypophyseal Dwarfism by B. Zondek, M.D. (illus.).
 Solitary Metastasis in Spleen in Carcinoma Simplex of Right Breast by W. H. McMenemey, M.R.C.P. (illus.).
- Lancet*, London - - - - - March 27, 1937.
 The Experimental Cutlook in Surgery by Sir David, Wilkie, F.R.C.S.
 Blood Pressure in the Years Following Recovery from Coronary Thrombosis by J. H. Palmer, M.R.C.P. (With chart).
 Acute Diffuse Non-Supperative Encephalitis by R. Lawford Knaggs, F.R.C.S. (illus.).
 Hypoglycaemic Shock in the Treatment of Schizophrenia by L. W. Russell, M.B.
 Sciatic Scoliosis by E. N. Wardle, F.R.C.S. (illus.)
 Early Bacteriological Diagnosis of Diphtheria by W. P. Cargill, M.B. and G. J. Crawford, M.R.C.P.
 Cephalic Tetanus by P. B. Wilkinson, M.R.C.P.
 Effect of the Mumps on the Wassermann Reaction by W. Smith, M.D.
- New England Journal of Medicine* - - - - - March 4, 1937.
 The Genesis of Thyroid Protein by W. T. Salter and J. Larman.
 Principles of Parathyroid Surgery by Edward D. Churchill.
 Factors Governing Calcium Equilibria in the Body by A. Baird Hastings.
 The Frequency, Recognition and Treatment of Chronic Subdural Hematomas by Gilbert Horrax and James L. Poppen.
 Femoral Hernia by Franklin G. Balch, Jr.
- New England Journal of Medicine* - - - - - March 11, 1937.
 Results of Total Thyroidectomy in Heart Disease by T. S. Claiborne and L. M. Hurxthal.
 The Age of Harvard Medical School in Relation to that of the Other Existing Medical Schools in the United States, by Frederick C. Waite.
 Fractures of the Mandible and Maxilla by Joseph A. Doherty.
 Irreducible Dislocation of the Ankle by Robert L. Maynard.
- New England Journal of Medicine* - - - - - March 18, 1937.
 Recent Advances in the Study of Typhus Fever by Hans Zinsser.
 Immunologic Application of Placental Extract by Charles F. McKhann.
 The Epidemiology of Influenza by Wilson G. Smillie.
 The Immune Reactions in Patients with Gonococcal Infections by Chester S. Keefer and Wesley W. Spink.

- Immunization in Yellow Fever and Other Virus Diseases by Andrew W. Sellards.
- The Antiserum Treatment of Pneumonia from the Standpoint of Public Health by Elliott S. Robinson.
- Some Aspects of Pneumococcus Infection in Man by Maxwell Finland.
- Studies in Filarioidea by Richard P. Strong.
- Trichinosis—Incidence and Diagnostic Tests by Donald L. Augustine.
- A Study of the Pathogenic Rickettsiae in Tissue Culture by H. Pinkerton and G. M. Hass.
- Oxygen Therapy; a Modification of the Box Method for Giving 95 Per Cent Oxygen by Alex. M. Burgess.
- Traumatic Intraperitoneal Rupture of the Bladder by F. J. C. Smith.
- New England Journal of Medicine* - - - - - March 25, 1937.
- The General Management and Treatment of Obliterative Peripheral Vascular Disease of the Lower Extremities by Theodore C. Pratt.
- The Iodine Tolerance Test as an Aid in the Diagnosis of Clinical Hyperthyroidism by H. J. Perkin and Frank H. Lahey.
- The Practitioner* - - - - - March 1937.
- Post-operative care; Medical Aspects by A. P. Thomson, M.C.,M.D., F.R.C.P.
- Post-operative Care; Surgical Aspects by I. R. Learmonth, Ch.M., F.R.C.S.E.
- Post-operative Care; Anaesthetic Aspects by J. W. Magill, M.B.,D.A.
- Nervous and Mental Post-operative Complications by Anthony Feiling, M.D.,F.R.C.P.
- Physiotherapy in Post-operative Convalescence by James Mennell, M.D.
- Bed-sores and their Treatment by R. J. McNeill Love, M.S.,F.R.C.S.
- Catheters and the Avoidance of Sepsis by Sir W. I. deC. Wheeler, M.D.
- The Treatment of Sea-sickness by John Hill, M.D.
- The Treatment of Epilepsy in Children, by Reginald Lightwood, M.D., F.R.C.P.
- The Knee-jerk in Health and Disease by Adolphe Abrahams, O.B.E., M.D.,F.R.C.P.
- General Practice IX.—Litigation by Robert Forbes, M.B.,Ch.B.,J.P.
- The Clinical Journal* - - - - - March 1937.
- Gastritis by Arthur F. Hurst.
- The Investigation and the Treatment of Leucorrhoea by Norman White
- Rheumatism of the Spine by R. G. Gordon.
- Recent Advances in the Pathology and Treatment of Prostatic Enlargement by Kenneth Walker.
- Some Neurological Problems of General Practice by J. MacDonald Holmes.
- The Management and Equipment of a Maternity Hospital by H. J. Thomson.
- Large Cystic Leiomyoma of the Bladder by Leonard Ley.

Department of the Public Health

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 Divisional Medical Health Officer - - DR. J. S. ROBERTSON, Sydney.
 Divisional Medical Health Officer - - DR. J. J. MACRITCHIE, Halifax.
 Director of Public Health Laboratory - DR. D. J. MACKENZIE, Halifax.
 Pathologist - - - - DR. R. P. SMITH, Halifax.
 Psychiatrist - - - - DR. ELIZA P. BRISON, Halifax.
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Murray, R. L., North Sydney.
 Townsend, H. J., Louisburg.
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 MacKinnon, W. F., Antigonish.

COLCHESTER COUNTY

Eaton, F. F., Truro.
 Havey, H. B., Stewiacke.
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 Fraser, R. H., New Waterford.
 Martin, H. J., Sydney Mines.
 McNeil, J. R., Glace Bay.
 McLeod, J. K., Sydney.
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 Drury, D., Amherst (Mcpy.)
 Gilroy, J. R., Oxford.
 Henderson, C. S., Parrsboro.
 Cochrane, D. M., River Hebert (Joggins).
 Withrow, R. R., Springhill.

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 Dickie, W. R., Digby.
 Rice, F. E., Sandy Cove (Mcpy).

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 Monaghan, T. T., Sherbrooke (St. Mary's Mcpy.)

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 Glenister, E. I., Dartmouth.

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 MacLellan, R. A., Rawdon Gold Mines (East Hants Mcpy).
 Reid, A. R. Windsor (West Hants Mcpy.)
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Lindsay, R. D., Port Hawkesbury.
 Boudreau, Gabriel, Port Hood, (Mcpy. and Town).
 Proudfoot, J. A., Inverness.

KINGS COUNTY

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 Bethune, R. O., Berwick (Mcpy.)
 de Witt, C. E. A., Wolfville.
 Cogswell, L. E., Berwick

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 Reh fuss, W. N., Bridgewater.
 Donaldson, G. D., Mahone Bay.
 Zinck, R. C., Lunenburg.
 Zwicker, D. W. N., Chester (Chester Mcpy).

PICTOU COUNTY

Blackett, A. E., New Glasgow.
 Chisholm, H. D., Springville, (Mcpy.)
 Whitman, H. D., Westville.
 Crummey, C. B., Trenton.
 Young, M. R., Pictou.
 Benvie, R. M., Stellarton.

QUEENS COUNTY

Ford, T. R., Liverpool (Mcpy.)

RICHMOND COUNTY

Dèveau, G. R., Arichat (Mcpy).

SHELburne COUNTY

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

VICTORIA COUNTY

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

YARMOUTH COUNTY

Hawkins, Z., South Ohio (Yarmouth Mcpy).
 Morton, L. M., Yarmouth.
 Lebbetter, T. A., Yarmouth (M.H.O. for Wedgeport).
 LeBlanc, J. E., West Pubnico, (Argyle Mcpy).

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

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

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

Report on Tissues sectioned and examined at the Provincial Pathological Laboratory from May 1st, to June 1st, 1937.

During the month, 211 tissues were sectioned and examined, which, with 28 tissues from 3 autopsies, makes a total of 239 tissues.

Tumours, simple.....	19
Tumours, malignant.....	25
Tumours, suspicious of malignancy.....	3
Other conditions.....	164
Tissues from 3 autopsies.....	28

**Communicable Diseases Reported by the Medical Health Officers
for the month of May, 1937.**

County	Chickenpox	Diphtheria	Cerebro Spina Meningit's	Influenza	Measles	Mumps	Paratyphoid	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc Pulmonary	Tbc.-other Forms	V. D. G.	V. D. S.	Whooping Cough	Goitre	Pink Eye	German Measles	TOTAL
Annapolis.....	1	..	..	..	184	7	..	..	..	..	1	..	..	..	..	..	..	..	193
Antigonish.....	10	..	..	..	..	..	..	..	..	..	..	..	..	..	..	10
Cape Breton....	..	6	..	7	..	..	1	..	16	..	..	..	..	..	9	..	..	..	39
Colchester.....
Cumberland....	16	16
Digby.....	1	..	..	..	1	..	..	..	3	..	..	..	1	..	..	..	..	..	6
Guysboro.....	1	..	1	..	..	..	..	..	2
Halifax City..	..	2	..	..	5	6	..	2	7	..	1	..	..	..	1	..	..	..	24
Halifax.....
Hants.....
Inverness.....	1	..	..	..	..	..	1
Kings.....	3	2	..	..	..	..	..	..	..	..	..	..	..	..	..	5
Lunenburg.....
Pictou.....	1	..	..	..	..	..	..	..	1
Queens.....
Richmond.....
Shelburne.....	3	..	..	..	1	..	..	..	..	..	..	..	..	..	..	4
Victoria.....
Yarmouth.....
TOTAL.....	2	8	..	23	192	13	1	3	26	..	4	..	3	..	10	..	..	16	301

Positive cases Tbc. reported by D. M. H. O's. 54.

RETURNS VITAL STATISTICS FOR APRIL, 1937.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis.....	17	22	7	10	21	0
Antigonish.....	18	11	0	7	9	1
Cape Breton....	69	93	42	35	42	5
Colchester.....	17	17	12	14	9	1
Cumberland....	47	25	19	23	20	2
Digby.....	15	11	14	12	13	2
Guysboro.....	14	13	8	5	9	1
Halifax.....	120	94	74	58	56	2
Hants.....	19	18	6	15	9	0
Inverness.....	27	19	5	14	9	0
Kings.....	26	27	14	18	18	1
Lunenburg.....	30	26	11	23	19	1
Pictou.....	29	38	22	23	21	0
Queens.....	12	7	7	11	6	0
Richmond.....	2	12	1	8	8	0
Shelburne.....	21	12	14	8	6	3
Victoria.....	5	2	1	3	4	0
Yarmouth.....	21	15	18	16	12	0
	509	462	275	303	291	19

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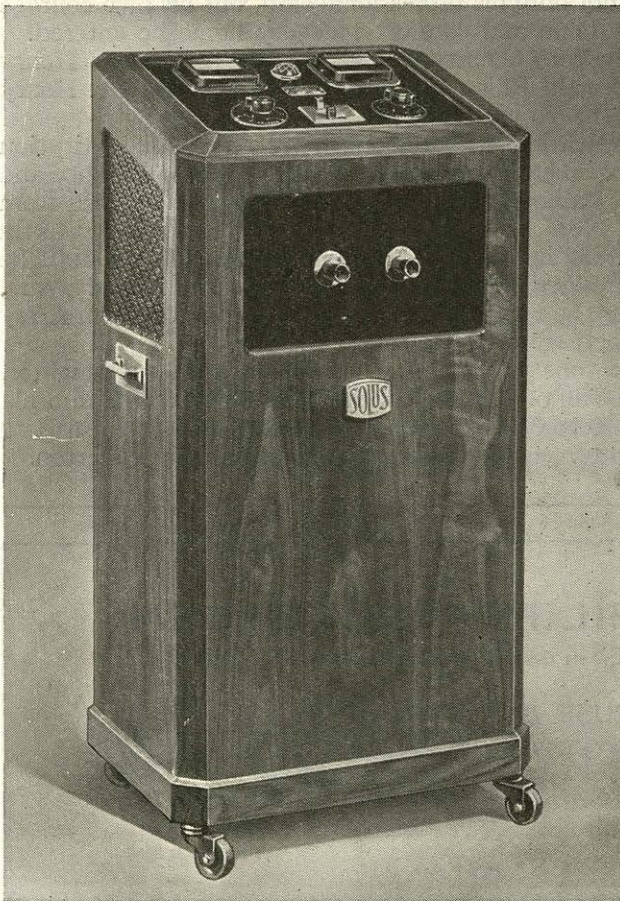
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OBITUARY

We regret to report the death of Dr. Charles Schomberg Elliot at his home in Halifax, in the seventy-third year of his age, on June 1st. Dr. Elliot practised his profession in Guysborough, Stellarton and since the war, in Halifax, and his passing reduces the ranks of the older family physicians of which he was an honoured and distinguished member.

Of the many who knew him, few have realized that for the past four years he has been a victim of a heart ailment, for he bore his illness with a fortitude and high courage that never allowed worry to infringe on a cheery and good-natured personality, that made his face a welcome one, and his visits eagerly anticipated in the houses of sickness that he cared for.

His loss will be keenly felt by many in the city and the province, but with none more so than in the poorer sections of the city, where he carried on a truly fine work, dispensing not only his professional skill, but his own courage and good-will that brought hope and comfort to every home he entered.

Born in Stillwater, Guysboro County in 1864, he was the son of Henry Elliot and Elizabeth MacDonald Elliot and grandson of the late Dr. Henry Elliot, first Lieutenant of the Royal Marines.

He received his early education in Pictou Academy when that institution was fathering so many men who have since brought fame to their province and school. Later he attended Dalhousie University and finally graduated from Bellevue Medical College, New York, in 1891. His first practice was in Guysboro town, where, in 1897 he married Miss Minnie Selden. In 1901 he went to Stellarton, Pictou County, where he practised for a number of years, later coming to Halifax where he was first connected with the Canadian Army Medical Corps. He has practised in Halifax since the war.

Surviving are his widow, one son, Dr. H. C. S. Elliot, and one daughter, Esther, and four grand-sons, all of Halifax; a brother and sister in California and two brothers in the Eastern States. The funeral was held from his late residence in Halifax with interment at Christ Church cemetery, Stellarton.

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Personal Interest Notes

Dr. E. A. Fergusson of Weymouth is visiting in New York.

Dr. and Mrs. Arthur E. Blackett of New Glasgow sailed on the Furness liner "Nova Scotian" for England. After attending the coronation ceremonies Dr. Blackett plans to visit Nice where he will represent Nova Scotia at the International annual meeting of Rotarians.

Dr. and Mrs. L. R. Morse of Lawrencetown sailed on May 4th for England and the Continent for two months. Dr. Morse will meet his brother Dr. Reginald Morse who is returning from medical work in China.

Dr. George H. Cox and his two daughters have returned to New Glasgow from an enjoyable winter spent at St. Petersburg, Florida.

Dr. Allister Calder, wife, and son Robert, of Glace Bay, were recent visitors at Middleton.

Dr. Bowman C. Crowell, associate director of the American College of Surgeons, visited his former home at Yarmouth on his way to Halifax.

The Librarian of the Medical Library of Dalhousie University would be grateful if any one interested would contribute the following numbers of the Nova Scotia Medical Bulletin to the files of the Library.

Vol. 1, nos. 1, 2, 3.

Vol. 3, no. 8.

Dr. and Mrs. S. W. Williamson of Yarmouth have arrived home from an extended trip to California and the Panama Canal.

Dr. John R. McNeil was reappointed medical officer at a recent meeting of the town council of Glace Bay.

Dr. and Mrs. S. J. MacLennan of Halifax are spending the summer at Baddeck.

Dr. A. R. Grant, Dalhousie 1937, has established practice at Summerside, P.E.I.

The wedding took place very quietly at Halifax on May 15th of May Eleanor, younger daughter of Mr. and Mrs. E. Chesley Allen, to Dr. Robert O. Jones, only son of Mr. O. C. Jones and the late Mrs. Jones, of Kentville. Miss Allen is a graduate of the Nova Scotia College of Art, and Dr. Jones received his medical degree from Dalhousie University this spring.


Dr. William V. Cone, Assistant Professor of Neurology and Neurosurgery, McGill University, will talk on "Treatment of Fracture Dislocations of the Cervical Vertebrae by Skeletal Traction and Fusion."

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 PICTOU LODGE, JULY 7th and 8th, 1937

Provisional Programme

TUESDAY, JULY 6th.

7.30 p.m. Executive Meeting, Pictou Lodge.

WEDNESDAY, JULY 7th.

9.30 a.m. Registration.

10.00 a.m. Formalities.
 Report of Executive.
 Business Session.

1.00 p.m. Adjournment.

2.30 p.m. "The Treatment of Fracture Dislocations of the Cervical Vertebrae by Skeletal Traction and Fusion", by Dr. Wm. V. Cone, Montreal.

3.15 p.m. "Post-Operative Thrombosis and Embolism", by Dr. Clarence Miller, New Glasgow, N. S.

3.45 p.m. "Empyema", by Dr. G. R. Burns and Dr. V. O. Mader, Halifax, N. S.

4.15 p.m. "The Treatment of Acute Gonorrhoea", by Dr. John C. Wickwire, Liverpool, N. S.

6.00 p.m. Dinner.

THURSDAY, JULY 8th.

9.30 a.m. Business Session.

10.30 a.m. Presidential Address.

11.00 a.m. President and Secretary of the Canadian Medical Association: Representatives from New Brunswick and Prince Edward Island Medical Societies.

11.30 a.m. "The Control of Tuberculosis", by Dr. G. J. Wherrett, Ottawa, Ontario.

12.00 noon. "Problems of Disease of the Blood in General Practice," by Dr. William P. Murphy, Peter Bent Brigham Hospital, Boston, Mass.

2.30 p.m. Golf or Other Entertainment.

DIARRHEA

“the commonest ailment of infants in the summer months”

(HOLT AND MCINTOSH: HOLT'S DISEASES OF INFANCY AND CHILDHOOD, 1933)

One of the outstanding features of DEXTRI-MALTOSE is that it is almost unanimously preferred as the carbohydrate in the management of infantile diarrhea.

In cases of malnutrition, and indigestion in infancy, the stools soon become normal in appearance, and improve rapidly, and the stools soon become normal in appearance. By this I refer to proper doses of dextrin and maltose. When there is a tendency to the sugars are intelligently prescribed. When there is a tendency to the proportions of dextrin and maltose, known as dextri-maltose, for infantile diarrhea, and the commoner of the diets used in the treatment of the same. —M. Ladd: *Further experience with dextrin and maltose*, *Arch. Pediat.* 33:501-512, July, 1916.

In diarrhea, “Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble.” —B. B. Jones: *A discussion of some of the commoner forms of infantile diarrhea, and the commoner of the diets used in the treatment of the same*.

“Dextri-maltose is a very excellent carbohydrate. It is made up of maltose, a disaccharide which in turn is broken up into two molecules of glucose—a sugar that is not as readily fermentable as levulose and galactose—and dextrin, a partially hydrolyzed starch. Because of the dextrin, there is less fermentation and we can therefore give larger amounts of this carbohydrate without fear of any tendency of fermentative diarrhea.” —A. Copper: *Facts and fads in infant feeding*, *West. J. Med.* 41:278-282, 1915.

SERIOUSNESS OF DIARRHEA

There is a widespread opinion that, thanks to improved sanitation, infantile diarrhea is no longer of serious aspect. But Holt and McIntosh declare that diarrhea “is still a problem of the foremost importance, producing a number of deaths each year. . . .” Because dehydration is so often an insidious development even in mild cases, prompt and effective treatment is vital. Little states (Canad. Med. A. J. 13:803, 1923), “There are cases on record where death has taken place within 24 hours of the time of onset of the first symptoms.”

“Maltose is more easily absorbed than cane or milk sugar, and by changing the carbohydrate one may prevent a deficient supply of sugar.”
 “When sugar causes diarrhoea one can change the form of it. Mead’s Dextri-maltose in small doses is more quickly absorbed and so superior to castor (cane sugar). Lactose is expensive and seems not to be better than castor sugar.” —H. B. Gladstone: *Infant Feeding and Nutrition*, *William Heinemann, Ltd., London*, 1928, pp. 11, 79.

“In cases of diarrhea, “For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice.” —W. H. McCaslan: *Summer diarrheas in infants and young children*, *Alabama*, 1:278-282, 1915.

“If there is an improvement in the carbohydrate may be added. The teaching of the originator of the carbohydrate added should be the most easily assimilated. Dextri-maltose is therefore the carbohydrate of choice.” —*Summer diarrheas in the young*, *International J. Pediat.* 9:111-118, 1915.

“The condition in which dextri-maltose is particularly acute attacks of vomiting, diarrhea and fever. It seems that recovery is more rapid and recurrence less likely to take place if dextri-maltose is substituted for milk sugar or cane sugar when these have been used, and the subsequent gain in weight is more rapid.”
 “In brief, I think it safe to say that pediatricians are relying less implicitly on milk sugar, but are inclined to split the sugar element giving cane sugar a place of value, and dextri-maltose a decidedly prominent place, particularly in acute and difficult cases.” —W. L. Hoskins: *Present tendencies in infant feeding*, *Indianapolis M. J.* July, 1914.

“The gradual transition to a whole milk or one and one-half to two ounces of whole milk to every pound of body weight, is reached. This also amounting to five to seven per cent.” —R. A. Strong: *Summer diarrheas in infancy and early childhood*, *Arch. Pediat.* 12:221-222, 1915.

“In the treatment of diarrhea, “The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose.” —H. E. Small: *Diarrhoea in bottle-fed infants*, *J. Maine M. A.* 12:154-158, Jan. 1922.

“It should be noted that a group of organisms thrive on and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found then stopped it and added dextrin and maltose to the formula.” —A. G. DeSanctis and L. V. Paider: *The value of calcium caseinate milk in fermentative diarrhoea*, *Arch. Pediat.* 33:233-236, April, 1916.

“The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose.” —H. E. Small: *Diarrhoea in bottle-fed infants*, *J. Maine M. A.* 12:154-158, Jan. 1922.

“The more complex carbohydrates, of which dextrin is the type, ferment more gradually and do not have this laxative effect.”
 Regarding the treatment of diarrhea, “In our experience, the most satisfactory carbohydrate for routine use is Mead’s dextri-maltose No. 1.” —F. R. Taylor: *“Summer Complaints,” Southern Med. & Surg.*, pp. 555-559, Aug. 1915.

“The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose.” —H. E. Small: *Diarrhoea in bottle-fed infants*, *J. Maine M. A.* 12:154-158, Jan. 1922.

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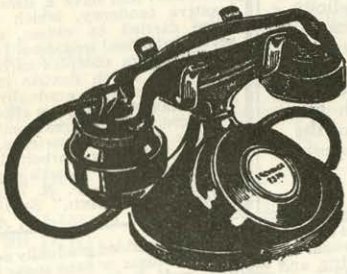
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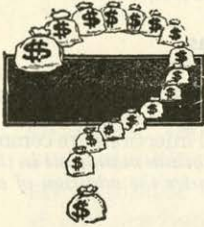
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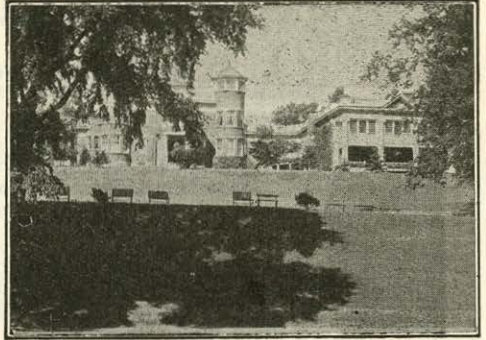


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