

CONTENTS

SCIENTIFIC ARTICLES:

Gonorrhoea in Women—W. G. Colwell, M.D., Halifax, N. S. - - - -	53
Allergy, Immunity and Infection—T. M. Sieniewicz, M.D., Halifax, N. S. - -	57
The Value of the Classics in Medicine—J. E. LeBlanc, M.D., West Pubnico, N. S. -	60

HISTORICAL SECTION:

A Trying Situation—Wm. Grant, M.D., Wolfville, N. S. - - - -	62
--	----

CASE REPORTS:

Spontaneous Rupture of a varicose vein complicating pregnancy—Frank J. Hebb, M.D., Liverpool, N. S. - - - -	64
Tuberculosis Laryngitis—A. Ernest Doull, M.D., Halifax, N. S. - - - -	65
A Cavernous Sinus Infection following Quinsy—R. H. Stoddard, M.D., Halifax, N. S.	66
Syphilitic Heart Disease—C. W. Holland, M.D., Halifax, N. S. - - - -	67
Fracture of the Fourth Cervical Vertebra—J. A. Langille, M.D., Pugwash, N. S. -	68
Gynatresia—G. Victor Burton, M.D., Yarmouth, N. S. - - - -	69
Osteomyelitis following Influenza—C. A. Herbin, M.D., Lockeport, N. S. - -	71

EDITORIAL:

The King George V Silver Jubilee Fund for Cancer in Canada - - - -	73
The Dalhousie Public Health Clinic - - - -	74

DEPARTMENT OF THE PUBLIC HEALTH - - - -

76

OBITUARY - - - -

79

Joint meeting of the American and Canadian Medical Associations, Atlantic City, June 10-14, 1935 - - - -

80

PERSONAL INTEREST NOTES - - - -

84

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Gonorrhoea in Women

W. G. COLWELL, M.D., Halifax, N. S.

THIS disease so widely prevalent and to which so little of value in treatment has been added in years is one of the most disabling diseases that women can suffer from. It constitutes about 60 per cent. of the practice of gynecology and is seen at least in its chronic form every day by every physician.

The general practitioner, as a rule, meets it at first and it rests upon him at least for the initial treatment, and it is his duty to inform the patient of the dire results of neglect of treatment. More ill health and disability results from neglected, improperly or ineffectively treated gonorrhea in the female than even from Tuberculosis. It is a common cause of sterility, especially one child sterility and occurs as a rule in women who are just on the threshold of their womanhood. The treatment is most difficult and painstaking and does not offer, as it does in the male, any ready signs of progress, there being so many ways in the female that gonorrhea can behave. In diagnosis too much dependence must not be put upon the obtaining of a positive smear. Too often this is not obtainable and a negative one does not, by any means, exclude gonorrhea. The diagnosis must primarily rest upon history and the physical findings.

History.

A vaginal discharge appearing for the first time after marriage or dating from an illicit intercourse and especially if it is profuse from the start and yellowish in color is almost invariably gonorrheal in origin. Urinary symptoms, such as frequency and a burning pain on micturition are important and together with the discharge almost clinch the diagnosis. The presence of a tender swelling in the region of one or both Bartholin glands is almost always gonorrheal in origin. Menstrual irregularities do not present themselves unless the disease has advanced further than the cervix and there is then present pelvic inflammatory disease. Menstrual upset may take the form of a gradual lengthening of the period of blood loss, or a shortening of the interval, or less often an increase in the interval with lessened flow, approaching ammenorrhea. Pain is not a factor in this disease unless the pelvic organs have become involved except in Bartholinitis, and is most marked, of course, in the acute stage of the infection. Later as the disease becomes chronic, the pain is usually associated with the periods, either before or during the period, and as a dyspareunia. Some cases complain of a heaviness or a bearing down sensation during the acute stage without pelvic inflammatory disease being present.

Physical Findings.

Inspection is of value. In the acute stage we have intense inflammation of the vulva and a profuse discharge from the vagina with or without Bartholin gland involvement. Here the diagnosis is easy and positive smears are not

difficult of obtaining. It is in the sub-acute and chronic forms that difficulty arises and with which we are most concerned. The external urinary meatus of the urethra should be inspected, it rarely escapes. The redness, oedema and pouting of the acute stage has disappeared but the orifices of the glands are large, red, and the mucous membrane is pale. The whole urethra is large, thick and sensitive, and pus can be expressed. If it is thick and creamy, it is gonorrhoeal, if not frankly purulent and is thin and small in amount it is highly suspicious. After all, what else can cause it from a practical standpoint. The vagina escapes the infection due to its resistant type of epithelium, but may be reddened and rough from the irritating cervical discharge. The cervix is either normal in size or slightly enlarged and the area around the External Os is usually reddened and congested and bathed in a muco-purulent discharge. If the infection has gone higher than the cervical canal, we find on examination tenderness on moving the cervix from side to side which is due to peritoneal irritation and on bi-manual examination, tenderness in both lateral fornices with or without the presence of masses. This latter depends upon the virulence of the organism and the resistance against it by the pelvic organs and the body generally. Pyo-salpinx is not commonly seen in the acute or sub-acute stages or in treated cases.

Management.

Acute Stage. Local treatment should be avoided because as Pelouze says the disease is the same in both sexes and if during the acute stage in the male local treatment is not carried out why should it be in the female? Rest in bed, no matter how little or much involvement of the various structures there is, is essential. General measures such as the relief of pain by sedatives, the application of heat to the lower abdomen where there is tubal involvement, gentle irrigation of the vulva and vagina with a mild antiseptic solution such as 1-5000 Pot. Permanganate and where the urethra is involved the giving of a urinary antiseptic and sedative of which Mist. Pot. Cit and Hyosyamus we find excellent.

The acute stage fairly rapidly subsides under such measures and then hot vaginal douches under low pressure and copious in amount should be used. The heat is the main virtue of the douche. If there is Bartholin gland involvement in which abscess formation has occurred, the gland should be incised, emptied and as much as possible of it dissected away, packed and allowed to heal from the bottom.

The general measures outlined above are carried on until the condition has entirely subsided as far as symptoms are concerned and very little, if any, pelvic signs if they have occurred remain. The next step is the eradication of the sites where the gonococcus is likely to lurk, namely, in the floor of the urethra, Skene's tubules particularly, and in the cervix. Both of these areas are lined by columnar epithelium which is readily infected and both are resistant to local treatment in the form of antiseptic applications. Particularly is this true in the cervix where by the nature of the structure of the part local applications cannot effectively, as a rule, get at the lurking place of the gonococcus, which is in the gland beneath the mucosa. Most authorities are agreed that the only effective way of ridding the cervix and to a less extent Skene's tubules is the destruction by means of the actual cauterization and Pelouze is very emphatic on this point, claiming that it is the only rational way to rid the cervix of gonococci. It is our practice to thoroughly cauterize

the whole canal linearly and the area around the External Os which is usually eroded, radially from the Os packing the canal afterwards with gauze which is left in place about twenty-four hours. The use of the cautery is not attended by any difficulty and can readily be carried out in the office without any anesthesia as it is not painful provided only infected and eroded areas are cauterized, because to touch an uneroded area of the cervix is decidedly painful. Skene's tubules can be treated in the same manner by passing a fine probe into the duct and cutting down on it with the hot wire although it is a more painful area than the cervix to cauterize and should probably be done under anesthesia.

Antiseptic solutions have been, are, and probably will continue to be, widely used in treating the cervix. Many there are in use. Of those used, perhaps Mercurochrome and tincture of Metaphen are probably the most effective.

In my own practice I lean towards Mercurochrome in a 2 or 5% solution on a pledget of cotton which is introduced well up into the canal and which is left there on the applicator from 10 to 15 mins., this treatment being repeated three times weekly. The patient gives herself a daily douche of hot lysol or Baking Soda solution, drams 1 to the quart former, and drams 2 to the quart for the latter, the douche being given under low pressure. If after two or three months of such treatment organisms are still found, and smears are only taken immediately after a period, then the cautery is resorted to as previously described.

A word about cervical smears. The cervix must be cleaned well and the applicator introduced into the canal, rubbing the floor thoroughly to be sure to bring to light gonococci if present and making a thin smear on a glass slide. Do not be too sure that extra-cellular cocci are not gonococci, if gram negative, better not to have any of them, intra or extra cellular.

Too vigorous treatment of the cervix as well as douches under high pressure are to be condemned. Especially so if given a case where no pelvic symptoms are or have been present. The great risk is that of forcing the organisms higher than the Internal Os which is somewhat of a natural barrier being closed, with resulting pelvic inflammatory diseases. The risk is great enough at the time of menstruation without increasing it by too forceful treatment.

Where pelvic inflammation has occurred it will, as has been stated, fairly quickly subside. If no indiscretions are permitted or indulged in, such as exposure to cold, wet feet, sexual excitement or alcoholic stimulation, or anything tending to lower bodily resistance occurs, the tubal disease cures itself and by eradicating the foci of infection the cervix, urethra, and Bartholin glands, there is no doubt of the possibility of a complete cure.

In cases of chronic pelvic inflammatory disease which according to most authorities only arises in improperly treated or neglected cases, diathermy is of value in some instances and should where possible be given a thorough trial. The reaction to foreign proteins, such as milk injection, is claimed by some to be useful in chronic pelvic inflammatory disease which does not seem to respond to other forms of treatment. Surgery in this type of case is a last resort and while curative is most unfortunate in having to be done in young women. It is essential where surgery is used to remove the whole uterus as well as tubes because of the cervix as a source of infection.

In conclusion may I quote Pelouze again with regard to treatment:—
“the acute stage calls largely for masterly inactivity. The acute for guarded

activity and the chronic, perhaps, for destructive activity. The hope during the first two stages is that the third may be ushered in without tubal involvement and it should be with this end in view that our treatment be tempered." A case properly treated from the onset with eradication of the gonococcus from the cervix, urethra and Bartholin glands can, and will be cured regardless of whether or not the tubes have been involved.

DISCOVERY OF CANCER SERUM IS ANNOUNCED.

London.—Discovery of a serum which kills cancer cells after they have been removed from the human body, and does no injury to healthy human tissue so removed, was announced here to-day by Dr. Thomas Lumsden, director of the London Cancer Research Laboratories.

Lumsden, one of the best known among conservative cancer scientists, said the serum cannot at present be used on human beings, he reported his discovery to the court of governors of the London hospital.

In Experimental Stage

The scientist, emphasizing strongly that the serum "is only in the experimental stage and has not reached the point where it can be tried on human beings," nevertheless said a stage had been reached in which the serum will kill cancer cells removed from the human body without damage to normal cells similarly treated.

The serum, Dr. Lumsden reported, was obtained from the blood of an animal after cancerous cells from an animal of a different species had been implanted.

(Human cancer cells live and grow indefinitely in laboratory test tubes and healthy tissues do the same. These furnish the material for experiments outside the body.

Further Step

As a further step in his investigation, the scientist said it was found that the serum will kill cancer cells implanted from one animal to another animal of the same species, and so raises the resistance that once animals are cured it is impossible to infect them with cancer again.

The report, stating that Lumsden and his co-workers are engaged in refining the serum concludes:

"The most that can be said is that this line of research offers distinct encouragement. It might be mentioned that there is no evidence that cancer is due to a germ or is infectious in the general sense."

New Conceptions of Allergy, Immunity and Infection

T. M. SIENIEWICZ, M.D., Halifax, N. S.

MUCH has been written about each of these within the last two or three years and it was thought desirable to review this subject even though briefly.

Our conceptions of the subject of allergy and immunity must be much modified. It was believed that non-fatal infection with tubercle bacilli produced immunity against subsequent reinfection. Enough immunity, no doubt, is established to prevent a rapid generalization of the infection, but it is the amount of hypersensitivity to the protein of the tubercle bacilli that will decide the degree of destruction of tissue which will take place in that body. Thus we have a state of hypersensitivity to the bacterial protein spoken of as allergy and the ability of the body to inhibit growth and invasion of bacteria, and to neutralize the toxins produced, which is spoken of as immunity.

Rich has shown that allergy and immunity can exist independently, and that allergy can be abolished while immunity persists. By three different methods he was able to separate the two.

1. Immunity can be established without the concomitant development of allergy. This particular experiment deals with syphilitic infection. The testes of the animals were inoculated with the spirochaetes derived from human chancres. Reinfection of these immunized animals was next carried out by intracutaneous injections of large numbers of virulent spirochaetes, and acquired immunity manifested itself not by allergic inflammation, but by a remarkable indifference of the tissues to the presence of the injected spirochaetes. The non-immune controls developed large local chancres and lesions in distant tissues were common. Allergic inflammation, therefore, was not necessary for the operation of acquired immunity in syphilis. Similar reinoculations performed on human beings in the primary stage of syphilis have demonstrated no exaggerated allergic lesion. It is only in the late secondary and tertiary stages that allergy can be demonstrated by the luetin test, and it is significant that it is in this latter allergic state that progressive destruction of tissue is most marked.

2. Immunity was separated from allergy by passive transfer. Animals were rendered highly allergic and immune to the pneumococcus by vaccination with killed cultures. Then the serum from these immune allergic animals was introduced into normal ones. The latter were then infected with virulent pneumococci and no allergic reaction occurred, yet a potent immunity was present as the animals survived huge doses of the infection.

3. Allergy was abolished by desensitization and immunity was left intact. These experiments were carried out with various infections including tuberculosis.

Large numbers of animals were first rendered allergic and immune by intracutaneous vaccination with dead organisms. Desensitization of half the animals was carried out by intravenous injections of large amounts of a killed

culture. The non-desensitized animals, the undesensitized ones and the normal controls were then infected intracutaneously with virulent organisms. The results showed that the desensitized animals gave no allergic reaction whatever and they were still immune to millions of lethal doses as were also the allergic or non-desensitized ones, but these developed highly inflamed and sloughing lesions at the sites of injections. Koch's phenomenon was always thought necessary for the protection of the body, but here we find that immunity is as effective in the one group as the other.

Rich goes on to state that, "In all of the experiments, blood cultures and microscopical studies made it perfectly clear that the immobilization of the bacteria in the immune, non-allergic body was just as effective as it was in the allergic one." Rich amongst his conclusions states, "I have sought merely to show you that allergy is not at all necessary for the operation of immunity, and to point out, that in the many cases in which hypersensitiveness is recognized by all to be doing great damage to tissues and to be endangering life itself, we may, when we possess an adequate method, protect the body by desensitization without sacrificing the ability of the body to resist the infection by means of the acquired forces of immunity. The present methods of desensitization in bacterial hypersensitiveness are far from satisfactory, but it is highly probable that safer and more efficient methods can be developed, and the search for such methods is a matter of major importance, not only for the investigation, but also for the treatment of bacterial diseases."

The presence of allergy in the absence of immunity is next considered. These studies were carried out by workers of the Rockefeller Institute and the Henry Phipps Institute for the Study of tuberculosis. These investigators have succeeded in establishing a high degree of allergy to tuberculin by treating their animals with large doses of purified tuberculo-protein. When these animals were tested for immunity by injection of virulent bacilli it was found that no immunity was present. They even found that the life of the normal controls was longer than that of allergic ones. Consequently the tuberculin test cannot be used as an index of immunity.

Clinically we have often noted in the negro a high degree of hypersensitivity and a very low degree of resistance.

Research in South Africa has shown that nearly 70 per cent. of the "boys" arrive at the mines tuberculin-positive, and that generalized tuberculosis is very common amongst them. This is clinical evidence of the disappearance of immunity while hypersensitivity persists.

Heimbeck, of Oslo, Norway, found that nearly all of the Pirquet-negative probationers became positive before the end of their training and that practically 30 per cent. develop some clinical manifestation of tuberculosis as contrasted with 2.6 per cent. in those Pirquet-positive. These manifestations consist of erythema nodosum and pleurisy, and pulmonary infiltrations of the mild childhood type. As a result of these findings he has adopted a plan whereby these tuberculin-negative probationers are given the attenuated virus of B. C. G. by mouth or subcutaneously. As it takes about two months for B. C. G. to convert a negative to a positive Pirquet, so the test is made then and if it is found to be still negative, another injection of the virus is given. The tuberculin test is made at the end of another two month's interval. If the reaction is still negative then the probationer is rejected

from further training. It is important to point out that during this interval of two or four months the person concerned must not come in contact with an infectious case of tuberculosis. After she has become tuberculin-positive, however, it is desirable that she be exposed to tubercle bacilli so that she may acquire a more lasting immunity.

Between 1927 and 1933 Heimbeck has thus treated 243 Pirquet-negative probationers. Of this number 119 became Pirquet-positive; there were 69 who remained tuberculin-negative: 16 gave a doubtful reaction, and 39 were omitted from this study. There was only one of the 119 who subsequently developed clinical manifestations of tuberculosis, and in contrast there were 22 (26.9 per cent.) among the 16 doubtful and 69 negative reactors.

Myers finds that nearly all the tuberculin-negative medical students at the University of Minnesota became positive during their training, but that this is accompanied in less than 25 per cent. by symptoms or physical signs of pleurisy with effusion or small pulmonary infiltrations or both which soon disappear. He states that adults tolerate well the first infection type of tuberculosis and that it hardly differs from that in children, most of whom pass through his phase without symptoms. They are, however, tuberculin-positive and the physical and X-ray findings show a lesion which may be localized in any part of the lung, with involvement of the corresponding lymph nodes; and with calcification eventually developing in the caseous lesions. A small percentage of children will develop with first infection the miliary and meningitic forms of tuberculosis. This corresponds with our findings in the examination of children at our Clinics who are, or have been, in contact with open cases of tuberculosis. I wish at this point to state that the tuberculin test in our clinic consists of the intradermal, that is, the Mantoux test: and that the first and second strengths of the Tuberculin P. P. D. (purified protein derivative) are used in place of the O. T.

Systematic routine examinations of the university students will disclose some with first infection type of tuberculosis. The adult type usually met with is the reinfection type, and it is apical in localization, the nodes are not involved, and the caseation will go on to excavation and fibrosis.

Reinfection may result from exposure to massive contagion (exogenous), or, when there is no source of such contagion, from the lowering of his general or specific resistance, thereby allowing living tubercle bacilli within his body to reinfect him, either by entering the blood-stream, or upon allergic tissues, which result in rapidly progressive miliary tuberculosis or chronic disease of the lungs, bones and joints, or other parts of the body (endogenous).

With these facts before us, we are still asking ourselves whether control of tuberculosis means satisfactory immunization as practiced on the Continent or the prevention of exposure to the infection, considered by most to be the chief epidemiological measure.

Diphtheria, once classed among the commonest of serious communicable diseases, has now become a rare affliction in New York State.

Department statistics show that in 1914 there were 5,341 reported cases of diphtheria in the state outside of New York City. In 1924 there were 5,883. Last year only 442 diphtheria cases were reported, a reduction of more than 92 per cent. in ten years.

The reduction is largely attributable to immunization of young children.

“The Value of the Classics in Medicine”

J. E. LEBLANC, M.D., West Pubnico, N. S.

AT the last meeting of our Western Nova Scotia Medical Society held in Yarmouth in November at the Grand Hotel, two very important lectures were given; one by Dr. H. K. MacDonald on the Surgery of the Chest and one by Dr. H. G. Grant, on Medical Education. The discussion of these two papers was most interesting, particularly that by Dr. Grant upon the value of the classics in medicine. Upon retiring he kindly invited me to write a paper on the subject for the BULLETIN and here I am.

We all know that in some of our Universities of today there are two cultures highly in vogue: i.e. The “Classical Culture”—and the “Modern Culture”. The former, before the middle of the Nineteenth Century was the one mostly taught but owing to pressure of some kind, to various opinions and tenets of doctrine upon Education, the latter succeeded in supplanting the former. But the result was disastrous as we shall try to demonstrate. France tried the experiment and failed. The United States also as we shall see later. France particularly was the one who once strongly advocated this new “Modern System” of a liberal education. By that we mean, the doing away of the Latin and the Greek and substituting in their places the living literatures of the day—English, French, German and Spanish. After a number of years she noticed that the standard of her educational schools was lowered for reasons we shall also explain, and hence recently the French Government has had to adopt another course in the curriculum of studies. France has restored the Classics to their former place or rather to a higher place on the curriculum of her secondary schools. In the Lycee the aim is to give the student a good general education. No country in the world feels the need for practical trained men more than France does for she has to reconstruct thousands of towns and industries that were wrecked in the Great War. France goes back to the classics as one of the requisites of a sound education: it is a significant fact.

The subject is a big one, one which has occupied the mind of many educationists within recent years. We are all familiar with the term “dead language”, and we are at once under the impression that it means a language devoid of life, of activity. But such is not the case. We are speaking *Latin* every day in our conversation not in the proper form of the language, so to speak, but with words that are mostly derived from it. Let us take, by way of an illustration, this simple phrase “*Felix qui potuit rerum cognoscere causas*”—i.e. when translated: “Happy who is able to know the causes of things”. From the word *felix*, we have *felicity*: from *potuit*, we have *potential*, *power*, from *cognoscere*, *recognition*; from *causas*, *causes*, and from *rerum*, the abbreviation *re*. We could go on indefinitely citing phrases in order to show how precious a gold mine the Latin is for our language, but space does not allow us to quote more.

The question of language in Medical Education is a very important one. It has a necessary function. It is the universal currency of thought. The gold and silver and baser coin of thought are the stored up treasure of the mind which circulates everywhere in the substitutes of words. On this all sciences and arts largely depend, the concern of business, all trades, and professions, literature, government, home life and education. All the symbols of science are merely language in short hand. The written and spoken word rules the world. We are getting here to some ancient things, so ancient that they seem eternal. This is all so alarmingly elementary that it seems needless to mention it. But it has to be mentioned because it is imbedded so deep in tradition that we have lost sight of its immense importance.

Granting then that language and thought are the double foundation and that they are so interlocked as to become the single foundation for education from beginning to end; Thought as the soul of language and Language as the embodiment of thought, audible in speech and visible in writing; what follows? That we ought to learn to use our language as well as possible.

"For the mass of English speaking men" says Andrew F. West, of Princeton University, "the best use of English is not attained without knowing the sources—whence its literature draws its life. Nearly half of it is Latin. The better we know Latin, then, the better our use of English. And, as the important modern languages, French, Spanish, Italian are simply Latin in modern guise, Latin is the surest and the quickest help of learning them. It is their ancestral home and largely, ours also. It is the key which opens many doors and many more than we have mentioned. Such are the simpler practical reasons for studying Latin."

From a purely clinical standpoint, the study of the Classics has an immense value. The American Universities are coming back to the Classics and I know of no better testimony than that of the Dean of the Medical School, of the University of Michigan, Victor C. Vaughan who says: "That there has been found nowhere a better training for the thinking apparatus of the young than the study of Latin and Greek. Carelessness and superficiality are incompatible with any thorough study of Greek and Latin. The student's observation is sharpened, his perception becomes more delicate and he finds increased pleasure in the intensity with which he seeks fully and correctly to interpret the author's meaning. And this habit of close observation, of attention to detail, of looking for fine distinction and shades of difference and the alertness of mind possessed by an individual of this habit will be of inestimable service to him should he choose medicine for his profession both in his experimental work in the laboratory and at the bedside of his patient."

Dr. Abraham Groves, of Fergus, Ont., was the first doctor in the world to remove anyone's appendix and also the first surgeon anywhere to sterilize instruments. "All in a Day's Work.," just published by the Macmillans, relates much of interest about Dr. Groves. Besides the 1883 appendectomy, Dr. Groves removed six gallstones from a 300-pound man on a kitchen table in a tavern in Guelph—away back in 1878. In 1874, before Lister introduced aseptics. Groves was first in the world to boil all instruments used in operations.—*Mail*, Dec. 6.

Historical Section

A TRYING SITUATION.

WILLIAM GRANT, M.D., Wolfville, N. S.

THE other day, while looking over some old records, I happened on a few notes I had made of a case I attended long ago. To me it was one of the most interesting I ever had; not from a scientific standpoint, it is true, but from the circumstances connected with it. I hesitate to tell of it, owing to its evident lack of interest to others, and of glory to myself; but, maybe it was sufficiently uncommon to bear mention.

It happened away back in 1893, shortly after I had left college. Confident at the time that I knew everything about human ills, I decided to proceed to Newfoundland to heal the sick of that country. When I reached Port aux Basques on that errand of mercy, and was stepping ashore from the steamer, I received an urgent call to see a Mrs.—. The messenger-boy who had seen her shortly before thought she had the “convulsion fits”. Would I go at once and he would show me the way.

My limited stock of drugs and instruments had not then been taken ashore, or released from the Customs. All I had with me in the way of equipment was a stethoscope and a thermometer. Nevertheless I decided to make the visit, not that it was my wish, but because of the earnest request of several representatives of the place who had gathered at the gangway to meet me.

Having travelled about a mile, I entered an isolated, dimly-lit residence on the outskirts of the settlement. There, lying on a small bed in one corner, I saw a gigantic young woman apparently in a desperate state. Her head was thrown back rigidly into the pillow, her face cyanosed and distorted, while she breathlessly held to the bedpost in what seemed a death-grip. I was thoroughly alarmed—some form of tetanus I concluded. I was provoked at not having medicine with me that I might relieve her. I had implicit confidence in the efficacy of drugs in disease—that was before I had begun to use them. I went over timidly to her side and felt her racing pulse. Presently she found sufficient breath to say—“Thank God, the baby is come at last sir.” “The baby!” I gasped, startled out of my wits. And yet, to my surprise, I found that such was the case; she had given birth to a plump, well-developed child.

At this point no one was in the house or in its immediate neighbourhood except the woman and me. Her labour having come on suddenly and unexpectedly, her husband had gone out on my arrival to look for a granny, evidently some distance away. I looked anxiously about the room for something to use, but could find nothing. Noticing this, the woman was now able to tell me that some things she had prepared for the event were in the next room, if I could find them. The next moment found me in there, search-

ing everywhere without success. Anyway my rummaging was cut short by an urgent call from my patient to come quick, and try to do something, because she was as bad as ever. I rushed back to her side in alarm only to find her delivered of another child.

It was awkward to be alone, and with nothing at hand to serve my purpose, seeing how eager I was to make a success of my first case in a new field. I decided to stay by her, however, and do all I could to encourage her, till the midwife should arrive. Indeed, it was all I could do. She was still groaning and feeling very weak and tired. Before very long she began to have occasional pains which I considered favourable. But after a while these grew so severe and threatening as to be alarming, until at length, Heavens! another bouncing baby had arrived.

Even now I can recall how nervous and flustered I was. Beads of perspiration were dropping from my brow, although the temperature of the room must have hovered around the zero mark. The patient was now trembling severely from cold. Still moaning, and declaring that she was dying, while the infantry continued to yell at the top of their lungs in one protesting chorus, I really felt that I should be doing something besides trying to prevent the infants from tumbling overboard. Would the midwife ever come!

After what seemed an age she did arrive, well muffled up in a reefer, and a masculine woollen cap on her head.

"Holy St. Patrick!" she exclaimed, throwing up her hands, "No less than three of them, and nary a maiden among the lot. Bless their little 'arts—you'll catch your death of cold in thy bare arms, with nar coat or weskit."

She being an expert at finding things about the house, we managed after a while to put everything in something like ship-shape order. Before I left the woman was comfortable, and in fairly good condition.

As a sequel to the foregoing I may say that Abraham, Isaac and Jacob—names common in Newfoundland—survived the ordeal, and grew up to be healthy, sturdy lads. So much alike were they that no one could tell who was who, dark, wavy hair, dark eyes and rosy cheeks. At the age of twenty they were as handsome and able a trio as could be seen anywhere, each six feet three in his socks, straight limbed and well proportioned. There was something fine about their plumb-line erectness and the width of their square shoulders.

As soon as the war was declared they all enlisted at once, and served with distinction in France. Abraham won the rank of Captain, Isaac, badly scarred but fit, won a lovely wife, a nurse who had cared for him in hospital, and Jacob D. S. O. served with the Flying Corps for a while, but unfortunately is now asleep in France.

CASE REPORTS

SPONTANEOUS RUPTURE OF A VARICOSE VEIN COMPLICATING PREGNANCY.

On August the second, of last year, an "emergency" call came to my office. I was told during the telephonic conversation that "a vein was bleeding", but the caller's receiver was disconnected before I could give emergency instructions. I arrived at the home of Mrs. E. L., taking in all, about two minutes to complete the journey.

Examination. The patient was found seated in a chair and immediately I discovered the common error of improper application of the tourniquet. Here it was found placed above the wound and applied tight enough to obstruct venous circulation, but not the arterial and the bleeding was quite severe, a column of blood "falling" from an aperture as widely circular as the tip of the little finger, on the medial aspect of the upper-third of the left leg, just inferior to the knee-joint.

Diagnosis. Spontaneous superficial varix rupture (ampulla dilatation). Later, examination revealed a gravid uterus of about eight and one half months.

Treatment. The tourniquet was immediately released, the patient placed in the recumbent position upon the floor, the leg elevated and a large pad of gauze applied, which was smoothly and firmly bandaged in place, taking great care that the turns of the bandage above the wound were not too tightly applied. Haemostasis was complete. It is extremely rare, I believe, to have to open such wounds and ligate bleeding vessels. The patient was placed in bed, the leg elevated and immobilized on pillows, the foot of the bed elevated, morphia given, fluids by mouth with light, nourishing diet and measures taken to maintain body-heat. The patient and relatives were instructed how to stop haemorrhage while waiting for help, should there be a recurrence. Daily visits found the patient progressing favourably and because of there being absence of pain, temperature and haemorrhage, I dared not meddle with the original pressure-dressing, apart from an occasional re-inforcement of the outside, but rather was content to wait until it was judged that the thrombus was firmly organized and the wound of the skin and subcutaneous tissue adequately healed by granulation.

Twelve days following the rupture, labour pains started and the patient was fortunately, easily and uneventfully delivered. On the tenth day following delivery or three weeks after the venous rupture, the pressure-dressing was removed for the first time. I found a small, superficial ulcerative area, about one centimeter in diameter, which weeped a slight serous discharge. This was gently cleansed with alcohol and an elastoplast bandage applied from the toes to the knee-joint line in order to support the column of blood and promote further healing. The patient was allowed to sit up on the following day. One week later, or about four weeks following the rupture, weight-bearing and walking were permitted. At the sixth week period, the elastoplast bandage was removed. A dry, healed, pigmented scar was Nature's welcome result. Ruptures of such severity are uncommon and despite the

fact that the haemorrhage was readily controlled, it might have even been fatal. The possibility of an embolus running amuck was appreciated throughout the course of treatment.

Aetiology. Varicosities are not due to pressure of the gravid uterus on the veins of the pelvis, because this is impossible, nor to increased intra-abdominal tension, because this seldom exists to such a degree. That there is some obstruction to the return circulation from the legs is highly probable, but there must be some change in the vessel wall or of the blood which predisposes to venectasis during pregnancy. Toxaemia has been suggested, also a vaso-dilating ferment from the corpus luteum. It may be the same condition which causes the pelvic vessels to enlarge and dilate with the progress of pregnancy. That some such relation exists is proved by the fact that in some women the veins enlarge as soon as conception occurs, and that they collapse if the foetus dies in utero. With other abdominal tumours, varicose veins of the legs are rarely observed, and this point may be used in the differential diagnosis.

Pregnancy has surely much to do with the development of varicose veins. Women who are much on their feet and have to work hard, as in the case under discussion, multiparae with pendulous abdomen, women with heart-disease, are most afflicted, and a special disposition can also be observed. This may be congenital. Frequent pregnancies and tight abdominal bands and garters also favour them.

FRANK HEBB, M.D.,
Liverpool, N. S.

NOTE: Due to an oversight this case was omitted from the Lunenburg-Queen, Edition of the Bulletin.—H.G.G.

TUBERCULOUS LARYNGITIS.

Female, Age 24.

This woman presented herself complaining of hoarseness. This was on January 4, 1935. About a year ago she said she had pneumonia and this started the hoarseness. It has gradually been increasing until at the present time she cannot speak above a whisper. There is no pain in her throat nor any referred pain. There is no cough and no pain on swallowing.

The past history showed she had her chest examined in April, 1932, and active pulmonary disease was present then. She had no treatment as far as I can find out and came back now with a far advanced pulmonary lesion.

Examination of the larynx shows marked involvement with ulceration. There is ulceration in the interarytenoid space with swelling of the mucous membrane over these bodies. The true vocal cords have a moth-eaten appearance. This was diagnosed as tuberculous laryngitis.

The prognosis in this case is not good as she will not go in hospital and get proper treatment for the pulmonary disease. The larynx is also markedly involved.

The treatment being carried out is absolute vocal rest and this means the use of a pencil and pad and not to speak at all. For local application to the larynx Chaulmoogra Oil (Burmese) is being instilled with a laryngeal syringe. This should be done three times a week. She should have the best

of general care for the pulmonary lesion. Rest is the most important treatment for the larynx, and in many cases a cure may be obtained by using no other means, provided the pulmonary lesion receives proper attention.

This case history is reported because tuberculous laryngitis is a common complication of pulmonary tuberculosis, and rest, with the use of the oil, gives the best results as far as the medical treatment of the condition is concerned.

A. ERNEST DOULL, M. D.,
Halifax, N. S.

A CAVERNOUS SINUS INFECTION FOLLOWING QUINSY.

A sailor aged 19 was admitted to Cogswell Military Hospital on January 6, 1935, suffering with Quinsy and swelling of the left upper eye lid. The patient being very sick and delirious made it very difficult to get a complete history. He had been away on leave and returned to Halifax the day of his admission to hospital.

The Quinsy began eleven days before, was opened twice without getting any pus. On Jan. 3rd and 4th he had headache and chills, and on the 5th the left upper eye lid became swollen.

On admission there was a left Quinsy, proptosis of the left eye, swelling of the left upper lid and an oedematous swelling about the left temporal area. The conjunctiva although slightly injected did not show any chemosis. Sight and ocular movements were normal and no tenderness was felt on direct orbital pressure. The optic disc was clear but the retinal veins were distended and tortuous. His temperature ranged between 103 and 104 degrees and leucocytes numbered 22,000. There were no signs of meningitis, cervical glands not enlarged and nasal cavities normal. A diagnosis of Quinsy with cavernous sinus infection was made.

That evening about half an ounce of pus was evacuated from an abscess situated well down at the lower pole of the tonsil. The patients' condition gradually became worse and he died at 5 a.m. January 8th. A Post-Mortem examination showed the left cavernous sinus filled with pus although the meninges showed only a slight degree of inflammation.

Cavernous sinus thrombosis following a peri-tonsillar abscess is not a very common occurrence. In a series of 55 cases at the Royal Infirmary, Edinburgh, only one was of peritonsillar origin; the others being of face, nose, para-nasalsinuses and middle-ear cleft origin.

The infection presumably in this case spread by a venous channel, from the pharyngeal and pterygoid venous plexis and the emissary veins of the foramen ovale and foramen of Vesalius: these veins linking the plexus with the cavernous sinus. As he did not have symptoms of internal jugular thrombosis we can exclude the spread by this route, also we can exclude the lymphatic way as there is no direct contiguity between lymphatics of peripheral parts and intra-dural structures. Also we exclude the arterial route in the absence of a blood stream infection.

I am indebted to Dr. Victor Mader and members of the Medical Staff of Cogswell St. Military Hospital for their permission to publish this case.

R. H. STODDARD, M.D.,
Halifax, N. S.

SYPHILITIC HEART DISEASE

G. W. K., a 30 year old married fisherman was admitted to the cardiac clinic May 30, 1934, complaining of a distressed feeling in the right side of the chest on walking.

Family History. Unimportant.

Personal History. Ordinary diseases of childhood. Pleurisy on the right side when 8 years of age. On account of repeated sore throats had tonsillectomy in 1929. No history of rheumatic fever, chorea, or venereal infection. Uses tobacco and alcohol sparingly.

Six months prior to admission patient noticed shortness of breath on exertion and was advised to give up working by a physician who told him he had heart trouble. During the past few months patient frequently would get a pain over the front and right side of his chest when walking. This was not severe and was relieved by belching. No other symptoms and patient said he felt rather well.

Examination revealed a well-developed and well nourished man with marked pallor of the skin and mucous membranes, no oedema and no dyspnoea. Pulsation apparent in all the superficial arteries, including the temporals and volars. Pharynx—negative. Teeth—fairly good. Thyroid—not enlarged. Finger nails—somewhat rounded. No clubbing of fingers. Heart—rate, 94; rhythm, regular. Heaving impulse all over praecordium. Apex beat in the 6th interspace, 5 in. from the mid-sternal line and lateral to the mid-clavicular line. Marked enlargement and increase in supra-cardiac dulness. Systolic and diastolic thrill. Loud systolic and diastolic murmurs audible all over praecordium, but maximum at the aortic area and transmitted downwards.

Fluoroscopic examination revealed marked enlargement of the heart and aorta, the latter protecting backwards.

Blood pressure, 162/0.

Corrigan pulse. Capillary pulsation, and Duroziez's sign present.

Lungs. Apparently normal. Liver and spleen—not palpable.

Kahn Test.++++Hinton, positive. Haemoglobin 70%. R. B. C., 4,210,000 W. B. C., 4,450. Urine, normal.

Patient was given potassium iodide and iron in the form of Blaud's pills. A few weeks later Bismuth injections were instituted. He was urged to rest as much as possible, and to refrain from all exertion and excitement, including sexual intercourse. He was seen at weekly intervals and seemed to improve somewhat under treatment. On August 26th he indulged in sexual intercourse. About one hour later he developed marked shortness of breath, restlessness, and began coughing frothy blood-streaked sputum. This continued for twelve hours before physician was called. Patient was removed to hospital immediately, with pulmonary oedema, and expired about six hours later.

Comment. This case of Syphilitic Heart Disease (Aortic Regurgitation) is interesting in that there was no history of any primary infection, relatively few symptoms considering the advanced degree of cardiac involvement, and that the terminal rapid failure was very probably precipitated by sexual intercourse.

C. W. HOLLAND, M.D.,
Halifax, N. S.

FRACTURE OF THE FOURTH CERVICAL VERTEBRA.

J. M., age six years, male.

I was called to see this boy on the evening of Nov. 16th; his parents told me that earlier in the day he had vomited twice, and had become somewhat delirious. He had then fallen asleep, and on awakening, as I arrived, seemed quite rational.

On the evening of Nov. 13th, he had fallen from a beam in the barn to the floor below, a distance of about twenty feet, alighting on his head and shoulders. He had been momentarily stunned, and cried for a few minutes but this soon ceased and he seemed none the worse for his accident.

On the following day, he complained of a sore neck, which did not, however, prevent him from playing outside. On the 15th, he had vomited once in the afternoon and still complained of his neck being sore, though not enough to alarm his parents. The boy was lying on a couch and appeared to be quite comfortable.

On palpating the back of his neck, I felt an unnatural hard prominence at about the level of the fourth cervical vertebra. This was movable and, on pressure, seemed to recede to its natural position.

On turning the head to the right, a small hard mass appeared on the right side about one half inch from the midline; on turning to the left, this mass disappeared, and a similar one appeared on the left side at the same distance from the midline.

A more careful examination of the neck showed this hard prominence to be the neural arch and posterior part of the transverse processes of the fourth cervical vertebra, which had separated from the body, and was held in a position slightly superficial to its natural abode, by the ligamentum nuchae and its muscular attachments. The lateral masses felt were the transverse processes, made prominent by the contraction of the erector spinae muscles. The general physical examination was essentially negative; the reflexes were all present, though somewhat sluggish. No motor weakness or paralysis could be found.

As it was thirty miles to the nearest hospital, and the roads quite rough I decided to keep him at home; and after instructing the parents not to allow him to move, I returned home.

On the following morning, I applied a plaster spica from the top of his head to the mid dorsal region, extending around his neck and to the tips of his shoulders.

Recovery was uneventful. Spica was removed at the end of six weeks, and adhesive applied about the neck and shoulders.

The neural arch seemed to be in good position, and no symptoms of pressure on the cord have occurred.

Consulting Cameron's Osteology, I find that ossification in this bone occurs from three centres; one for each lateral half of the neural arch, and one for the body. Bony union between the halves of the neural arch occurs at about two years, but does not occur between the neural arch and the body, before the sixth year.

J. A. LANGILLE, M.D.,
Pugwash, N. S.

Gynatresia.

Case I.

Miss L. C., age 15.

Admitted Yarmouth Hospital, Sept 9., 1927. Discharged Yarmouth Hospital, Sept. 23, 1927.

C. C. Pain in abdomen.

F. H. Irrelevant.

P. H. Irrelevant.

P. I. Patient taken acutely ill 4 days before admission to hospital with sharp pain in right lower abdomen accompanied by fever, nausea and no vomiting. Bowels moved well since onset. Pain steady sharp in character and moderately severe. Patient gave history of having been treated for 6 months previous to admission for recurrent attacks of right sided abdominal pain, which were believed due to her appendix but never as severe an attack as present one. No important symptoms referable to the C. R. or G. U. symptoms. Patient had not menstruated.

P. E. W. D. and N. young girl apparently not seriously ill and not in severe pain.

Is essentially negative except for abdominal examination which shows:—a general spasm of whole lower abdominal muscles more marked on right with an acutely tender palpable mass filling lower part of right lower abdominal quadrant.

Rectal and Pelvic examinations not made.

Urine—negative. W. B. C., 24,200.

In consultation with physician bringing patient to hospital Diagnosis of

(1) Acute Appendicitis with Abscess.

(2) Ovarian Cyst with Twisted Pedicle.

Operation:—At operation found large hematocolpos with left hematosalpinx (mild) and cystic ovary. Right appendages normal. Appendix injected and slightly inflamed. Appendectomy and left salpingo-oophorectomy done in usual way.

After closing abdomen with drainage, patient prepared vaginally and a thickened hymen removed with escape of large quantity of old thick bloody material.

Post operative course uneventful. Discharged on 14th post-operative day with abdominal wound well healed and vaginal discharge about ceased.

Patient not seen for examination since operation, but by letter reported in 1930, that she had been well and had no further trouble since discharge from hospital.

Case II.

Mrs. S. B., age 28, M. W.

Admitted April 7, 1930. Discharged April 27, 1930.

F. H. and P. H. Unimportant except for history of attack of leucorrhoea at 16 years lasting 1 year.

C. C. Pain in left lower abdomen and in lumbar spine.

P. I. Dating back 3 years patient has suffered from more or less steady pain in left lower abdomen which radiates to pelvis and back. In past 6 months

pain much worse in character and is now severe enough to interfere with her work. No acute attacks accompanied by fever and requiring her to go to bed. Bowels are regular. No important C. R., G. I. or G. U. symptoms. Catamenia began at 15 years, irregular up until a year ago—since every 28 days. Flow is scanty, last 6-7 days and accompanied by severe pains particularly in L. L. Q.

P. E. Is generally negative except:—

- (1) Definite tenderness in left lower abdomen, but no muscle spasm or masses felt.
- (2) Vaginal orifice closed by thick hymen, with small pin-point opening.
- (3) Rectal examination shows cervix hard and elongated. Uterus normal size and more or less fixed. Whole pelvis tender.

Diagnosis—Atresia of Vagina. Imperforate Hymen. Pelvic Inflammation.

April 8, 1930, operation:—

Hymen removed, found whole vagina adherent. Adhesions broken up and cervix exposed and dilated thoroughly. Vagina packed with vaseline gauze.

April 27, 1930. Patient made uneventful convalescence, having had menstrual period while in hospital with good free flow and practically no pain. Discharged.

Readmitted July 16, 1930. Discharged Aug. 1, 1930.

C. C. Patient continues to complain of pain in left lower abdomen, which is getting worse all the time. Is much better in every other way since first operation.

P. E. Unchanged except pelvic examination which shows easily examined short vagina—cervix well exposed and normal. Uterus anterior normal size fixed. Whole pelvis tender and thickened.

Diagnosis. Pelvic inflammation.

July 17, 1930. Operation.

Laparotomy. Found old chronic pelvic inflammatory disease necessitating Right Salpingo-oophorectomy, Left Salpingectomy. Appendectomy and Ventral Fixation.

August 1, 1930. Patient had uneventful post-operative convalescence, and discharged to-day.

Patient followed for 3 years after discharge and was very much relieved of pain and other symptoms.

Catamenia remained regular and were relatively free from discomfort.

Case III.

Miss A. D., age 14, S. W.

Admitted Feb. 27, 1930.

F. H. and P. H. Unimportant.

C. C. Cramps in abdomen.

P. I. In past 6 months recurring attacks of cramp-like abdominal pain in lower abdomen, getting increasingly severe with each attack, last starting 2 days ago and accompanied by vomiting. No fever or chills. No important C. R., G. I. or G. U. symptoms. Child has not menstruated.

P. E. Generally negative except:—

- (1) Abdomen which shows a palpable non-tender movable mass in R. L. Q., rather firm and hard.
- (2) Vaginal—Completely closed hymen.

(3) Rectal a large baggy mass filling whole pelvis and a part of abdominal mass.

Diagnosis. Imperforate Hymen. Hematocolpos. Hematometra.

February 27, 1930. Operation:—

Hymen removed entirely—whole vagina filled with dense adhesions and with difficulty these freed up but cervix could not be exposed. No permission for laparotomy so vagina packed with vaseline gauze and patient returned to ward.

February 28, 1930. Laparotomy:—

Found some leakage of blood through tubes into pelvis, but both tubes and ovaries normal. Uterus somewhat large and soft and below cervix could be felt large cystic mass apparently due to a complete atresia of vagina about $\frac{1}{2}$ " below cervix. While pelvic organs exposed assistant re-entered vagina and opened through second obstruction allowing escape of old menstrual blood. Appendix removed. Patient stood operation well.

March 12, 1930. Uneventful convalescence. Patient discharged to-day relieved.

With this case I had much difficulty as vagina closed at site of upper end of atresia leading to stricture. Several operations were done and finally got opening admitted speculum and through which cervix can be seen and felt. Patient menstruates regularly and painlessly, and feels well, but there is enough stricture still present to interfere with child birth if pregnancy does occur.

In reporting these three cases of gynatresia there are several points of interest which I feel should be of value.

1. In case one which pathologically was due to complete obstruction at hymen is demonstrated that one must always look for and consider this condition in young girls who present clinically an acute abdomen. A rectal examination which should always be made would have given the correct diagnosis in this case, and perhaps saved the patient from a laparotomy.

2. Cases II and III demonstrate I think, clearly that these were due to a vaginitis sometime during childhood, and fall in line with the generally accepted thing that all cases of gynatresia with normal pelvic organs are due to some cause coming after birth and are not congenital abnormalities. These two cases also present some of the surgical problems in the handling of such patients.

G. VICTOR BURTON, M.D.,
Yarmouth, N. S.

Osteomyelitis following Influenza.

Case H. F. During February, 1933, patient had an attack of influenza. The febrile attack lasted four days, with apparent complete recovery.

Some weeks afterwards the patient consulted me complaining of a localized pain on pressure on the front side of the femur. On examination pain and tenderness seemed to be deep seated either in muscles or bone, and an X-ray was suggested.

June 12, X-ray showed on the inner side of femur, in the middle third, a definite break and elevation of the periosteum, some signs of overgrowth of bone and underlying rarefaction. A diagnosis of chronic periostitis of the femur was made.

The leg was opened on June 20th by an incision between the vastus internus and rectus femoris in order to avoid injury to muscles, nerves, etc. The outgrowth of bone was chiselled away, exposing a sequestrum which was free. The sequestrum was small, about the size of a raisin seed, and round as a shot pellet. It was lying in a small cavity filled with soft unhealthy granulation tissue and disintegrating pus cells. The soft unhealthy tissue was curetted away and healthy bone found, leaving a small saucer-like depression in the bone. A drain was put in and patient made an uneventful recovery.

The origin of this condition was no doubt his febrile attack some months earlier, with blood borne infection localizing in bone surface or under the periosteum.

C. A. HERBIN, M.D.,
Lockeport, N. S.

Doctors Operate on Woman's Heart.

San Francisco.—San Francisco's woman with a "heart of stone" sat in an invalid's chair to-day and heard two surgeons tell how they had opened a "window" into her heart in a delicate operation that saved her life.

The woman, Mrs. Regina Bramy, 40, smiled as she said she was recovering "in a most uninteresting way" from the hazardous operation 12 days ago.

"My appetite is good and I'm feeling better than I have for six years," she said.

Dr. Harold Brunn, performed the operation assisted by Dr. A. L. Brown, told more than 100 surgeons attending a symposium on heart diseases that only six previous cases of persons with "hearts of stone" are known to medical history.

"We took on the sternum from about the third to the sixth rib," Dr. Brunn said. "The right side of the heart was thus exposed.

"The triangle of safety of the heart was then seen—a triangle between the pleura on the left side. The pleura bulged into the wound and under the sternum. From the other side appeared the pleura from the right side. This little space lies between them.

New Vaccine Against Infantile Paralysis.

New York, Nov. 16—Positive immunization of children against infantile paralysis has been accomplished by the New York City Health Department, Dr. William H. Park, director of its research laboratories, disclosed to-day.

Vaccine obtained from experimentally-infected monkeys, he said, made a group of 25 children immune from the disease, but the research scientists are still studying the duration of the immunity. Blood tests, made six weeks after the children's vaccination, showed a satisfactory degree of immunity.

Dr. Maurice Brody, formerly of Ottawa, Ont., was a leader in the research work preceding discovery of the serum.

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and the Secretaries of Local Societies

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No. 2

THE KING GEORGE V. SILVER JUBILEE FUND FOR CANCER IN CANADA.

HIS Majesty, the King, has graciously given his consent to the twenty-fifth anniversary of his accession to the throne being recognized in Canada by way of a campaign to raise funds to combat cancer, the campaign to be in charge of His Excellency, the Governor General of Canada. His Excellency has announced that the campaign will be inaugurated at an early date and will close on May 5th. It is hoped that all Canadian citizens will desire to contribute to the fund, having regard to its testimonial character for so beloved a sovereign, and the purpose for which the fund is to be used, namely, to combat the ravages and growing menace of the dread scourge, cancer.

When the fund is completed, it is to be turned over to a Board of Trustees of seven men, as follows:—

The Chief Justice of Canada (Chairman).

The Prime Minister of Canada.

The Leader of the Opposition.

The Minister of Health for Canada.

The Chairman of the Cancer Committee of the Canadian Medical Association.

A representative of the French Speaking Medical Schools.

A representative of the Health Committee of the Canadian Life Insurance Officers Association.

The Canadian Medical Association is honoured in having been invited to occupy a seat on this Board, and is particularly pleased that that place is to be filled by Dr. A. Primrose of Toronto, Chairman of the Association's Study Committee on Cancer.

The announced objective of the fund is two-fold:—

(1) to carry on an educational campaign to assist the medical profession in their fight against cancer; and (2) to carry on an educational campaign to enlighten the laity as to the part which they should play in combatting cancer. With the magnificent assistance of the Sun Life Assurance Company of Canada, the Canadian Medical Association carried on, over a period of seven years, a plan of extra-mural post-graduate medical education covering

the entire Dominion. The value of this service has long since been fully recognized by the medical profession. It is hoped that, when the cancer fund is available, the Board of Trustees will invite the Association to resume its extra-mural work by assuming the responsibility of carrying to the medical profession of Canada information dealing with the manifestations of cancer in all its forms and phases.

Realizing the full significance of this campaign, it is hoped that the medical profession will support it most heartily, not only with personal contributions, but by enlightening the people in their respective communities as to the opportunity which is being given to them to pool some of their resources to wage war upon cancer.

THE DALHOUSIE PUBLIC HEALTH CLINIC.

LOOKING back some twenty odd years to the days of the Halifax Medical College one cannot refrain from comparing the out-patient service of those days with that of the present.

Before the Dalhousie Public Health Clinic was built the "out-patient" teaching was carried out at the Halifax Visiting Dispensary at the corner of Brunswick and Prince Streets. As a rule few patients came for attention and time and again we faced the inclemency of winter weather to find to our disappointment that no patients had come.

To-day the students attend out-patients at the Dalhousie Public Health Clinic. The building was a gift to Dalhousie University from the Rockefeller Foundation. It was erected in 1924 at a cost of approximately \$250,000.00. The initial equipment was a present of the Carnegie Corporation. The Clinic serves as an out-patient department for the Medical School and also supplies free medical treatment to the indigent of Halifax. The staff consists of the Medical Director, the Superintendent, thirty-four Doctors, five Dentists, five Nurses and four Clerical Workers. The attendance at the Clinic has grown from 7,000 visits in 1924 to over 31,000 in 1934 (by "visits" is meant the number attending the different departments—each patient would, on the average, visit from four to five different departments per year). The Clinics conducted are as follows: General Medicine; General Surgery; Ear, Nose and Throat; Eye; Skin; Gynaecology; Pre-natal; Post-natal; Genito-urinary; Dental; Pre-school Dental; Paediatrics; Orthopaedic; Massage; Chest; Heart; School Dental; Immunization; Gastro-intestinal; Neuro-psychiatric. The students attend in groups of five or six—not more than six—and their schedule is arranged so that during the year each student spends some time at each clinic.

The Dalhousie Public Health Clinic was established as an out-patient department for the Medical School. The attendance has grown to such an extent, however, that it now renders valuable assistance to the City of Halifax in providing free medical service to the indigent of that city. The amount of free medical treatment provided to the poor of Halifax is indicated by the fact that from 1924-34 over 20,000 individuals have been treated at the Clinic.

Through the Dalhousie Public Health Clinic there is now provided sufficient material for clinical instruction on cases not sick enough to go to hospital. It is conveniently located—within a stone's throw of the Victoria General Hospital, the Pathological Institute, the City Tuberculosis Hospital,

the Infectious Disease Hospital, the Children's Hospital, and the Grace Maternity Hospital.

A report on the Dalhousie Public Health Clinic would not be complete without acknowledging the help we receive from other organizations. The Halifax Visiting Dispensary—a separate organization—is housed in the same building. They supply medicines and dressings, and maternity outfits to the needy of Halifax. During the year 1934 over 10,000 prescriptions were provided by this Institute for patients attending the Clinic. The Rotary Club outfitted the orthopaedic clinic and has helped to maintain it up to the present time. The Junior League brings patients to and from the Clinic and several of the members help with clerical work. The Department of Public Health of the Provincial Government maintains the Genito-urinary clinic. The Halifax County Anti-Tuberculosis League helps to pay the cost of the chest clinic and also maintains a milk fund. The Victorian Order of Nurses supplies nursing service for the pre-natal and post-natal clinics. The Good Samaritan Club supplies splints and orthopaedic apparatus for crippled children. We are also much helped and most cordial relationships exist between the Dalhousie Public Health Clinic and the hospitals above named.

H. G. G.

Editor's Note: In view of the fact that the Dalhousie Public Health Clinic has just completed another year and because of the part that this institution plays, both in medical education and health matters in the City of Halifax, we have asked the Medical Director of the Clinic for a description of its work.

VITAMIN ADVERTISING AND THE MEAD JOHNSON POLICY

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

Silent, Profound Tribute.

In the hall of the School of Tropical Medicine at San Juan, Puerto Rico, stands a bust of the late Dr. Bailey K. Ashford, the army surgeon who relieved Puerto Ricans of the scourge of hookworm.

Dr. Ashford died some six weeks ago. Every morning since then, his bust has been found banked with flowers—big bouquets and little ones, many of them in strange little home-made native jars. No one knew who put them there; so at last a watchman was appointed to keep an eye on the bust all night long and see what happened.

He found that poor folk from the country were tramping in to town each night with their arms full of flowers to lay at the feet of their benefactor—the one tribute they could pay to the man who had done so much for them.

Men who have served humanity have won many kinds of memorials, in different times and places; but was there ever one more beautiful or expressive than this?

Department of the Public Health

PROVINCE OF NOVA SCOTIA

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

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

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

OFFICERS OF THE PROVINCIAL HEALTH OFFICERS' ASSOCIATION

President - - - - DR. F. O'NEIL - - - - Sydney.
1st Vice-President - - DR. H. E. KELLEY - - - - Middleton
2nd Vice-President - - DR. W. R. DUNBAR - - - - Truro.
Secretary - - - - DR. P. S. CAMPBELL - - - - Halifax.

COUNCIL

DR. C. G. MACKINNON - - - - Mahone Bay.
 DR. B. C. ARCHIBALD - - - - Glace Bay.
 DR. G. V. BURTON - - - - Yarmouth.

MEDICAL HEALTH OFFICERS FOR CITIES, TOWNS AND COUNTIES

ANNAPOLIS COUNTY

Hall, E. B., Bridgetown.
 Braine, L. B. W., Annapolis Royal.
 Kelley, H. E., Middleton.
 Messenger, Carl, Granville Ferry (County).

ANTIGONISH COUNTY

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

CAPE BRETON COUNTY

Tompkins, M. G., Dominion.
 Fraser, R. H., New Waterford.
 MacDonald, N., Sydney Mines.
 Archibald, B. C., Glace Bay.
 McLeod, J. K., Sydney.

O'Neil, F., Sydney (County).
 Murray, R. L., North Sydney.
 Townsend, H. J., Louisburg.

COLCHESTER COUNTY

Dunbar, W. R., Truro.
 Havey, H. B., Stewiacke.
 Johnston, T. R., Great Village (County)*

CUMBERLAND COUNTY

Bliss, G. C. W., Amherst.
 Drury, D., Maccan (County).
 Gilroy, J. R., Oxford.
 Henderson, C. S., Parrsboro.
 Eaton, R. B., River Hebert (Joggins).
 Walsh, F. E., Springhill.

DIGBY COUNTY

Dickie, W. R., Digby.
 Melanson, H. J., Weymouth (County).
 Doiron, L. F., Little Brook (Clare Mcpy).

GUYSBORO COUNTY

Chisholm, A. N., ort Hawkesbury
 (Mulgrave).
 Sodero, G. W., Guysboro (County).
 Moore, E. F., Canso.
 Monaghan, T. E., Sherbrooke (St. Mary's
 Mcpy).

HALIFAX COUNTY

Almon, W. B., Halifax.
 Forrest, W. D., Halifax (County).
 Payzant, H. A., Dartmouth.

HANTS COUNTY

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

INVERNESS COUNTY

MacLeod, J. R., Port Hawkesbury
 LeBlanc, L. J., Cheticamp (County).
 Proudfoot, J. A., Inverness.
 Chisholm, D. M., Port Hood.

KINGS COUNTY

MacKinnon, Hugh, Berwick.
 Bishop, B. S., Kentville.
 Bethune, R. O., Kentville (County).
 deWitt, C. E. A., Wolfville.

LUNENBURG COUNTY

Cole, W. H., New Germany (County).
 Rehfuss, W. N., Bridgewater.
 McKinnon, C. G., Mahone Bay
 Zinck, R. C., Lunenburg.
 Zwicker, D. W. N., Chester (Chester Mcpy)

PICTOU COUNTY

Blackett, A. E., New Glasgow.
 McKay, W. A., Thorburn (County).
 Whitman, H. B., Westville.
 Stramberg, C. W., Trenton.
 Dunn, G. A., Pictou.
 Whitman, G. W., Stellarton.

QUEENS COUNTY

Ford, T. R., Liverpool (Town and County).

RICHMOND COUNTY

LeBlanc, B. A., Arichat (County).

SHELburne COUNTY

Brown, G. W., Clark's Harbour.
 Churchill, L. P., Shelburne (County).
 Fuller, L. O., Shelburne.
 Banks, H. H., Barrington Passage
 (Barrington Mcpy).
 Herbin, C. A., Lockeport.

VICTORIA COUNTY

Gillis, R. I., Baddeck (County).

YARMOUTH COUNTY

Blackadar, R. L., Port Maitland (County).
 Burton, G. V., Yarmouth.
 O'Brien, W. C., Wedgeport.
 Fox, C. J., 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 January 1st, to February 1st, 1935.

The number of tissues sectioned is 138. In addition to this, 22 tissues from 5 autopsies were sectioned, making 160 tissues in all.

Tumours, malignant.....	20
Tumours, simple.....	8
Tumours, suspicious.....	1
Other conditions.....	109
Tissues from five autopsies.....	22

Communicable Diseases Reported by the Medical Health Officers
for the month of January, 1935.

County	Cer-Spi. Meningitis	Chicken Pox	Diphtheria	Influenza	Measles	Mumps	Pneumonia	Scarlet Fever	Typhoid Fever	Tbc. Plmonary	V. D. G.	V. D. S.	Whooping Cough	Pink Eye	German Measles	Scabies	TOTAL
Annapolis.....	∞	..	33	1	..	..	..	..	..	..	..	..	..	..
Antigonish.....
Cape Breton.....	3	..	7	2	107	..	..	..	..	..	..	..	..	..	22	..	141
Colchester.....	..	1	..	..	143	..	..	1	..	..	..	..	..	..	..	..	145
Cumberland.....	110	..	1	..	..	..	2	..	..	..	35	..	148
Digby.....	1	..	..	..	1	..	3	..	..	..	..	..	..	..	5
Guysboro.....	3	..	..	..	..	..	..	..	4	..	..	..	7
Halifax City.....	..	1	8	..	..	..	..	17	..	1	..	..	3	..	2	..	32
Halifax.....
Hants.....	..	1	..	..	..	..	..	..	..	1	..	..	..	..	..	..	2
Inverness.....	1	..	2	..	..	1	2	..	..	..	12	2	20
Kings.....	8	4	..	1	1	..	..	2	..	..	..	5	..	21
Lunenburg.....	1	..	..	..	..	9	..	..	..	..	..	..	..	..	10
Pictou.....	..	1	..	..	53	..	1	1	..	..	..	1	..	12	4	..	73
Queens.....
Richmond.....	2	..	..	..	..	..	..	2
Shelburne.....
Victoria.....
Yarmouth.....
TOTAL.....	3	4	17	18	421	33	7	29	3	5	6	1	7	12	80	2	648

RETURNS VITAL STATISTICS FOR DECEMBER, 1934.

County	Births		Marriages	Deaths		Stillbirths
	M	F		M	F	
Annapolis.....	9	9	13	11	5	0
Antigonish.....	6	11	0	9	4	4
Cape Breton.....	106	106	58	54	41	3
Colchester.....	26	15	23	15	8	1
Cumberland.....	30	27	37	17	15	1
Digby.....	20	8	9	11	7	0
Guysboro.....	13	9	4	4	7	2
Halifax.....	116	96	65	56	48	9
Hants.....	19	22	16	6	8	1
Inverness.....	27	22	5	12	4	5
Kings.....	15	17	16	8	7	1
Lunenburg.....	36	28	28	14	18	3
Pictou.....	25	24	11	10	15	1
Queens.....	10	7	3	7	5	0
Richmond.....	8	11	1	6	7	0
Shelburne.....	10	16	6	6	2	1
Victoria.....	6	6	8	5	2	0
Yarmouth.....	23	17	10	14	9	2
	505	451	313	265	212	34

OBITUARY

THE death occurred at her home in Sydney, N. S., on December 28th, 1934, of Mrs. Bruce, wife of Dr. James Bruce. Mrs. Bruce who was born in Sydney, was the daughter of Mr. and Mrs. Angus McLeod, was widely known and her passing is deeply regretted. Mrs. Bruce was an active member of the Ligan Country Club, the Sydney Badminton Club and a member of the Louisburg Chapter of the I. O. D. E. Mrs. Freeman O'Neil, wife of Dr. O'Neil, is one of a large number of relatives who mourn Mrs. Bruce's death. Members of the profession will extend sympathy to Dr. Bruce and other mourning relatives.

At Economy, N. S., on January 12th, 1935, the death occurred of Mrs. James Cavanaugh, at the age of seventy-seven. Mrs. Cavanaugh was the mother of the late Mrs. W. P. Mackasey whose death was noted in a recent number of the BULLETIN.

The BULLETIN regrets to announce the death of Mrs. William MacK. McLeod, of Sydney, in Halifax on January 29th, 1935. Her husband, Dr. Wm. McK. McLeod, predeceased her several years ago.

News of the death in Camp Hill Hospital, Halifax, on February 13th, of Dr. Francis Alexander Roberts Gow, will be received with regret by a wide circle of friends. Dr. Gow was born in Southsea, England, studied at King's College, Dalhousie University and Trinity Medical College in Toronto, graduating in 1889. After graduation he practised in Halifax and Dartmouth and went overseas in 1915 as medical officer with the Sixth C. M. R. In recent years Dr. Gow was surgeon on Canadian National "Lady" liners, making his home in Greenwich, N. S. The BULLETIN extends sympathy to Mrs. Gow and the surviving children, three sons and two daughters.

Muscular Rheumatism, neuritis, sciatica, lumbago, torticollis, as well as other forms of fibrositis, are the cause of a great deal of disability in all walks of life, with a corresponding economic loss.

In the physical treatment of these conditions heat, as supplied by a poultice of Antiphlogistine, which maintains a warm, even temperature for hours, may afford more grateful relief to the patient than any other measure.

By promoting correction of the local blood and lymph circulations it helps to relieve the inflammation and congestion, so that the pain is reduced and greater ease of movement follows.

Its therapeutic advantages, coupled with the plastic and adhesive nature of the Antiphlogistine, go far towards helping the patient to carry on efficiently with his daily tasks.

JOINT MEETING OF THE AMERICAN AND CANADIAN MEDICAL ASSOCIATIONS, ATLANTIC CITY, JUNE 10-14, 1935.

The Canadian plans for the conjoint meeting are developing satisfactorily. The Council of the Association will convene in Haddon Hall Hotel on Monday and Tuesday, June 10 and 11. At the Monday luncheon, Dr. J. S. McEachern, our President, will present his valedictory address and install his successor, Dr. J. C. Meakins of Montreal. It is expected that officers and members of the Board of Trustees of the American Medical Association will be guests at this function.

On Tuesday evening, the installation ceremonies of the joint convention will be held in the Auditorium, at which addresses will be given by Dr. James S. McLester of Birmingham, Ala., and Dr. J. C. Meakins of Montreal, Presidents Elect of the American Medical Association and the Canadian Medical Association, respectively.

General Sessions will be held on Monday and Tuesday, in which four representatives of Canada will take part. They are as follows:—

DR. WILLIAM BOYD, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lon.), F.R.C.S.

Professor of Pathology, University of Manitoba, Winnipeg.

Subject: Growth, Normal and Abnormal.

DR. ROSCOE R. GRAHAM, M.B., F.R.C.S. (C.).

Assistant Professor of Surgery, University of Toronto.

Subject: The Surgical Contribution to the Therapy of Duodenal Ulcer.

DR. A. H. GORDON, M.D., C.M., F.R.C.P. (C).

Associate Professor of Medicine, McGill University, Montreal.

Subject: Bone changes in certain medical diseases.

DR. H. B. ATLEE, M.D., C.M., F.R.C.S. (Edin.), F.R.C.S. (C).

Professor of Obstetrics and Gynaecology, Dalhousie University, Halifax.

Subject: Arguments in favour of a more active puerperium based on a study of 600 cases.

During the remainder of the week, the convention will be divided into eighteen sections, officered by representatives from both Associations. The Canadian officers are as follows:—

President.....Dr. J. S. McEachern, Calgary.

President-Elect.....Dr. J. C. Meakins, Montreal.

General Secretary.....Dr. T. C. Routley, Toronto.

Chairman of Council.....Dr. Geo. S. Young, Toronto.

Chairman, Central Programme Committee.....Dr. A. Primrose, Toronto.

Section of Medicine.

Chairman—Dr. Duncan Graham, 100 College Street, Toronto.

Secretary—Dr. K. A. MacKenzie, 89 Spring Garden Road, Halifax.

Section of Surgery.

Chairman—Dr. W. E. Gallie, Medical Arts Building, Toronto.

Secretary—Dr. A. R. Munroe, McLeod Building, Edmonton, Alberta.

Section of Obstetrics and Gynaecology.

Chairman—Dr. John Fraser, 1390 Sherbrooke St. W., Montreal.

Secretary—Dr. D. C. Malcolm, 136 Charlotte Street, Saint John.

Section of Paediatrics.

Chairman—Dr. Alan Brown, Medical Arts Bldg., Toronto.

Secretary—Dr. Howard Spohn, 825 Granville Street, Vancouver.

Section of Ear, Nose and Throat.

Chairman—Dr. W. J. McNally, Dept. of Physiology, McGill University, Montreal.

Secretary—Dr. W. Hackney, Herald Building, Calgary.

Section of Eye.

Chairman—Dr. W. G. M. Byers, 1458 Mountain Street, Montreal.

Secretary—Dr. A. R. Cunningham, 260 Barrington St., Halifax.

Section of Military Medicine—(Under Section of Miscellaneous Topics).

Chairman—Dr. John Gunn, Herald Building, Caigary.

Secretary—Dr. W. H. Delaney, 30 Garden Street, Quebec.

Section of Urology.

Chairman—Dr. D. W. MacKenzie, Medical Arts Bldg., Montreal.

Secretary—Dr. E. R. Myers, 415 Avenue Building, Saskatoon.

Section of Radiology.

Chairman—Dr. W. A. Jones, General Hospital, Kingston.

Secretary—Dr. H. H. Murphy, Provincial Royal Jubilee Hosp., Victoria, B. C.

Section of Anaesthesia—(Under Section of Miscellaneous Topics).

Chairman—Dr. Wesley Bourne, McGill University, Montreal.

Secretary—Dr. W. L. Muir, 240 Jubilee Road, Halifax.

Section of Public Health and Industrial Medicine.

Chairman—Hon. Dr. W. J. P. MacMillan, Charlottetown, P. E. I.

Secretary—Dr. A. Grant Fleming, McGill University, Montreal.

Section of Historical Medicine—(Under Section of Miscellaneous Topics).

Chairman—Dr. W. W. Francis, McGill University, Montreal.

Secretary—Dr. H. E. MacDermot, Medical Arts Bldg., Montreal.

Section of Pharmacology and Therapeutics.

Chairman—Dr. V. E. Henderson, Medical Bldg., University of Toronto, Toronto.

Secretary—Dr. G. F. Strong, Medical-Dental Bldg., Vancouver.

Section of Pathology and Physiology.

Chairman—Dr. Wm. Boyd, Manitoba Medical College, Winnipeg.

Secretary—Dr. C. H. Best, Dept. of Physiology, University of Toronto, Toronto.

Section of Nervous and Mental Diseases.

Chairman—Dr. A. T. Mathers, Medical Arts Bldg., Winnipeg.

Secretary—Dr. W. V. Cone, 687 Pine Avenue, W., Montreal.

Section of Dermatology and Syphilology.

Chairman—Dr. J. F. Burgess, 1414 Drummond Street, Montreal.

Secretary—Dr. Paul Poirier, 2073 St. Denis Street, Montreal.

Section of Orthopedic Surgery.

Chairman—Dr. R. I. Harris, Medical Arts Bldg., Toronto.

Secretary—Dr. G. A. Ramsay, 443 Clarence Street, London, Ontario.

Section of Gastro Enterology and Proctology.

Chairman—Dr. R. H. M. Hardisty, Medical Arts Bldg., Montreal.

Secretary—Dr. J. K. McGregor, 250 Main Street, E., Hamilton.

Section of Scientific Exhibits.

Chairman—Dr. Sclater Lewis, 1540 Crescent Street, Montreal.

At the time of writing, the Canadian contributions to the programme are reported as coming in splendidly and represent the profession from coast to coast.

Haddon Hall, one of the finest hostelries on the American Continent,

has been chosen as Canadian Headquarters. The hotel rates are as indicated hereunder, and reservations should be made direct:—

European Plan—room and bath—one person, per day, \$3, \$4, \$6, \$8.
two persons, per day, \$5, \$6, \$8, \$10.

The daily rate for three meals on the American Plan is \$3.00.

Single meals on the American Plan are as follows:

Breakfast, \$1.00; luncheon, \$1.50; dinner, \$2.00.

Further particulars with regard to any phase of the meeting will be gladly supplied upon inquiry addressed to Dr. T. C. Routley, 184 College Street, Toronto, General Secretary of the Canadian Medical Association.

Canada's Arctic Doctors

Medical care for the native inhabitants of Canada's Far North is provided by the Canadian Government, and for thousands of miles along the Arctic coast of the Dominion, in fair weather and in foul, medical officers in the service of the government bring their healing art to the aid of the eskimo citizens, while inland, Indians, half-breeds and indigent whites are also given medical aid. Winter and summer patrols of hundreds of miles are not unusual, and nearly every mode of transport known to the North country, such as aeroplane, steamboat, motor boat, canoe, and dog-sled has been used to extend this service. Eight doctors are employed in the work, and their efforts to prevent serious illness among the northern natives are bearing fruit.

While civilization has brought many benefits to the Eskimos, its contact with these happy and hospitable people has also resulted in a number of ill effects. Although a healthy and organically sound race, the Eskimos are seriously susceptible to ailments which ordinarily cause white people only minor discomforts. Before the coming of the white man the Eskimos were isolated along Canada's Arctic coast, and they knew nothing of such common ills as colds, influenza, and other kindred ailments. There had been no need for their bodies to build up a resistance to the attacks of these diseases. Consequently the arrival of the first whaling and trading vessels each season was followed by widespread outbreaks among the natives, with often disastrous effects. To-day the medical services in the Far North take particular care upon the arrival of the first ships to check the spread of these diseases, and it is hoped that in time, as closer contact is made with the outside world, the natives will have built up the necessary resistance to ward off such attacks. By instructions as to the proper diets, the doctors have reduced considerably the number of deaths due to dietary causes. The most striking success has been made in the correction of methods of feeding infants and older children.

In this and in other ways the health of the Eskimos is being safeguarded and improved so that the benefits being derived from their contact with civilization are preserved and any harmful effects overcome or avoided.—*Berwick Register*—Feb. 6.

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



Dr. Armstrong

Kindness of Bobby

Dear Dr. Armstrong:

Nothing would do but that Bobby bring this to you himself, in person.

It's partly because you and he became such good pals when you pulled him through that siege last summer.

But more than that, he had heard his Dad and me talking, and he knew that this was different from the ordinary check we send out—that it deserved something more than the slapping on of a stamp and routine delivery by the mail man.

And Bobby is right.

You couldn't have done more if he had been your own child. We've always known this, and yet your bill has lain here, put off month

after month, while bills for other things have been paid.

It wasn't that we didn't want to pay you, for we did. But after we bought those things necessary to keep us going—food, and clothing, and coal—our bank balance was pitiful to behold.

Now, thank heavens, things are a little brighter. And here at last is our chance to send you something more than thanks for all you did for Bobby and for us.

Sincerely,

Mrs. J. _____ B. _____

PARKE, DAVIS & COMPANY

WALKERVILLE, ONTARIO

*The World's Largest Makers of Pharmaceutical
and Biological Products*

Personal Interest Notes

DR. A. Vance Fraser, Dalhousie '32, a son of Professor H. J. Fraser of the Nova Scotia Agricultural College at Truro, is now assistant to the resident surgeon of the Cleveland Charity Hospital. He received his "A" at the Colchester County Academy, took three years at Dalhousie in Science before entering upon his medical course. After graduation Dr. Fraser spent two years on the staff of the Nova Scotia Sanatorium, Kentville, and last year went to Cleveland.

And This Is Nova Scotia!

The Sydney Post-Records carried this small advertisement recently:
Wanted—To remedy 200 or more cases of Cancer, Eczema, Psoriasis, etc. The charge for thirty days from date of issue being very reasonable. Terms, if necessary. Over McLeod's Bookstore, W. B. Carroll, Specialist."

Mrs. Amyot, wife of Dr. G. F. Amyot of Vancouver, B. C., is spending part of the winter with her parents, Dr. and Mrs. Dan MacDonald of North Sydney, N. S.

Dr. A. B. Campbell of Bear River, at the time of the big January freshet, had the misfortune in crossing a washout on the Bear River road to smash one of the headlights of his car. Two days later on the Landsdowne road a similar accident got the other lamp.

Dr. C. N. Morrison, Dalhousie '33, son of Dr. M. D. Morrison, of Halifax, has recently returned from a year spent in the Maternity Hospitals in London and Dublin.

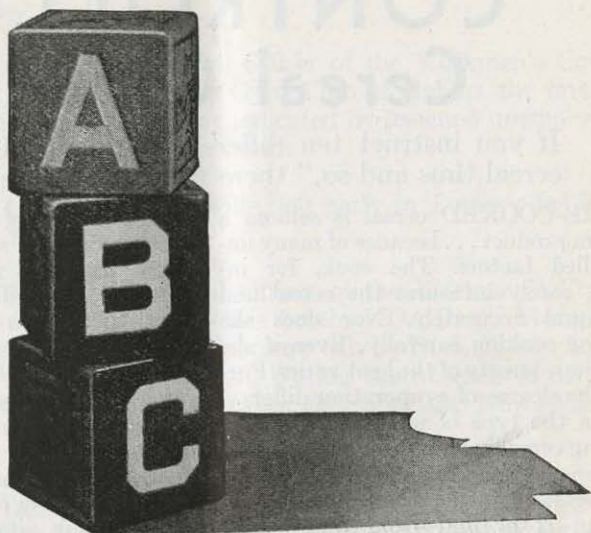
"When you have a cold you should concentrate on keeping the head loose. This will enable you to shake it off." This appears in the advertising in a Nova Scotia newspaper of a popular preparation for breaking up a cold. But if he shakes off his head why take the remedy?

Dr. Gordon R. Mahaney, of Granville Ferry, spent Christmas with his parents at their home in Wolfville.

Dr. J. B. Reid, of Truro, was elected President of the Colchester County Hospital staff at the recent annual meeting in January, with Dr. E. M. Curtis Vice-President and Dr. H. V. Kent, Secretary-Treasurer.

Even doctors in these modern days have to make hazardous trips, as witness the experience of Dr. M. R. Elliott, of Wolfville, going to and from Evangeline to his home. Part of the going trip was accomplished by the use of a canoe. On the return trip he ventured on thin ice, broke through, waded hip deep to the road, and drove home in frozen clothes.

*As
simple
as*



mineral-vitamin therapy
with **"CALCIUM A"**

"Calcium A" provides a medium for mineral-vitamin therapy that is as simple in its administration as it is valuable in its therapeutic application.

"Calcium A" is indicated as a dietary supplement in pregnancy and lactation, tubercular conditions, convalescence, or in any condition where additional calcium and phosphorus is desirable.

Each "Calcium A" capsule contains approximately 70 milligrams of organically combined calcium and phosphorus in association with a standardized concentrate of defatted cod liver oil. Each capsule exhibits the complete vitamin A and D value of one teaspoonful of cod liver oil*, thus ensuring a more effective calcium-phosphorus utilization.

* conforming with requirements of the U.S.P. X (Revised 1934).

AYERST, McKENNA & HARRISON
Limited

Biological and Pharmaceutical Chemists

MONTREAL

CANADA

CONTROLLED Cereal Cookery

If you instruct ten different mothers, "Cook baby's cereal thus and so," there will be ten different results.

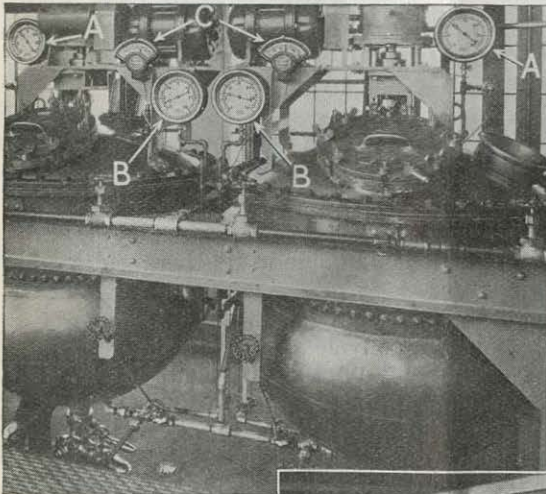
HOME-COOKED cereal is seldom a uniform product . . . because of many uncontrolled factors. The cook, for instance, rarely measures the cereal and the liquid accurately. Nor does she time the cooking carefully. Even if she does, the intensity of the heat varies. Further, the degree of evaporation differs.

Even the type of utensil is a factor. Cooking cereal in a double boiler is likely to cause a surface "skin" to form that is even less digestible than raw starch, Carman *et al* find from digestibility

studies *in vitro* of breakfast cereals. They also report that single-boiler cooking for more than 15 minutes actually "decreases digestibility because of the formation of lumps produced by too rapid evaporation of water." This clumping is unavoidable without a condenser and with ordinary household utensils.

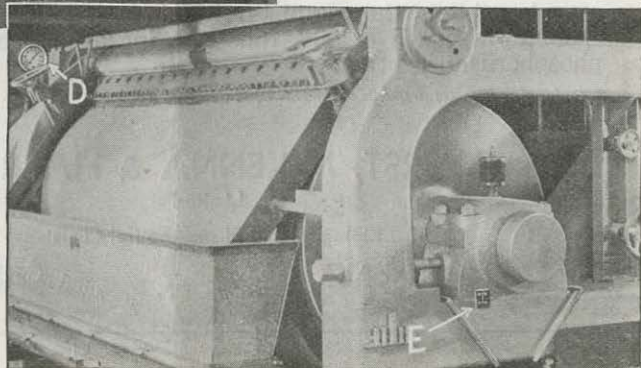
Pablum*, in contrast, is manufactured by a patented process and precision methods which insure a thoroughly cooked and uniform cereal. This is substantiated by *in vitro* studies of Ross and

Burrill, which show that the starch of Pablum without additional cooking is more rapidly digested than that of oatmeal, farina, cornmeal, or whole wheat cooked 4 hours in a double boiler.



Left—Two double-jacket cookers in which Pablum is steam-cooked under rigid control. Live steam of uniform pressure and temperature flows into the cookers and displaces air above the cereal thus preventing oxidation and affording protection to vitamins and flavor. A unique paddle-knife constantly agitates the mixture so that a fresh surface is constantly presented to the steam. Note three gauges used in controlling cooking: (A) gauges maintaining uniform steam pressure in tops of cookers; (B) gauges regulating steam pressure in surrounding jackets; (C) thermometers for control of temperature (control of steam pressure and of temperature are both essential).

Right—One of many drum dryers used in the manufacture of Pablum. After the cereal mixture is steam-cooked it is dropped between revolving steam-heated rollers which roll and dry it in a uniform layer of material. Gauge (D) is used as a check on the steam pressure within the drums. Distance between them is maintained within thousandths of an inch by means of a micrometer plate (E).



*Pablum (Mead's Cereal pre-cooked) is a palatable cereal enriched with vitamin and mineral containing foods, consisting of wheatmeal, oatmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast and sodium chloride. Patent pending.

Please enclose professional card to Mead Johnson & Co. of Canada, Ltd., Belleville, Ont., when requesting samples of Mead products to cooperate in preventing their reaching unauthorized persons.

Dr. R. B. Eaton, of River Hebert, also spent Christmas with his parents at their Wolfville home.

Dr. M. D. Morrison, Chief Medical Officer of the Workmen's Compensation Board, Halifax, spoke before the Gyro Club of Halifax the first week in January on economic improvement as indicated by lessened unemployment and improved business throughout the world.

Dr. and Mrs. A. C. Fales, of Wolfville, left early in January for Florida where they will spend the winter.

Dr. M. D. Morrison, Chief Medical Officer of the Workmen's Compensation Board, Halifax, accompanied by his brother, Dr. J. C. Morrison, of New Waterford, Cape Breton, left on February 6th by S. S. "Lady Somers" for a six weeks' trip to the West Indies. During the absence of his uncle, Dr. Clarence N. Morrison, of Halifax, takes charge of the New Waterford practice.

Dr. C. J. W. Beckwith, Assistant Superintendent of the Nova Scotia Sanatorium at Kentville, addressed the Council of Lunenburg at their meeting on January 16th on Tuberculosis, illustrating his talk with X-ray photographs of infected people. He emphasized the importance of Municipalities sending patients to the Sanatorium in the early stages of the disease. Dr. Samuel Marcus, Bridgewater, was elected Health Officer of the Municipality of Lunenburg, in place of Dr. W. H. Cole, New Germany, who resigned the office.

Dr. T. R. Ford, of Liverpool, was re-appointed Medical Health Officer by the Municipal Council in January.

Dr. Frank J. Hebb, of Liverpool, has received word from England that his brother, Dr. Harvey D. Hebb, recent graduate of Dalhousie Medical School, has been appointed to the surgical interne staff of the Royal South Hants and Southampton Hospital, at Southampton.

Dr. George H. Cox, of New Glasgow, left on January 14th on his annual pilgrimage to St. Petersburg, Florida. There on the burning sands he will muse on the mutability of all that is earthly and watch political developments in Canada with an appreciative mind and eye. The genial Doctor in view of the Bennett sensation, describes himself as a Conservative Liberal. He was accompanied by his daughter, Miss Edith.

Dr. H. B. Atlee, of Halifax, has purchased the residence, 119 South Park Street from Mr. Peter R. Jack, and has taken up residence there.

Dr. L. W. Johnstone, M.P. and Mrs. Johnstone, of Sydney Mines, left January 11th for Ottawa, where Dr. Johnstone will attend the session of the Federal Parliament. During his absence Dr. Johnstone's practice will be taken over by Dr. Hugh Martin of Sydney.

Dr. E. A. Ferguson, of Weymouth, left early in January to spend a few days in Montreal.

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INTERNAL MEDICINE: Collapse, failure of circulation during infectious diseases, chronic cardiac affections, asthma. Respiratory crises, traumatic shock.

SURGERY: Accidents during narcosis, collapse, post-operative respiratory and cardio-vascular crises; also to interrupt or regulate the duration and intensity of Evipan-sodium narcosis and basal anaesthesia.

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DOSAGE. Subcutaneously, intramuscularly or intravenously: 1 to 2 ampoules of 1.7 c.c.

Orally: 25 to 50 drops in any liquid as often as necessary.

In severe poisoning, 5 to 15 c.c. may be given intravenously, the injection being made very slowly and with short pauses. The effect of the intravenous injection is considerably prolonged if an intramuscular injection is given immediately afterwards.

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Dr. M. E. McGarry, of Margaree, is now quite convalescent from illness that had incapacitated him for some two months. The genial doctor's many friends trust his recovery is complete.

D. L. R. Meech, of North Sydney, gave an address before the Holy Name Society of that city on January 27th on "Alcohol, its use and abuse".

Dr. D. W. Archibald, of Sydney Mines, was the guest speaker to the members of the police and fire department at the first aid class held on January 9th at Sydney Mines.

The marriage took place on January 31st at Glace Bay of Miss Phoebe Marie, youngest daughter of Mr. and Mrs. James Daye to Dr. W. W. Patton, M.L.A., of Port Morien. Dr. Patton graduated from Dalhousie University later completing post-graduate work at the University of Dublin, Ireland. He began his medical practice in Glace Bay, later going to Broughton, C. B., where he was colliery physician until the outbreak of the Great War, when he enlisted and was appointed to the Imperial Medical Corps. On his return to Canada he practised in Dominion until 1923, when he moved to Port Morien.

A very pleasant function took place in the General Hospital at Glace Bay on February 7th when the members of the Glace Bay Medical Society presented Dr. Patton with an address and a beautiful case of silver. The address was read and presentation made by Dr. F. Bates. Dr. Patton thanked his fellow members of the medical profession for their kindness and lovely gift.

NOTICE

It has been suggested by a number of members that an attempt be made to secure special rates, either for steamship or train, for those attending the conjoint meeting of the Canadian and American Medical Associations to be held at Atlantic City from June 10th to 14th. If you have decided to go to this conference, and wish to travel in this manner, kindly notify me, as soon as possible so that I may make arrangements.

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

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In the prophylactic and curative treatment of congenital syphilis, STOVAR SOL by mouth is advised because of its ease of administration and the resulting co-operation of the parents.

For adults, STOVAR SOL is most useful as a form of "follow-up" or supporting therapy between courses of Arsphenamine compounds or Bismuth.

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- For the "follow-up" treatment of syphilis;
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ACETYLARSAN for adults: *Ampoules of 3 c.c. of a 23.6% solution containing 0.05 Gm. of arsenic per c.c.*

ACETYLARSAN Infantile: *Ampoules of 2 c.c. of a 9.4% solution containing 0.02 Gm. of arsenic per c.c.*

In boxes of 10 and 100 ampoules.



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THE MODERN PHYSICIAN SURVEYS THE ECONOMIC CHANGES.

Editor, Public Forum:

Today the age-old and venerable profession is confronted by myriads of problems and changes in economics. Many physicians are now faced with a new trend in economic pressure that has been brought about by the telephone, automobile, radio and the industrial age with complicated machinery. The world-wide depression has so wounded the standard of living of the doctor that it will take many years to heal.

Some of the existing conditions which have undermined the doctor's income at present are as follows: Private business corporations use as their keyword to the doctor, when solicited, that their products are only advertised to the practising physician. After the commercial products have been popularized through the medical man's prescriptions, the promises of these money making corporations are forgotten. Subsequently, these companies begin advertising campaigns over the radios and, by a series of advertisements in all sorts of periodicals, never forget to mention that the medical profession encourages its use. The city physician has developed a poor habit of writing patent medicines because it helps him to save time by not having to calculate the dosage of all the ingredients. Patients, however, rapidly lose confidence in such practices and soon they learn to ask for such medications over the counter of the drug store. Then we have the unscrupulous advertisers over the radios through which channels much incorrect information is given to the public by quacks who either run their own clinics or are highly paid by commercial enterprises.

The physician, as a rule, volunteers without charge to treat deserving poor patients in dispensaries, but the hospitals, however, do not have adequate social service assistance to investigate those who do not deserve charity. Nevertheless, there is unfairness on the part of a good number of hospitals in not protecting the physician's economic status.

At times the medical profession is exploited by several small private incompetent health insurance companies which work on a basis of profit. The companies of varied sources offer doctors very small annual fees and in return large numbers of families are attended by the overworked and underpaid poor physician who usually does very inferior type of work because of the tremendous amount of petty responsibilities. Also, there are numerous societies, lodges and endless benevolent and fraternal organizations which work on the very same principles and the helpless doctors fall for such insignificant tactics. There are numerous other causes which limited space does not permit the writer to mention at this time.

There are various groups and cults taking advantage of the doctors' lack of interest in the welfare of the medical profession, and so these strings of cults are constantly exploiting humans in their misery for their financial gain. The medical societies are weak without the individual physician's interest and understanding, as there must be concerted effort on the part of the medical profession to help solve these problems rather than allow those who are out of the profession to dictate what ought to be done.


Since there is an approach to an oversupply of physicians in this country, there should be proposed a moratorium by the American medical schools which will aid in the equalization of distribution of physicians. Dispensaries should be put out of business if they are of a commercial nature; which can

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be done by having a state law passed prohibiting commercial dispensaries from making a charge to use clinics or medicines. A specialist or general practitioner should never use patent medicines for prescribing. There are too many age old, useful drugs in the materia medica and pharmacology textbooks; students now at medical schools should be admonished against the evil practice of patent drugs. The druggists and the physicians should have mutual understandings and never infringe upon each others' fields. Cheap contract lodge practice, either on a small or large scale, is a pernicious, destructive economic force and should not be tolerated by medical societies. In short, the art of medicine has been constructed on basic principles of truth for which men in the past century have fought valiantly. We, too, must try and uphold those very fine principles and ethics which help to make our profession stand out characteristically from all the rest.

M. Martyn Kafka, M.D.,

Reprinted from New York Medical Week, March 3, 1934.

EARLY ADVENTURES WITH CHLOROFORM IN PICTOU, N. S. Pictonian is Pioneer in Revolutionary Medical Discovery.

By K. A. MACKENZIE, M.D.

The family Bible is responsible for the preservation of many interesting records. Of special interest to the medical profession is the following from the family Bible of the late Mr. R. P. Fraser of Pictou: "Robert Peter, born March 22nd, 1848. At the birth of this, the seventh child, chloroform was used for the first time in Canada during child birth." The child referred to was Mr. R. P. Fraser, a highly respected citizen of the town of Pictou, who died on August 30th, 1923, at the age of seventy-five. He frequently boasted to his friends that he was the first child at whose birth chloroform was used in Canada, and was evidently proud of this unique distinction.

The *Presbyterian Witness* has preserved for us some interesting records on the use of chloroform. In the copy of February 5th, 1848, appears the following: "Dr. Almon amputated the thumb of a woman in the Poor Asylum, Tuesday morning, in the presence of Doctor Parker of this city, and Doctor Brown of Horton. This case is published, not for the purpose of inviting attention to the operation, but to the effects of the agent employed to prevent pain. The chloroform was administered by inhaling from a soft rag applied to the nose and mouth for a few minutes. The patient very soon became insensible to pain, and the operation, occupying perhaps ten minutes, was finished before sensibility returned. On waking, the poor woman expressed her gratitude in the warmest form and in the judgment of all present the success of the operation was complete."

In the same paper of March 11th, 1848, the following appeared: "An operation was performed on Friday last, by Dr. Almon at the Halifax Poor's Asylum, in the presence of many of the medical men of the city, upon a poor woman, under the influence of chloroform. The patient upon first inhaling the chloroform was a little excited, but after a short time became more tranquil, and finally sank into a state of partial lethargy. The operation, (amputation of the leg above the knee) was then commenced. Before it was completed, she so far came to herself as to sing and converse, though rather incoherently, with those about her. When the operation was finished and the stump partly dressed, on being asked if she was ready to have her leg taken off, she gave

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her assent, and, for some time, could not be persuaded that it had already been done, as she had experienced no pain. The medical men present expressed themselves satisfied with the result of the chloroform which quite equalled their expectations.

The chloroform made use of on this occasion (on the purity of which the producing of its characteristic effect depends) was manufactured by J. D. B. Fraser, Esq., Chemist of Pictou."

Both of these antedate the date of Mr. Fraser's birth. At this point, one should recall that Sir James Young Simpson first administered chloroform in childbirth on November 4th, 1847, and published his notes about one week later. The news of this wonderful discovery had barely reached this side of the Atlantic when a modest chemist in a small shop in the town of Pictou began experimenting with chloroform under conditions which to us appear truly remarkable. He found the formula in a London medical journal and set to work to produce the substance himself. He prepared it, purified it, and supplied it to doctors in Halifax. This was less than four months after Simpson's first administration. Two weeks later he had the courage to administer it to his wife for the relief of labor pains.

Mr. J. D. B. Fraser was born in Pictou on February 11th, 1807. He established his drug business in 1828 and carried on his business until his death in 1869. He was a man of more than ordinary ability. He was a chemist in the true sense and represented a type not usually found in a modern drug business. In his day, drugs were manufactured locally. The large manufacturing houses had not appeared. Besides his early adventures with anaesthesia, he was interested in other new features, especially antiseptics, and his wisdom and achievements are still discussed by his admirers in the old town. His name still adorns the shop window, although the business has passed out of the Fraser family.

In 1853, Mr. R. P. Fraser had an operation on his eye under chloroform, but this was five years subsequent to his birth, and anaesthesia had ceased to be a novelty. His father for a considerable time supplied chloroform for use in Nova Scotia.

(*Canadian Medical Journal*, Vol. 14, 1924).

New Glasgow News, August 7, 1934

A new cure for undulant fever is announced by a group of University of Cincinnati medical scientists.

It is a serum produced from goats milk after the goats were inoculated with chemically treated suspensions of organisms or "germs" that cause the disease.

Undulant fever is a serious long-drawn-out affair which often ends fatally. It is caused by an organism by various means. Neuralgic pains, swelling of joints, recurring fever attacks, weakness, anemia are unpleasant features.

The producers reported that first 20 patients treated were restored to health and activity.

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Office Boy—"Yes, sir. When they get old enough the firm sends them out as travellers."



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