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*H. Beckman: *Treatment in General Practice*. 3rd. Edition: 1938, p. 395.

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*The Earliest Physicians of Colchester

(Several years ago that estimable lady, whom many of us remember with affectionate regard, the late Mrs. Susan Lynds (Blair) Page, widow of Dr. A. C. Page, gave me in manuscript the following brief sketches, written by her husband, of the earliest physicians of Colchester County. So far as I know this manuscript has never been printed and it is of such general interest that it seems best to me to let it appear in the columns of the *Truro News*. The exact date of the manuscript I have no means of determining; it was probably written to be read to some audience of medical men.) Arthur Wentworth H. Eaton.

THE first physician located in Colchester of whom I can find any account was Dr. John Harris who came from Pictou in 1778, (some authorities say 1776.) He was of somewhat noted Scotch ancestry, his great grandfather, Edward Harris, and his wife Flora Douglas, so Dr. Patterson informs us in his "History of Pictou County", having left Ayreshire, in Scotland, in the reign of Charles 2nd or James 2nd, after losing a fine estate for their attachment to Presbyterianism.

John Harris was the youngest son of Thomas Harris, and was born July 16, 1739. His college education he obtained at Princeton, (the College of New Jersey, of which Rev. Dr. John Witherspoon, the only clergyman signer of the Declaration of Independence, was then and for many years after President) and his medical education he secured in Philadelphia. Coming to Nova Scotia with the little group who settled in Pictou County, members of the Philadelphia Company, he acted as attorney for that company and so had much to do with the early settlement of Pictou. He was the first magistrate of that district and held other public offices. After coming to Colchester he was made clerk of the peace, which office he held for some years. He also represented the County in the Nova Scotia Parliament from 1779 to 1785. As a part of his magisterial labors he celebrated marriages, and Mrs. Nancy Soley informs me that in her early childhood she saw him marry a Mr. Davidson of Upper Stewiacke with a Miss Downing of Brookfield, and says for aught she knew he did it as well as any person could. Dr. Harris was an active public spirited man, and is highly spoken of by the old inhabitants as a physician and a citizen. He died of apoplexy April 9, 1802. He was sitting on his horse when the fit seized him and brought him to the ground.

Doctor Daniel Eaton came to Colchester from Haverhill, Manchester, in 1789. He married in 1790 and practised his profession in Truro for some years. He was skilful as a physician, and was noted for his gentlemanly bearing. He was the father of the late William Cater, Daniel, Phebe and James Eaton. Dr. Eaton went to Boston in 1801 on business or for his health, and died there. His widow afterwards married Capt. Simon Kollock. She died only a few years ago, a hundred and five years old. Dr. Eaton, who was a nephew of David Eaton, founder of the Cornwallis Eaton family, is thought to have been educated in Philadelphia. He was a cousin of David Page, founder of the Page family of Colchester, who like Dr. Eaton came from the west parish of Haverhill, Mass.

Dr. John Murray Upham, son of George Upham of New Brunswick came to Colchester about the time Dr. Eaton left. He married Mary, twin daughter of Charles Dickson of Onslow, who bore him three children, two daughters and a son. His eldest daughter, Mary, married Scott Flemming. His second

*Published in the *Truro News*, September, 1915, by the late Dr. A. C. Page, and prepared for the BULLETIN by the late Dr. H. V. Kent of Truro.

daughter, Olivia, married William Campbell of Tatamagouche, and his son Charles, who died recently at a ripe old age, married a daughter of the late James Linton of Onslow. Dr. Upham's reputation as a physician was good. Socially and professionally he was very popular.

Dr. David Barnes Lynds, son of Thomas Lynds of North River, Onslow, studied his profession with Dr. Head of Halifax. He spent a year or more in Philadelphia, and returned here to practise very early in the present century, but I cannot say in what year. He married in 1810 Sarah, second daughter of John and Nancy Blair of Onslow. Their only daughter Susan was the first wife of Dr. John Waddell long Superintendent of the New Brunswick Insane Asylum. She and her twin children were burned about a year after her marriage. Dr. Lynds was somewhat celebrated as an accoucher and in that branch of the profession was called "very lucky". He made no pretensions to skill as a surgeon, and some of his attempts at bone setting would indicate that his own estimate of his proficiency was about correct. A well authenticated anecdote of his experience in one surgical case is worth preserving. He had a brother-in-law who was something of a wag but who was so unfortunate as to require the Doctor's help in binding up an oblique fracture of the tibia and fibulae, just above the ankle. The first union was so unsatisfactory to the doctor that he broke the ankle again, but his second attempt at reduction was very little if any better than the first. He made a great many visits to his suffering relative and often took him large bottles of medicines, which were never uncovered but were stowed away on an upper shelf in the cupboard "for future reference."

Some time after any further attendance was necessary the doctor sent his bill itemized, so that he charged for a certain number of visits at so much, and sundry bottles of medicine at so much. Upon receipt of the bill the relative got down all the uncorked bottles put them into a large basket and hastened to the doctor's office, where after setting the basket carefully down he remarked that he had got the bill in which so much was charged for medicine and so much for visits. "I return the medicine just as you left it, Doctor," said he, "and I will return the visits from time to time when I am over this way." "What!" said the Doctor, "with that crooked leg? Please don't, here is a receipt in full." Doctor Lynds was a most expert phlebotomist and heroic in his efforts to rid his patients of their "pesky fangs" but not always lucky enough to get the right tooth. He had such an aversion to blood and was so tender hearted that the amputation of even a finger or a wart would quite overcome him. Chloroform and ether were unknown to him; he had no faith in "new fangled notions," as he expressed it. He had been a pupil of the old Masters Phisic and Rush, and thought that anything they did not know was not worth knowing. He died June 4th, 1871, in his 90th year and probably did as little harm during his long life and practice as any physician that ever lived having the same opportunities, and that is high praise. For some years during the earlier years of his practice he had no competitor on the north, nearer than Amherst, on the east nearer than Pictou, nor on the south nearer than Halifax. He not only visited every part of this county of Colchester then inhabited, but went to Wallace and Westchester, in Cumberland, Rawden and Shubenacadie in Hants, and Gay's River and Musquodoboit, in Halifax. For many years his only mode of conveyance was on horseback.

Doctor Benjamin Stearns came from Boston in 1804, and passed through Truro on his way to Antigonish, thought it a goodly place. Not being pleased

with Antigonish he left there and came to Truro about 1810. He practised in Colchester while his health lasted. He reared a family of nine children, and lived with them at Bible Hill. He died at the residence of his son, Henry, in Pictou. I have not been able to learn any particulars about his education or family, although I have talked with one of his sons, now living in Halifax, aged about 80 years.

Doctor Peter Suther was a navy doctor. He came to Truro about the time as, or soon after, Dr. Stearns. He married Sarah, daughter of William Dickson, and had one son who died quite recently as the Right Reverend Bishop Suther of Aberdeen. Dr. Suther was gentlemanly, genial and kind, very considerate for the poor, and very popular generally. Everybody regretted that his duties to the empire demanded his removal to more important and active work than the practice of his profession in Truro, and deprived the inhabitants of a much loved and valuable member of its Society. When I was a child his praise was in all the people's mouths.

Doctor William Grigor was a stately, noble-looking Scotchman, contemporary I think, with Drs. Lynds, Suther and Stearns. He found Truro pretty well supplied with doctors, and perhaps for that reason moved to Halifax, where he found a larger and much more congenial field of labor. In the capital he took high rank professionally and socially. He married a Miss Forman, who still survives him, and is living now in England. He was a member of the Legislature Council, and died in 1857 universally regretted. When the history of the profession in Halifax is written Dr. Grigor ought to occupy much more space than I have given him here.

Doctor Charles Head, son of Dr. Charles Head of Halifax, came to Truro about 1825. He married the widow of John, son of the late Hon. S. G. W. Archibald, and had three children born in Truro, a son and two daughters. He moved to Halifax about 1835, where he died soon after. His widow married Snow P. Freeman, and is again a widow living in Halifax. Dr. Head did not devote all his time and attention to his professional work, and I think, he never got so firm a hold on the affections of the people as some of his predecessors here, whose labors like those of physicians of the present day were not always by any means solely for gain.

Doctor Edward Carritt came to Truro about 1834 or '35, and built the house Sheriff Crowe now occupies. After a few years residence in Truro, about 1804 to 1842, he moved to Guysboro, where I believe he still lives. He was considered skillful as a physician, and was highly thought of as a citizen.

Dr. Robert F. Crowe was a native of this County, the fifth son of Thomas and Esther Crowe of DeBert River and born in 1805. His medical education he got chiefly at the University of Pennsylvania. He practised in Clinton, New York, and was a member of the Clinton County Medical Society. He also practised in Ontario, but I have not learned where. He attended two courses of lectures at the University of Pennsylvania, the first in 1836-7. The second in 1840-41. Between the two courses he graduated, for on the tickets for his second University Course he is styled "Dr." I am unable to state in what years he practised in Colchester, but the years he spent here as a physician were not many. Although his career was short, however it was very successful. He was a keen observer of human nature, had a good deal of "dash", and became very popular. In 1830 he married Rebecca, fourth daughter of Mark Paton Martin, who bore him one daughter. This lady is now living in Halifax,

the widow of the late Thomas McCulloch. Mrs. Crowe died in Truro, July 6, 1843, aged 33 years. The Dr. died in Londonderry on October, 1844, aged 39 years. Dr. Crowe had some striking eccentricities. For instance, he had his coffin made and brought to his house some time before his death. A short time before he died he took a notion he would like to die in his native village, and although feeble he was removed there, his coffin following at a respectful distance in another wagon. Those who remember him speak in high praise of his professional skill and his great kindness of heart.

Jonathan Borden, M.D., of the Harvard Medical School, was born at Grand Pre, in June, 1809. He took a course in 1836-7 at the College of Physicians and Surgeons in New York, entered Harvard in November, 1837, and graduated at Harvard in February, 1840. Soon after he commenced practice in Londonderry, where he remained for six years, then returning to his native County, Kings. Settling in Cornwallis, he had there extensive practice for many years. The people of Londonderry became so much attached to Dr. Borden during his stay among them that after his settlement in Cornwallis they sent him a requisition numerously and influentially signed, urging him to return and I have been informed that their confidence in his skill was so great that frequent pilgrimages were made by the sick from Londonderry to Cornwallis, to seek his advice. Dr. Borden was generous to the poor, and while he made hosts of friends in Londonderry, I fear he did not make much money there. His six years labour yielding him, in addition to a not over-luxurious living, only the sum of one hundred pounds currency. In Cornwallis he made a rival and whether he was the equal in medical knowledge and skill of his rival or not he certainly was his match at repartee. His rival said to him one day in the presence of a number of friends: "Borden you never let one patient go till you get another." "I am sorry I cannot return the compliment", said Borden, "yours die so quickly that you never have time to get others before they are gone."

Dr. Waddell, L.R.C.P. and S., Edinburgh, was the third son of the Rev. John Waddell, and was born in Truro, March 10, 1810. He did not begin the study of medicine till after his first marriage, which occurred in 1833, to Susan only daughter of Dr. David B. Lynds. He commenced practice in Truro about 1839, and continued it till 1849, when he took charge of the New Brunswick Lunatic Asylum, which position he filled for more than a quarter of a century with great credit to himself and satisfaction to the people of the sister province. He manifested great skill and tact in treating and managing that unfortunate class under his care, and he was on more than one occasion indebted to his great presence of mind for his life. Once at least, he owed his life to his superior muscular power. His position in New Brunswick was one of great responsibility and no little danger, but both as physician and Superintendent his administration was eminently successful and many are now clothed and in their right minds who attribute their good fortune to his kindness and skillful care. Dr. Waddell was a gentleman of somewhat imposing appearance, with a warm, genial manner, who always met his friends with a pleasant smile and a friendly grasp of the hand. His second marriage was in June, 1844, to Cane, second daughter of Edward S. Blanchard. He died in Truro a few months after resigning his New Brunswick trust, his resignation having been much against the wishes of the Government of New Brunswick. His death occurred in August, 1878. His wife died very suddenly three or four months later.

Samuel Allan Muir, M.D., L.R.C. Ph., Glasgow, L.R.C.S., Edinburgh, Coroner, was a Scotch Irishman, or Irish Scotchman, and either country might well have been proud to claim him. Dr. Muir came to Nova Scotia in search of his diploma which had been stolen by an adventurous youth whose name for certain reasons I suppress. He did not intend making a home in this colony when he came here, but he saw almost every person driving his own horse and carriage and he thereby got the impression that all the people were wealthy and concluded it would be a fine country in which to build up a practice. He lived to learn that the possession of such property did not mean so much here as it did in the old country. He first settled at West River, in Pictou county, but when Dr. Crowe's health failed he came to Truro and bought the latter's house and succeeded to his practice. Under Dr. Muir this practice soon embraced a much wider range than his predecessor's ever had done. Dr. Muir did a great deal of consultation practice in distant parts of the country and even beyond it, which involved long and tedious journeys and before the introduction of railways caused an amount of exposure and fatigue that might have appaled any but the stoutest heart and that fully taxed the staying powers of the most robust and resolute. Dr. Muir was president of the Nova Scotia Medical Society for eighteen years. He was a man of varied and extensive reading and familiar with all the best literature of his profession. He was full of anecdote and had a keen appreciation of wit and fun. In his social relations he was exceedingly genial, and he was never happier than when enjoying an evening's chat with educated men. He was quick to recognize and acknowledge ability in others and took great pride in developing any spark of intellect discoverable in those with whom he was brought in contact. He was the "Medical Father," so to speak, of many of the best practitioners in the province today, and of some that have become eminent in foreign countries. He had a happy faculty of adapting himself to the plain requirement of every situation and he thereby avoided collision with a people always exacting but never any too eager to render hasty justice for favors received. Muir enjoyed the confidence of his patrons to an almost unlimited degree, and there were but few who came in contact with him who had not warm feelings of attachment for him. He married Esther Hunter Crowe, daughter of David H. Crowe of Onslow, and died in Truro in 1875, aged 64. His widow and five children survive him, two of his sons being medical practitioners in Truro now.

Edward True McRobert, M.D., Coroner, was the oldest son of William Edward and Elizabeth McRobert. He was born at Walton, Hants Co., June 10, 1846, and was educated at Sackville, New Brunswick, and at Harvard University, where he graduated in Medicine in 1867. Immediately after graduation he commenced practise in Great Village, Londonderry and there he continued to practise while he had strength to do so. He was married June 19, 1873, to Emma Margaret, daughter of Robert and Margaret Smith of Truro, and had fairly entered upon what promised to be an active, useful and eminently successful life, when he was called to give an account of his stewardship. He died after a painful illness, on the 25th of May, 1879, leaving a young widow and three children to mourn an irreparable loss. He is still spoken of among his many friends in Londonderry with much tenderness and regret.

Henry Kirkwood, M.D., (Jefferson Medical College, 1859), is a son of the late Dr. Kirkwood of Pictou. He commenced practice in Tatamagouche but remained there only a very short time. From Tatamagouche he removed to

Cow Bay, Cape Breton, where he practised for some years, but at his father's death he came to Pictou and took the latter's practice.

Dr. Henderson practised in Londonderry for some years but I have not been able to ascertain whether he graduated at London or Edinburgh. He went from Londonderry to Mount Thom, in Pictou County, where he died a few years since very suddenly. He fell out of his sleigh, became unconscious, and soon died. I do not know whether his death was caused by the fall or whether the fall was the result of a cause that terminated in death.

Dr. Marshall was a son of the late George Marshall, so long and favorably known in connection with the temperance cause. He was educated at Acadia College and at Edinburgh University, and practised in Tatamagouche for some years. He is said to have been very well taught in the mysteries of our art, and skillful in the application of his knowledge. He died quite young, very generally regretted.

Elisha D. Roach, M.D., is a native of Cumberland, a son of John Roach and Sarah Amelia Dickson. He was educated at Sackville, New Brunswick, and graduated at the University of Pennsylvania in 1860. The same year he commenced practise in Tatamagouche, where he still resides, enjoying the full confidence of a large circle of friends and patrons. His field of labor is large and involves such fatigue and exposure as sometime to threaten seriously his life, but thus far he has managed not only to attend to his own practice but in time of need to lend a helping hand to a neighbor's brother. He was married August 6, 1874, to Mary S. McKeen, of Tatamagouche.

Dr. Patrick Francis, a clever Irishman, commenced to practise in Upper Stewiacke about 1846. I am not aware what his qualifications were, but I have heard him spoken of as cautious and skillful. He never attempted difficult surgical operations, but had the good sense when he had a doubtful or difficult case either in medicine or surgery to call to his aid the advice of some brother practitioner. He enjoyed the confidence of his patrons both for skill and for integrity. He married a daughter of Daniel Tupper and died about 1870.

Charles Bent, M.D., of the University of Pennsylvania, Coroner, a native of Cumberland County, was born at Amherst and educated at Amherst, at Sackville and in Philadelphia, where he graduated in 1847. The same year he began to practise in Pugwash, where he remained for six years, but in 1853 he came to Truro, where he has remained ever since. Soon after the first appearance of diphtheria in this county (and Province) he published a pamphlet giving in a condensed form about all, I presume, that was at that time known of that unmanageable disease. He has taken a deep interest in the public affairs of the town, before incorporation, as a school trustee, and since then as Councillor. In May, 1882, he was elected Mayor, being re-elected in May, 1883, for a second term. He is exceedingly quiet and unobtrusive in his department, but very firm in maintaining his own opinions, when fully convinced of their correctness.

Dr. Bent married first, Mary, eldest daughter of John Goudge formerly a merchant on Bible Hill, Truro. After her death he married Libbie, daughter of William Metzler.

William Norrie, M.D., M.B.M.A. (since April 1882) son of William Norrie and Elizabeth Stephenson, was born May 22, 1841, at Broughty Ferry, Forfarshire, Scotland. He was educated at Dundee, in Truro, and in Cambridge Massachusetts, graduating at Harvard, July 17, 1867. The same year he

commenced practise at Earltown, where he remained till July 6, 1880, when he removed to the West Branch of River John, where he now resides.

Dr. Norrie is a good student and keeps well abreast of the advances in medical knowledge. He is independent, bold, vigorous, and original in thought, and whatever his hands find to do he does with all his might. About the close of his last term at College an incident occurred which with an ordinary mortal would, I fear, shake all confidence in College Professors. He relates it thus: (The story is not given).

Dr. Norrie's first marriage was in 1867, with Anne McDonald. His second marriage was in 1875, with Jessie F. Parker.

Walter Thomas, eclectic College, Philadelphia, insisted upon sharing with Dr. Francis the honors and emoluments connected with the peopleing of the Upper Stewiacke cemeteries. He was an Englishman, and was in receipt of a pension or annuity, from his native Country which he never expended so far as is known in Bibles or other religious books. What he earned by the practice of medicine enabled him, I suspect, to drink himself to death sooner than he otherwise would have done.

William Edward McRobert, Coroner, a Licentiate of Nova Scotia, is a native of the state of Maine, U. S. A. A son of Edward and Abigail McRobert, he was born in Durham, Maine, June 28, 1822, and was educated at Portland, Maine. He first practised in Boston, Massachusetts, but in September, 1852, he commenced practise in Londonderry, Colchester County. He had a very wide and difficult field of labor, and he acquired a more than local reputation in the treatment of cancer. He was a neat and expert operator, was cautious and particular about details and never failed in an operation, through negligence on his part of the smallest minutia necessary to success. Although Dr. McRobert was always popular as a physician and probably did as well in his profession financially as any of us, if not better, he seemed to have grown weary of the drudgery and care of a Doctor's life, and in May, 1871 gave up his field to his son, E. T. McRobert, and engaged in the manufacture of furniture in Truro, where he still continues this business. He has been an active public spirited worker in the affairs of church and state, a great friend of the temperance cause, and a valuable citizen generally. He married Sept. 16, 1845, Elizabeth Corbett of Londonderry. Duncan McLean, M.D., Coroner, a native of Pictou, son of David and Maggie McLean, was educated at Pictou and at Harvard University. He graduated at Harvard in 1860, and soon after commenced practise at Shubenacadie, Hants County, where he still resides. A large part of Dr. McLean's practice is in the County of Colchester, although he lives in Hants. His field of practice is large and laborious, he is very self-sacrificing in his devotion to his profession, and is a safe and reliable practitioner. Having no medical man in his vicinity to consult with he is often placed in circumstances where his tact and ingenuity carry him safely over difficulties, when one not so largely endowed with those valuable qualities would fail. He is kind and considerate to the poor, is a lover of sport and is quick to resent an injury, but he is very forgiving and is generous to a fault. He married Maggie McHeffey.

John Leander Peppard, M.D., Coroner, was born in Fredericton, New Brunswick, May 15, 1840, the eldest son of John Peppard and his wife Sarah Davis, now of DeBert River, Upper Londonderry. He was educated at Fredericton Grammar School, at Truro, at Wolfville, at Dartmouth Medical College, where he graduated in 1865, and at Harvard University, where he

graduated in 1866. He commenced practise in Boston in 1865, but the next year removed to Londonderry, where he has remained ever since, a diligent, faithful and safe practitioner. He takes a lively interest in public affairs, is progressive in his ideas, and is blessed with good sound judgment in professional and secular matters. He married first in March, 1866, Arabella P. Morse, secondly in June, 1883, Clara A. Balcom. Dr. Peppard is a self-made man and a credit to his Maker.

Suther Corbett Murray, M.D., Coroner, son of George A., and Jane Murray, was born in Economy in Colchester County, November 1, 1846 and educated at Harvard University. He graduated at Harvard in March, 1871, and commenced practise at Great Village, Londonderry almost immediately after. In June, 1873, he removed to Albert, Albert County, New Brunswick, and there he still resides. He married Harriet E. McRobert, daughter of Dr. W. E. McRobert, April, 1871.

David McLean, M.D., son of John McLean, was born at Green Hill, Pictou, in 1836, and educated first at West River. In 1864 he graduated in medicine at the University of Pennsylvania. After graduating he secured an appointment as assistant surgeon in the United States Navy and while he was attached to a gun boat in the Gulf of Mexico his health gave way. He then went to Edinburgh to pursue his studies there, but poor health compelled him to take the advice of his physician there which was that he should immediately return to Nova Scotia. Before studying medicine he had taken a course of training for teaching in New Brunswick, and for a while he taught in that province. On his return from Edinburgh he commenced practise in River John, Pictou County, but afterwards he moved to Tatamagouche and became associated there with his ever after warm friend, Dr. Roach. From Tatamagouche he went to Wallace, where he made many friends, but his physical strength was not equal to the situation and he yearned for his native county. He consequently removed to Stellarton, where he soon had a remunerative practice. His health, however, was no better, and on the 30th of August, 1876, he died. He married Maggie O'Brien of Wallace, and his wife and one child survive him.

The following extract from a memoir of Dr. McLean, written by the Rev. Mr. Tuttle, will give some idea of how much Dr. McLean was loved and appreciated by those most intimate with him.

"As a gentleman Dr. McLean possessed a high sense of honor and detested anything mean. With a peculiarly sensitive nature he was noted for his kindliness of disposition and his unwillingness to give pain. Besides extensive acquirements in medical and other sciences he was well read in divinity. A firm believer in the great truths and doctrines of the Christian religion, he was not afraid or ashamed to confess his Saviour before man, or to pour out his heart in prayer to the Great Healer. Brought up a Presbyterian and adorning the Gospel in that church by a singularly gentle and upright life, he was yet eminently catholic in his spirit, and strongly believed that the true Church of Christ stood isolated from and far above all merely human sects, creeds or conventionalisms. He joined in our prayer meeting with much earnestness only a fortnight before his death. Pleasant have been the writer's interviews with this genial man."

A. C. Page, M.D., (Harvard), third son of David Page and Eliza Cutten, was born in Truro December 11, 1827, and educated at Truro and at Harvard University. He graduated at Harvard, March 12, 1856, and began practise

in Truro the next month. He was elected president of the Nova Scotia Medical Society in 1875, for one year, was a member of the Provincial Medical Board for three years, and in May, 1883, was elected first President of the Colchester County Medical Society. He married, September 1860, Susan Lynds, youngest daughter of Colonel James D. Blair.

(In an early part of the manuscript Dr. Page mentions also Drs. Gilmour, Landsburgh, Hogan, and George Harvey, who he says practised in Colchester during the first ten years of the 19th century, but he evidently knows little about them and gives no sketches of them.—A. W. H. E.—)

The Treatment of Chronic Arthritis

By M. H. DAWSON, M.D.

Associate Professor of Medicine, College of Physicians and Surgeons, Columbia University.
Assistant Attending Physician, Presbyterian Hospital.

Clinical Director, Research Division for Chronic Diseases, Department of Hospitals, New York City.

THE treatment of chronic arthritis is predicated upon an accurate diagnosis of the type of arthritis present. One cannot generalize any more about the treatment of chronic arthritis than one can about the treatment of fever.

The following classification of the various forms of arthritis is presented for consideration.

I. *Infectious:*

A. Of known etiology, due to specific micro-organisms demonstrable in joints.

- | | |
|--------------------|------------------------------|
| 1. Gonococcal. | 6. Meningococcal. |
| 2. Tuberculous. | 7. Luetic. |
| 3. Streptococcal. | 8. Influenzal. |
| 4. Staphylococcal. | 9. Lymphogranuloma venereum. |
| 5. Pneumococcal. | 10. Miscellaneous. |

B. Of know etiology but specific micro-organisms not demonstrable in joints.

1. Scarlet fever.
2. Dysentery.

C. Of unknown etiology.

1. Rheumatic fever.
2. Rheumatoid arthritis.
including—Still's disease.
—Ankylosing spondylitis.
—Psoriasis arthropathica.
—Felty's syndrome.

II. *Degenerative:*

Osteo-arthritis.

- including—Heberden's nodes.
—Malum coxae senile.
—Osteo-arthritis of the spine.

III. *Traumatic.*

IV. *Metabolic*—Gout.

- Scurvy.
—Ochronosis.

(Condensed from a lecture delivered at the New York Academy of Medicine January 19th, 1940)

Dr. Dawson, being a Truro boy, kindly forwarded this up-to-date interesting article, on request, and we appreciate his cooperation.

D. S. McCURDY.

V. *Neuropathic*—Tabes dorsalis.

(Charcot's joints) Syringomyelia.

VI. *Allergic*—Serum sickness.VII. *Unclassified and combinations of the above.*

Rheumatoid and osteo-arthritis comprise approximately 70 per cent of the cases of chronic arthritis seen in general practice. Since these two forms of arthritis constitute separate and distinct diseases, it is of the utmost importance that they should be clearly differentiated before any treatment is instituted.

The chief distinguishing features between rheumatoid and osteo-arthritis are presented in the following table:

	Rheumatoid Arthritis	Osteo-arthritis
1. Family History.	Not infrequently a history of rheumatic fever or rheumatoid arthritis in an immediate member.	Frequently a history of osteo-arthritis in older members of the family.
2. Past History.	Occasionally a history of rheumatic fever; frequently a history of tonsillitis or sore throats.	Not characteristic. Sometimes a history of trauma.
3. Age at Onset.	Any age: 80 per cent between 20 and 50.	Rare before 40: most frequent 40-55. In women most common at menopause. (menopausal arthritis).
4. Mode of Onset.	Occasionally acute; usually sub-acute or insidious; may commence with migratory pains.	Insidious; not accompanied by migratory pains.
5. Patient's General Condition.	Usually undernourished, anemic and chronically ill.	Well nourished, frequently obese; not anemic.
6. Constitutional Reaction.	Slight to moderate degree of fever in some cases; tachycardia common; occasionally slight leucocytosis.	No fever, leucocytosis or tachycardia.
7. Joint Involvement.	Symmetrical and generalized; smaller peripheral joints, especially proximal interphalangeal joints and wrists.	Usually symmetrical though less generalized; weight-bearing joints, especially knees, but also distal interphalangeal joints. Heberden's nodes.
8. Appearance of Joints.	Early; periarticular swelling, fusiform fingers. Late; ankylosis, extreme deformity, ulnar deflection.	Early; slight bony enlargement; effusion uncommon. Late; more pronounced bony enlargement; ankylosis rare and never complete.
9. Muscular Atrophy.	Often marked.	Not present.
10. Cutaneous Changes.	Extremities frequently cold and clammy; skin atrophic and glossy; occasionally brownish pigmentation, rarely psoriasis (3 per cent).	No characteristic features. Skin may be harsh, dry and coarse.
11. Subcutaneous Nodules.	Present in 15 to 20 per cent of cases.	Never present.

12. Sedimentation Rate	Usually greatly increased; values above 30 mm. in nearly all active cases.	Normal or only slightly increased; rarely above 30 mm.
13. Roentgenological Findings.	Early; osteoporosis, periarticular swelling and joint effusion. Late; narrowing of joint space, bone destruction, ankylosis and deformities.	Early; no osteoporosis; slight lipping at joint margins. Late; marked lipping, osteophytes.
14. Agglutination Reaction with Hemolytic Streptococci.	Positive in the majority of typical cases.	Never definitely positive.

The Treatment of Rheumatoid Arthritis.

The various measures employed in the treatment of rheumatoid arthritis may be appropriately considered under three headings: 1. Measures of No Value, II. Measures of Questionable Value, III. Measures of Proven Value.

I Measures of No Value

- | | |
|--|---|
| 1. Dietary Restrictions and Dietary Fads. | 7. Colonic Irrigations. |
| 2. Vitamins—
(in massive doses). | 8. Sulfanilamide and its Derivatives. |
| 3. Drugs—as specifics (except Gold Salts). | 9. Fever Therapy. |
| 4. Endocrine preparations. | 10. Vaccines—stock or auto-genous.
(as a specific curative procedure). |
| 5. Sulphur. | 11. Removal of So-called Foci of Infection. |
| 6. Bee-venom Therapy. | |

In considering measures of unproven value I should particularly like to say a few words concerning the doctrine of focal infection. A great philosopher once said that certain things repugnant to reason and experience find acceptance among rational people simply because they are universally spoken of. This is true of the theory of focal infections. Rooted in plausibility, nurtured on half-truths and pseudo-scientific experimentation, it has blossomed into one of the most pernicious doctrines in contemporary medicine. Fortunately, however, in recent years a change has occurred and new voices are constantly being added to the chorus of protest. It is now the accepted practice in our clinic to remove foci of infection only as a general health measure and not with the hope that the arthritis will be specifically benefitted.

So far as vaccine therapy is concerned, long and intimate experience has convinced us that this procedure is entirely without merit in the treatment of the disease rheumatoid arthritis.

II Measures of Questionable Value.

1. Foreign Protein Therapy.
2. Psycho-therapy.

Foreign protein therapy sometimes produces temporary improvement but there is little or no evidence that this procedure significantly affects the course of the disease.

III Measures of Proven Value.

1. General Nutrition.
 - cod liver oil.
 - egg powder.
2. Rest—general.
 - local.
3. Salicylates.
4. Transfusions, (iron?).
5. Prevention of Deformities.
6. Correction of Deformities and Postural Defects (especially weak feet).
7. Sunshine in an Equable Climate.
8. Occupational and Physical Therapy.
9. Gold Salts. (unfortunate toxic effects in many cases).

Rest and maintenance of the general nutrition are almost as important in the treatment of rheumatoid arthritis as they are in tuberculosis. But in prescribing rest, intelligence and insight are necessary. Some patients are actually more relaxed if permitted moderate exercise and activity.

Gold salts probably represent the greatest single therapeutic agent in the treatment of this disease. Unfortunately, however, they are quite toxic and in certain instances definitely dangerous. It is now our custom to commence with very small doses and to discontinue on the sign of any toxic symptoms such as pruritus or dermatitis. An attempt is being made to control the untoward manifestations by the simultaneous administration of crude liver extract and liberal amounts of vitamin C in the diet.

The Treatment of Osteo-arthritis.

Since osteo-arthritis is a totally different disease from rheumatoid arthritis it follows that the treatment should be entirely different. The measures indicated may be summarized as follows:

1. Reassurance.
2. Salicylates.
3. Weight-reduction (thyroid extract?)
4. Physical therapy.
5. X-ray therapy?

Of No Value:

1. Removal of So-called Foci of Infection.
2. Vaccines and Foreign Protein Therapy.

Once patients with osteo-arthritis are informed that the disease is an age-period degenerative one and that they will probably never be seriously handicapped, they will usually bear their troubles with fortitude and resignation.

Endometriosis

(With Report of a Case)

DR. F. D. CHARMAN, TRUFO, N. S.

Origin. Primary Endometriosis is due to the proliferation of the endometrial tissue cells through the walls of the uterus and tubes from lymphogenous metastases and may originate from embryonic remnants of the Wolffian or Mullerian ducts.

Types. There are said to be five distinct types.

1. *Uterine Tumor.* These grow slowly, are soft, and may reach the size of an orange. They are situated usually near the cervix, and often give rise to profuse haemorrhage. They are rarely painful, and are often mistaken for fibroids or carcinoma.

2. *The Obstructive or Invasive Type.* This type is most often found in the recto-vaginal space, with scattered nodules projecting into the rectum or vagina. Pain during defecation and bloody mucus are common. These are often treated as cancer of the rectum and mutilating operations are performed. Most of them occur in women under forty and it is said that there is nothing so pathognomic of Endometriosis as these nodules in the vault of the vagina, in a young woman who is not emaciated.

3. *Tubo-ovarian Mass.* In this class the case to be reported comes.

In these cases there may be a mass on either side of the uterus, often tender and nodular, and in places cystic. These cases are often treated as of inflammatory origin, and if the attacks of acute pain are recurrent with vomiting are often diagnosed as appendicitis.

The mass present consists of distended tube, usually attached to the uterus, and often involving the ovary and other surrounding structures. The bladder is frequently involved, also the bowel and even the umbilicus has been reported to be the seat of invasion.

The condition in these cases is produced as follows. If endometrial tissue is present in the uterine tube, tubal menstruation is the result. In time this leads to closure of the abdominal end of the tube. If only small amounts of blood are excreted a chocolate or tar tube develops gradually. If profuse bleeding takes place after closure of the end of the tube, formation of an acute haematosalpinx is the result, with severe symptoms. These are often taken for tubal rupture, ruptured ectopic gestation, acute salpingitis, or torsion of the pedicle of an ovarian cyst.

When more slowly distended, small cysts develop as the process extends, which often rupture from tension on the wall of the cyst, or simply from the progressive hyperplasia of the cells. The fluid extravasated is intensely irritating and will cause pain and low-grade fever for days.

If the quantity of cyclic hormones is small and the functional transformation of the glandular epithelium is slight, instead of pure blood there is a sero-sanguinous fluid excreted and instead of a chocolate or tar tube a hydrohaematosalpinx is formed, which is what we have to deal with in the case to be reported.

4. *Symptomatic Type.* The patients in this group are mostly spinsters, widows or elderly married women. The first and maybe the only symptom is dysmenorrhoea.

Dysmenorrhoea coming on late in life, or rectal pain, or bearin-down pain in the sacral region may be the only symptom for months or years, before an examination proves that a growth of undeniable endometrial origin is invading the vagina.

Each month at the menstrual period these grafts, or cell extensions swell up and form small cysts filled with menstrual-like fluid. The second symptom, and it may be the only one, is the presence of a low-grade fever which comes on before the period and may last for a week or more.

5. This type takes place in post-operative scar tissue, is rare, and not important.

From the foregoing it may be seen that endometriosis is more important and much more frequent than is commonly supposed. In one clinic it is reported that in one thousand cases of abdominal operations on females endometriosis was found to be present in some organ in 8.9% of the cases.

There is also the important question as to whether these cases are always benign, or whether they may undergo malignant degeneration, and it is stated that all cases should be kept under observation for five years.

Case Report

Mrs. K---. Age 41.

Family History. No bearing on case.

Personal History. Patient had the usual diseases of childhood, with no special complications. Had typhoid fever when a young woman, was fairly ill with this, but made a good recovery.

Has been married eighteen years, and had three children, with no great difficulty, and with good recovery after each birth. Has considered herself a very healthy woman except that for years she has been very constipated. For the past seven years she has had attacks of pain in lower right abdomen, many of these coincided with her menstrual periods, but she also had some attacks between her periods. For the past two years these attacks have been much more severe.

I saw her in only one of them, between her periods and thought it probable—from the right sided tenderness with slight fever and vomiting and from the fact that I could make out nothing by pelvic examination (which was imperfect without anaesthesia, due to very poor cooperation and relaxation by patient)—that she was having an attack of appendicitis. This cleared up, however, with rest in bed, in a few days; and although she frequently told me of having similar attacks, I did not see her in any more. She also complained constantly of difficulty in getting her bowels moved, and of pain coming on (in her right side) some time after eating. I suggested at different times that she enter hospital for diagnosis and operation if deemed necessary, which suggestion she always scorned until taken with the present very acute attack.

History of Present Illness. She was taken ill on the morning of November 29, with pains in right lower abdominal area. These were followed by some nausea and at two p.m. pain became much more severe with vomiting, which lasted off and on until evening. I was called to see her about 8.30 or 9 a.m., and found her in great pain, and vomiting, and quite prostrated.

Her pulse was around 100 and temperature sub-normal. There was very marked tenderness over the appendix region, and extending well down into the pelvis. Rebound pain was marked, and there was very marked rigidity of the right recus, almost board-like. She was an extremely ill woman and I felt we were dealing with an acute abdomen, with probably a ruptured appendix, and considerable peritoneal irritation. She was therefore taken to the Colchester County Hospital and at eleven o'clock was on the operating table.

Operation. Incision was made through the right rectus muscle, and on opening the peritoneum, the first thing which struck us was the presence of a considerable quantity of serosanguinous fluid. The caecum and appendix were then located, and it was noticed that the caecum and colon beyond it, were absolutely flat and empty of even gas—the appendix and indeed the whole region was the seat of considerable inflammatory reaction; appendix was congested, doubled on itself, and the distal end considerably distended. It was not, however, gangrenous, or in any way near rupture. It was now removed and stump invaginated.

As nothing was found so far to account for the thin bloody fluid present, the pelvis was next explored. Here was found a large mass, involving the right tube and ovary and firmly adherent to the uterus. The ovary was completely disorganized by a large cyst, which had ruptured. The whole right side of pelvis was more or less filled with adhesions. With considerable difficulty, the whole mass was freed from the uterus and removed, as was also the left tube which was considerably distended. Raw surfaces were as well covered as was possible.

Having satisfied ourselves as to the source of the fluid we now returned to the region of the caecum and on investigating further found that the ileum, about three inches above the ileocaecal valve, was practically completely obstructed by a series of kinks extending for about three inches along its lumen. It was only possible with great difficulty to force a small amount of gas from the distended upper portion through the constricted area into the empty portion below.

It was felt that although the patient had already been subjected to quite a long operation and considerable trauma, that it would be useless to close the abdomen, without resecting this part of the bowel. This was accordingly done removing about three or four inches of the ileum with some difficulty, owing to its proximity to the ileo-caecal valve, and making an end to end anastomosis. The cause of this obstruction we were unable at the time to determine, but thought of the possibility of a malignancy.

The incision was closed without drainage and patient returned to bed in fair condition.

Post Operative. For two days, recovery was uneventful, but on the third day, patient had a very serious time, was taken rather suddenly with weakness, rapid pulse, sighing respiration, was pale and clammy and felt she was dying.

The foot of the bed was elevated, stimulants and sub-mammary salines with glucose given and also large dose of haemostatic serum.

It was presumed she had a post-operative haemorrhage. After some time she began to respond, and in twenty-four hours was considerably improved.

On the sixth day after operation bowels were moved by small enema, she was taking fluids and soft solids, and from then on made a good recovery,

leaving hospital on Dec. 18th, twenty days after operation, in very good condition. She has been well ever since. Her constipation is relieved, and her menses practically free from pain.

Pathological Report. It was unfortunate that owing to a misunderstanding only the resected portion of the bowel was sent to a laboratory for examination. The report of this which cleared up the diagnosis was as follows.

"*Gross appearances* here reveal an ulcerated Peyer's patch, with some fibrosis and haemorrhage towards its serous coat, also some stenosis.

Histological section confirms the gross diagnosis of a simple chronic ulcerative condition of the intestinal wall, involving a Peyer's patch. In the muscle toward the serous coat, two glandular areas with a cellular stroma are seen, which have the character of endometrial tissue. They do not indicate an adeno-carcinoma of bowel. In consequence I feel we are dealing here with an endometrioma associated with the enteritis. I can detect no evidence of tuberculosis, nor are the appearances those of an adenocarcinoma of the bowel. The blood stained fluid in abdomen would support this finding.

RALPH SMITH, M.D., D.P.H.,
Prov. Pathologist.

Medical Practice Among the Indians of Nova Scotia

D. F. MACINNIS, M. D., Shubenacadie, N. S.

FOR the last twenty years I have been part-time Medical Officer for an Indian Reserve with an average population of one hundred and thirty, and for the last ten years for a residential school of one hundred and sixty pupils.

Our pure breed Indian is of the purest Mongolian stock. His ancestors migrated from the plains of Mongolia across eastern Asia and the Bering Sea so early that there was no admixture of any other races. Over 60% of pupils at the school are in blood group IVV (O). They still retain many of the physical characteristics of the race including the Mongolian spot of the new born.

So much for the racial history. We now pass on to the diseases common to the race.

Syphilis was supposed to be endemic in this race when Columbus discovered America. In doing a blood test on the pupils at the Residential School I found 6.6% Kahn positive which compares favorably to like institutions of delinquent white children. The cases were all congenital except one little girl who returned from her summer vacation with a huge chancre on her upper lip.

One boy eight years of age was positive, the father having contracted the disease twenty years before and both he and the mother were still positive but several younger and older children were negative, one of the vagaries of syphilis. Neuro-syphilis is almost unknown in the Indian.

Tuberculosis is not any more prevalent than among the white population, probably due to better housing conditions, better food and clothing and also to the mixture of the blood of the white race in them. No death has occurred on the Reserve from tuberculosis during the last ten years.

I never came across a case of prostatic hypertrophy which required treatment in an Indian. I do not know if this is a characteristic of the race.

There is the occasional emergency call to the school where one young brave tries to scalp another. They never fuss or cry over having a few stitches put in. I came across three cases of cancer of the cervix uteri but cannot recall any other cancer cases.

The incidence of appendicitis is the same as among the white race.

Children's diseases such as measles are not any more severe than in the white race. They evidently have developed an inherited immunity since the coming of the white man.

Rheumatism and arthritis is just as prevalent as among the whites. Their teeth are of a poor quality and the pupils at the school require a large number of extractions each year.

The Indians still have a great deal of faith in their own medicines, made from herbs. When they think they have any ailment they are fond of "medicine" and a touch of color will add to its curative value. English White Liniment is a cure all and receives more testimonials than any other patent medicine.

The general health of the children at the Residential School is much better than that of an equal number of children of any race outside an institution. They are given plenty of milk, fruit, vegetables, and bread, also plenty of Cod-liver oil and fresh air which accounts for their good health.

The Indian children on the reserve are very prone to impetigo and other skin diseases. They are also liable to intestinal worms.

We also have a neat tidy school of over twenty pupils on the reserve presided over by one of our native Indian girls who is a graduate of the Provincial Normal School.

The Indian population in this district is definitely on the increase. The births outnumber the deaths by four to one. They are far from being a dying race.

Case Report

A male Indian 27 years of age complained of abdominal pain and vomiting for two days. When called to see him I found a tender mass the size of a small orange in the left upper quadrant. He also had considerable dysuria and frequency. I had him removed to hospital at once where the pain subsided but the mass remained. Two weeks after admission to hospital an incision was made in left loin and the mass which was a large abscess drained. In a few days he developed a faecal fistula through the incision. Evidently a case of diverticulitis with abscess formation.

Since then he has passed several segments of a tape worm through the fistula.

Tuberculosis in Colchester County

D. S. McCURDY. M. D. Truro N. S.

IN 1937 Colchester County, Nova Scotia, had 48 deaths from tuberculosis per 100,000 of population. This was fourth place for the Counties of Nova Scotia. The death rate for the whole Province was 74 per 100,000.

In Colchester County the T. B. League, under Pres. Dr. V. D. Crowe, and an active executive, works very successfully in co-operation with the Municipalities, etc. Special stress is placed on prevention, so toward this end, they plan to spend their money on:

1. Diagnoses, including X-ray.
2. Help send cases to the Sanatorium for a period at least to render them less infective, and to teach them to care for themselves.
3. Help improve nutrition by supplying milk, eggs, groceries.
4. Building sun porches, giving pneumothorax treatment at the Colchester County Hospital, etc.

Funds are raised by the sale of T. B. seals, and under the active leadership of Mrs. F. H. Patterson about \$1,500 to \$1,700 is raised annually and spent wholly within the County. Referred cases receive as much consideration as the funds permit and we believe the T. B. League is doing an effective work. By co-operating with the Municipalities, patients themselves, Colchester Branch British Empire Service League, etc., it is sometimes possible to share the cost of treatment, thus making the cost less to the League.

Recently the following questionnaire was submitted to Dr. J. J. MacRitchie, Divisional Medical Health Officer, and his responses are herewith given—

Question 1, "What Field Workers are in the county." There is one clinician and one nurse supplied by the Department of Public Health. The clinician covers more than Colchester County in carrying out the work and the county is a part of a division. Colchester County now has a full time Public Health Nurse. Previous to August last, the Public Health Nurse could only devote part of her time to Colchester County as the counties of Pictou and Antigonish were included in her territory. A full time nurse for Colchester County is a big improvement in the nursing service, and as the nurse is located in Truro she can be called on at any time to meet any problems that come within her jurisdiction. In addition to the above nursing service two nurses are supplied by the Victorian Order in the town of Truro and there is also one school nurse in Truro supplied by the School Board.

Question 2 "number of clinics and persons examined during 1939 in Colchester County." Clinics are held as often as possible, at least once a year and if possible, twice. In addition, smaller clinics are held at various times to look into single isolated cases or small groups of cases. During the past year from December 1938 to the end of December 1939 there were eight clinics held. At these clinics 692 persons were examined and 178 of these were X-rayed, making a total of 870 examinations.

Question 3 "what is the effect on the tuberculosis problem in the county by such efforts as are being used." This is rather a difficult question to answer and I do not know how to evaluate or what yard stick to use in making

an estimate, but by the use of comparison we can safely assume that the programme which has been in existence for some years has been of some value. The drop in the tuberculosis morbidity and mortality rate has been marked. While we admit that many factors, biological and otherwise, enter into the cause of such a drop, the interest and efforts of those concerned must be accepted as one of the factors.

Question number 4 "what improvements can be suggested for more effective work." As you fully realize, in any undertaking in Public Health effort, as well as any other the first consideration must be given to finances. Any programme launched depends on the amount of money available. There is one suggestion I would like to make and that is, that an effort might be made to secure more money for X-ray purposes during clinics. The Colchester County Tuberculosis League has done splendidly in sponsoring X-rays for the clinics, but as we all know, judgment has to be used in what cases should be X-rayed and how many, as the fund of this League is limited. If more money could be made available, more X-rays could be taken and this would be a great improvement and assistance, as X-rays are a valuable aid in diagnosis, and all contacts could be given the benefit. This refers to the town of Truro only. For the outside districts, the Department's portable X-ray Unit is available at all times and the matter of film taking is thus simplified. This I might point out as another big improvement in field work during the past year. The open cases of pulmonary tuberculosis is the outstanding problem in the prevention of the disease, and the isolation of these cases in Institutions is the first phase in the programme of prevention. Getting these people institutionalized sometimes is quite a problem in Colchester County as well as any others, but I will say this, that the Colchester Municipality and town of Truro has always done well sponsoring isolation and Sanatorium treatment of cases when brought to their attention. I do not think that many within the borders of Colchester County have been denied Institutional treatment, and in that respect I do not think there are many suggestions for improvement.

In summarizing, I think the situation in Colchester County on the whole is quite a satisfactory one. 10 or 12 deaths from pulmonary tuberculosis in the year means that a very small percentage of the total population of the county died of this disease. If this is compared with the number which undoubtedly was very high many years ago, we cannot but say that there has been a rapid trend downwards in pulmonary tuberculosis as the cause of death among the people. To reach the ideal condition when the people will not die of tuberculosis, is at present, out of reach, but the objective should be to have the number kept down to a minimum. Until such time as modern medical science can develop inoculation similar to that used in Diphtheria and Smallpox, we shall have to carry on with the methods only known to us at the present. I previously stated that Colchester County now has a full time nurse. I firmly believe, and I have always been of the opinion, that a competent nursing service used in the prevention of tuberculosis is more effective than any other methods we might use. Doing school work she is continually in contact with those of the early ages and her instruction with reference to health in general does not always fall on deaf ears, and I feel will produce results in the years to come. Again she visits the home of the tuberculous patient and there she carries out her instructions, not only for the patient alone, but for other members of the household for their own care and protection. If members of such a household will follow the advice given with reference to prevention, there is no particular reason why they should become infected.

The Intravenous Use of Morphine Sulphate

T. W. MACLEAN, M.D.

THE April 1938 issue of *The Canadian Medical Association Journal* in the section on "Abstracts from Current Literature" gives a resume of an article by C. J. Betlach on this subject.

Some of the statements made in the article are these. "The effect of the drug given intravenously is more pronounced and comes on immediately as compared with the more delayed action of subcutaneous injection. The effect lasts about as long as that following subcutaneous injection. . . . A tablet of morphine sulphate gr. 1/6 or gr. 1/4 is dissolved in 1.5 or 2c.c. respectively of sterile water. . . . injected slowly at first. . . . to allow for any idiosyncrasy to appear. . . . The remainder of the drug is then injected slowly until the desired effect is obtained. . . . preoperative medication. . . . gall-bladder colic, angina pectoris etc. . . . The advantages of the intravenous method over the subcutaneous are: (1) the full analgesic effects are obtained immediately; (2) the drug can be given at the moment it is needed; (3) the dose may be regulated accurately."

In my own practice a few years ago there occurred an experience which adds a few interesting lights on this subject. The experience occurred in the care of an addict who had been taking morphine for more than twenty years. Somewhere during the course of his addiction he was receiving intravenous medication for some other condition when it occurred to his sharp mind that in such a method there might be a thought whereby he could "get more kick out of his shots". And for two or three years all the morphine he took he administered to himself by this route. He liked the results better than those from subcutaneous administration.

The risk of infection which the patient runs with intravenous medication as compared to subcutaneous was interestingly demonstrated in the thousands of injections which this man gave himself. His syringe was always old and filthy, and the needle was usually dull and rusty. He took the water to make his solution where he got it—from the kitchen pump, from a rain-barrel, from a cow-track. While he was using the subcutaneous route tremendous abscesses were a commonplace occurrence, one had to be opened every now and then. But after he switched to intravenous therapy there was no more trouble with infection. The antiseptic powers of the blood must be great.

He also used to give me frequent demonstrations of the risk of air-embolism which is run when air is injected into a vein. While I watched, fascinated, he would gurgle a whole syringe of air with his solution into the circulation. When asked if he always injected air he answered, "Oh yes, I always put in more or less air. I don't pay much attention to that."

It is also worth noting that after the man had been an addict for more than twenty years, when he was so thin and wasted and so near the end of the journey that he could hardly be recognized as a man, he was treated in The Nova Scotia Hospital for his addiction with complete success. For several

years after leaving hospital, at any rate, there was no relapse. The man regained his strength and almost doubled his weight—although he did occasionally console himself with rubbing alcohol taken internally. Another little point is that although the man was repellant in appearance while an addict his mind was always bubbling with flashes of wit; but after treatment this was all gone, he was no longer good company being dull and sullen.

It is a good idea to be on the look-out for chances to relieve monotony, and this looks like an interesting little field to explore, the giving of morphine intravenously.

Salvaging Lives in Intestinal Obstructions

T. W. MACLEAN, M.D.

IT is purposed in this article to make references to several cases of intestinal obstruction with which the writer has been associated, either as intern or practitioner, during the past fifteen years. The references to these cases are not to be regarded as case-histories but rather as a scaffolding on which to tack up various thoughts in reference to an interesting subject—the saving of life in desperate cases of intestinal obstruction. Most of these thoughts must now be classed as “previously used”, although a few of them when they first came swimming into the thinker’s ken to be of help in saving the lives referred to, did seem to have about them some signs of nascency.

During my internship there was admitted a woman of young middle-age who had been complaining of rectal symptoms for a good many months.

Examination disclosed a growth in the lower pelvic colon. The first striking feature about the case was that although this woman had been troubled by her symptoms for over a year and had consulted several doctors this was the first time she had ever had a rectal examination. She was penalized for being unmarried, for had she had an obstetrical history her condition would have been diagnosed early, and her life might have been saved.

Her operation was skillfully performed by two of the best surgeons available. It was formidable; to give access to the growth a transverse incision across the rectus muscle had to be added to the usual vertical one. But finally the growth was resected and a colostomy done. The woman retained a brave hold on life and next day was in reasonably good shape.

In those days it was considered—erroneously—that the actual intestinal contents were the damaging entity in these cases. So on the morning following operation the surgeon, with commendable conscientiousness, came himself and spent his time in personally washing out that bowel through the colostomy opening. As he was doing so his intern admired the careful and workmanlike way in which he took care of his task; and he also admired the massive results obtained, thinking, “Now in a short time this woman will feel much better.”

In less than half an hour that woman “went bad”, and in a short time she was dead.

After her death her surgeon kept saying over and over, “I did too much! I did too much! If I had only been content with doing a colostomy and had left the resection until later her life might have been saved!”

This is, of course, as true today as it was then. Acute intestinal obstruction is a deadly disease. It kills quickly, and if the patient has been exposed to its effects more than a short time he is in no condition to withstand a major operation. If there is the least doubt of his being able to do so it is better to be content with a colostomy in the first stage and the major undertaking can be done at the surgeon’s, and the patient’s ease sometime later. Rule one in saving lives: Always do a colostomy rather than a major operation where

there is any indication that the patient's condition is not good. This is an old rule known to everyone but still worthy of the place of honor.

But the sudden change which occurred in the patient's condition after the bowel was washed out. There could be little doubt that this treatment was the straw that finally tipped the scale against the patient. Of this more later.

After internship was over, and after active practice had been carried on for several years I was forced to this sobering and thought-stimulating conclusion. "Of all the cases of acute intestinal obstruction with which I have been associated during these years not more than one has survived."

Now all these people who had died, in their deaths resembled one another. The way of going out was alike in every case. These deaths were not like deaths from surgical shock or like deaths from infection. They seemed to be an entity in themselves. The patient would apparently withstand the operation well. Then a few hours later there would be a pronounced change. He would start on a sharp downward slant. No form of treatment would "touch him." And in just a few hours he would die.

It seemed to the observer that these people were dying like ones who had received a lethal dose of poison. Such conclusions were the cause of intense mental searchings in the effort to find out what the poison was that was carrying off these patients. This problem has, of course, been solved for us now for several years. We know that the condition really was a poisoning, and that the poisoning was *alkalosis*. We also know that the body can overcome alkalosis if it has on hand enough negative ions in the form of chlorine or chlorides, wherewith to make acid substances; and that these needed ions can be supplied very handily by the use of intravenous salines which are hypertonic rather than normal. How we should treasure each little advance in medical knowledge! Most of these precious lives could have been saved by the simple expedient of tossing a few extra cubes of sodium chloride into the intravenous salines used.

There is, so far as I know, no exact rule whereby we can estimate the amount of excess salt needed in the individual case. The amount is *q. s.*, that is, the amount needed to neutralize the alkalosis and correct the acid-alkaline balance; and this varies with the individual case. We remember that common salt is poisonous in itself when taken in excess. A favorite method used by the Chinese in committing suicide is to eat a cupful, or less, of salt. But here the gastro-intestinal irritation caused is a predominating factor in the injury, for when injected into a vein remarkable strengths of solution can be used without apparent harm. One guide as to the upper limit of solution-strength is that solutions of greater than five per cent strength are likely to cause sclerosis of the vein into which they are injected. This is the upper limit of strength but there is no need to go nearly thus far. We recall the fact that we sometimes produce acidosis with another chloride in certain conditions—ammonium chloride—and that great quantities of the drug are not required. We think of the urine which in its reaction is an indicator of the pH of the body fluids. We glance back for a moment and think of our use of mandelic acid in conjunction with ammonium chloride in protracted cases of urinary infection; and of ammonium and sodium mandelate. We consider the various factors and try to estimate the amount of excess chlorides which will be required in the individual case. The method of trial and error also comes to our aid: if the first saline does not seem to be sufficient it is followed by another.

Some years later another case occurred which tied in well with the first one cited.

This was a boy of fourteen who had been ill four days when his doctor was called. On examination the abdomen was found greatly distended, with ladder-pattern, visible peristalsis, and the usual evidence of the far-advanced and nearly hopeless case.

At operation the terminal ileum was found obstructed by a string adhesion just as neatly as if a grocer had tied it off with twine. When this was released the intestinal contents could be seen flowing into the caecum. This was the first case where I have had the opportunity to use hypertonic salines, and they did their work stoutly both before and after operation. That dreaded change with the quick descent down the steep slope a few hours after operation did not occur. But there was another place in the post-operative care where, I think, the boy's life might have been sacrificed.

Keeping in mind the case of the woman who had gone bad when her bowel was washed out, orders were given to the nursing staff that on no account was any attempt to be made, either by laxative or enema, to have this boy's bowels move, but rather that he was to be kept quiet with small doses of morphine. This was continued for four days while the boy seemed pitifully and dangerously sick.

There was in our hospital a good spirit of team-work between the doctors and the members of the nursing staff; and the latter felt free to express their concern over the case. They felt restive and very anxious that this boy was being left so long, that one so ill should go without his bowel being emptied for more than eight days from the onset of the obstruction. But it was explained to them that the bowel which has suffered complete obstruction for four or more days is a very sick bowel. It is sick almost unto death. That a sick man should not be driven to work, he must have rest. And so must the sick bowel. That the actual intestinal contents are not the damaging entity, that they are not of very great importance. It is the interference with circulation in the intestinal blood-vessels, caused by the gradually increasing pressure within the intestine, pressure which becomes more devastating every hour, and the profound chemical upset,—it is these, and not the fecal contents of the intestine that kill.

On the beginning of the fifth day a small olive-oil enema was injected to be retained. And twelve hours later the great adventure of the case, greater even than the operation, was undertaken—an attempt was made to open the bowels. An enema was given. And the boy filled a bed-pan! He filled a bed-pan with liver-colored, blood-stained fluid.

For the rest of his stay in hospital there wasn't a cloud in the clinical sky. There isn't a doubt in my mind that this boy would have died if his intestine had been driven to work soon after operation, before it was able for the job.

The old text-book picture of intestinal obstruction has slain its thousands—yes its tens of thousands.

A year or two after graduation I was called to see a man, prominent in our small community, who was suffering from abdominal pain and cramps. My intuition or my conscience, or something, told me that the man's condition was serious. But reasoning from the old text-book picture nobody could say that his bowel was obstructed. The uneasy feeling that there was something seriously wrong persisted, however, and during the following hours the patient was visited frequently. A colleague who was also a contemporary in time o

graduation was called in consultation. His opinion was the same as my own. At the end of twenty-four hours the diagnosis was plain; but by this time it was too late, a section of the bowel had to be resected, and within an hour after leaving the table the man died of oedema of the lungs. He was not killed by my neglect or incompetence. He was killed by the old text-book picture of intestinal obstruction.

But in recent years we have been supplied with a fine and effective new yard-stick wherewith to measure up our cases of suspected obstruction. The yard-stick is this. Abdominal pain, vomiting, storms of peristalsis, and failure of one, or two, enemas to give results, this spells intestinal obstruction.

The case of G. W. M. was one that brought a fine supply of material from which to build thoughts on this subject.

This was a man who had often "cried wolf" about his health, and a case where the diagnosis might have been so obscured. But by applying the simple new yard-stick it was plainly seen that this time the wolf had arrived. A history of constipation for three weeks, abdominal pain of one day's duration, vomiting, and storms of peristalsis indicated obstruction. And one or two enemas confirmed it. The size of the enema that could be injected was an illustrative point. The amounts of fluid which could be retained on this and subsequent occasions were always identical, just about two-thirds of a pint. So the diagnosis was settled. The yard-stick said *obstruction*; the man's age and history said *cancer*; and the size of the enema said *sigmoid*, just as distinctly as the X-ray could have said it. And they all spoke truth.

But when the urgent need for operation was explained to the man he announced, very profanely, "No— — —, I'm not going to hospital, if I have to die I'll die right here by my own fireside, or in my own bed." And from that perch it seemed that nothing could move him. For more than four anxiety-filled days he held stubbornly to this. Then on the fifth, when it was far too late, he ran true to form, the form of the blustering patient who refuses operation, for he then demanded that he be taken to hospital for immediate operation. The man, by this time, was more nearly ready for autopsy than for operation, but there was nothing for it but to do what could be done.

Sitting there pondering before operation canvassing the possibilities for saving the man the following was the line of reasoning that presented itself.

"The simplest operation under general anaesthetic will certainly blow out the candle. And the man's chances with spinal are scarcely better. In his present condition it would be almost impossible to operate under local, the peritoneum could be opened but with that enormous distention it could never be closed. There would be a ghastly struggle trying to replace mighty coils of distended bowel, and the abuse would kill the patient. But we must not let the man die. Perhaps an operation could be devised. An operation should be fitted to a patient's needs just as individually as a man's suit is tailored to his person—every operation. Why not operate so that there will be no need to sew up the peritoneum? It would be simple to go down to the peritoneum under local, make only a nick in that membrane which will not require sewing-up, allow the first knuckle of bowel that presents itself to extrude, sew it to the skin, then spill its contents."

The work was carried out as planned. When the peritoneum was nicked a knuckle of distended colon immediately obliged by starting out as anticipated. But now a little drawback appeared. The bowel would look out but it would not come out, its mesentery was too short. This seemed easily overcome but

was nearly the cause of tragedy. It is dismaying the havoc that four or five day's obstruction can work on the bowel wall. Here when traction that really was gently and only tentative was applied a great flake of sero-muscular coat was peeled off, leaving the mucous membrane herniating through. Now the operator was in a quandary. The loop of bowel would not come up to make a colostomy and it could not be returned to the abdomen for if the rent were sewed over it would surely slough. Farther down the bowel would have a longer mesentery but now it could not be utilized.

The best was made of a bad situation. A few stitches fixed the mesentery to the rectus sheath, and with care, but with many misgivings, the bowel was sewed—or rather, tethered—to the skin. There was no time to wait for protective adhesions to form between bowel and peritoneum, the obstruction must be relieved immediately. But there was comforting reassurance in the fact that the opening in the peritoneum was only a nick which would hug the neck of bowel snugly and make the opening almost water-tight. (This is something well worth considering in such cases. Contrast the chances of the peritoneum being soiled when in it there is only a little incision which hugs the neck of bowel tightly with those where the membrane is split widely and is perforated with stitch holes.)

The bowel was opened and its contents allowed to spill and ooze. Hypertonic salines stood stoutly by and did their work before and after operation. The peritoneum was not soiled. And the man lived—something which, I think, would have been humanly impossible if advances had not been made during the preceding few years in our surgical knowledge.

This case was long and in the following two years presented many interesting experiences but the description of these is apart from our present thoughts.

Summary

A few methods are reviewed by which lives can be saved in neglected cases of intestinal obstruction, such as:

- (1) Tailoring the operation to fit the patient's needs, especially by making the first stage simple so that it can be performed easily and safely under local anaesthesia.
- (2) Correcting the pH of the blood.
- (3) Giving the sick bowel a few days rest instead of whipping it up to work soon after the operation.

Public Health and Woman's Institutes of Colchester County

HELEN J. MACDOUGALL, Director, Home Economics,
Truro, N. S.

THE Women's Institute is widely known throughout the Dominion of Canada and the British Empire and is recognized as taking an active part in many worth while activities.

This organization, which has enlisted so many of our capable and energetic women throughout the country, is a rural organization under the auspices of the Department of Agriculture, and is more and more becoming an important factor in our Provincial life.

Many people have the idea that the Women's Institute is a welfare organization, or a social service group, or a community club whose duty is to undertake any and even all problems which may arise in a rural community. While many of the branches do a great deal of welfare and community work because the need exists and the members desire to help, yet the Women's Institute is really an educational organization whose purpose is to study and promote the knowledge of all subjects which will contribute to the welfare of our people. It may be regarded as an adult education group with home economics in its many phases as a primary interest.

The purpose of such study is to develop better home conditions and better communities. With this in mind the study of all subjects which may improve the health of our people is important. Health education for the home includes the study of nutrition, that is food values and food selection as related to health; sanitation, home nursing, first aid, child welfare and related subjects.

The welfare of the community is benefitted by such studies and activities in promoting public health education as arranging public health meetings, organizing clinics of various types, enforcing public health laws, such as quarantine, sanitation, etc. Cooperation with the doctors, the Department of the Public Health, the Red Cross, and other existing health agencies is a feature.

Much work has been done in the schools, such as maintaining a school lunch, providing washing facilities, improving water supply, improving sanitary arrangements. Also public health education has been aided in the Junior Red Cross, and assistance given the public health nurse in her school work. Many clinics have been organized in cooperation with doctors and nurses.

Material assistance has been given hospitals and First Aid and Home Nursing classes have been organized.

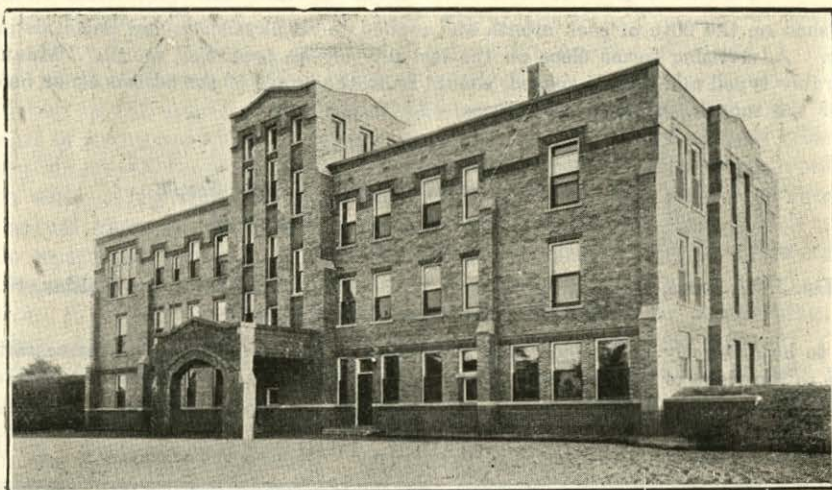
The statement has been made that the Women's Institute is one of the most effective mediums in promoting public health education, indeed that before the Women's Institute was organized very little educational work was possible in rural districts.

When we realize that there are twenty Women's Institutes in Colchester County with over four hundred members engaged in furthering this work, it becomes evident that the Women's Institute contributes in no small degree to the progress of public health education.

At the present time the Women's Institute headquarters has outlined a War Time Program in our effort to help the branch Institutes carry on constructive studies in their regular meetings. This program includes a series of lessons on nutrition, with particular reference to health. The majority of the branch Institutes are studying these lessons.

Also our Public Health Convener has placed before the Institutes a fine program of public health activity, recommending the improvement of sanitary conditions in homes and schools, the assurance of pure water supply with instructions as to where to get reliable information, and how to make improvements at least expense. They are urged to study the importance of immunization and vaccination. The study of laws relating to public health is encouraged in the hope that they may be enforced.

I would like to take this opportunity to express our gratitude to those doctors and nurses who have willingly and generously given of their time and knowledge to address Women's Institute meetings and to help with clinics and other public health activities fostered by the Women's Institutes. This has been done frequently at a great inconvenience to themselves and with no reward but the satisfaction of knowing that they have contributed to the public good.



Colchester County Hospital, Truro.

The Colchester County Hospital at Truro was opened in 1926, succeeding the Ainslee Hospital on Prince Street, which was privately owned by Dr. D. L. MacKinnon.

Dr. E. A. Randall, the President at that time, stated that this Hospital became a reality after years of effort by various organizations and personal gifts. Years of accumulated funds and a public subscription list combined to build a very suitable structure but only last year was the remaining building debt finally paid off by a generous gift of the Misses Clara and Frances Yuill of Truro.

Forty-six beds, 4 cribs, and 10 bassinets make up the available bed space and the management is under a Board of Trustees with Mr. R. B. MacLellan as President.

Admissions are taxing the capacity of the Hospital and before long extensions will have to be made. A maternity wing would be of particular service.

Many of the rooms in the Hospital as well as special equipment were furnished by various organizations or individuals and bear copper plates to that effect.

The Ladies Auxilliary is very active in keeping up the linen supply, and the general public cooperate in many ways to keep the Hospital standardized.

An adjoining Nurses' Home is now under renovation and when the extensive alterations are complete the nurses will have a roomy, modern home.

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

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DRUGGISTS, DRUGS AND DOCTORS

EVERY mail brings us sheaves of brightly irresistible advertising matter and dainty boxes of "professional samples". We are flattered, at frequent intervals, by the visits of friendly and accommodating travelling salesmen. We are presented with attractive trade catalogues that list, under novel names, ready-made remedies for most of the known human ills. There is no doubt that most of us find this free service rather handy, and would see no point in objecting to it. The large drug houses, moreover, deserve much of the good will that they solicit from us, because they perform certain useful services that are scarcely within the scope of the private pharmacist. It would be unfair to forget this. But—it must be admitted that the situation has at least one disquieting aspect.

Let us consider the position of the neighbourhood druggist. He has spent three or four years in study, at considerable expense. But now what happens? He finds that many of the prescriptions he receives from practising physicians call for proprietary or semi-proprietary commercial preparations, and that his task consists merely of pouring a mixture from a large bottle into a small one, and licking a label. Any grocery clerk could do as much. Moreover, a particularly embarrassing situation faces him frequently because of the fact that a number of different pharmaceutical companies put out similar products under individual trade names: he must keep on hand a stock of each company's product—although all the products contain the same medicinal ingredients—or run the risk of not being able to fill prescriptions. And this not because of any valid medical consideration, but merely because doctors prescribe arbitrarily by trade names instead of by essential ingredients. He is placed at a crippling disadvantage economically—a disadvantage that also faces him when, as often happens, doctors' prescriptions call for new drugs—and costly ones—not listed in the pharmacopoeia. He puts himself to much expense stocking these drugs, only to discover after a short time that they have gone out of date.

It may be argued that this state of affairs is the druggist's headache, not ours, and that there is nothing to be done about it. But let us look at what a prominent authority has had to say:

"The British Pharmacopoeia, with the Canadian Formulary, includes almost every drug which a practising physician needs. Further, a careful study of medical literature shows that the use of any new and important drug is described in the medical literature that every physician should read within two years of its introduction. Many new drugs, which at first appear effective, are soon shown to be of no value or even dangerous. A physician would be wise to wait, using some known remedy, rather than risk poor treatment or doing actual harm by accepting the sales talk of an agent about a new one."¹

Do not these words suggest a line of action that would be of benefit to ourselves and our patients as well as to the druggists? And is not this line of action, in effect, a return toward scientific discipline in prescribing, and away from an easy-going pursuit of the commercialized *ignis fatuus*?

There is a little book with which we are all presumably familiar, but which does not come to us recommended by all the resources of modern advertising, and which does not offer us any of the magic charm of untried novelty. This book is the *Canadian Formulary*. In it are given types of prescriptions which any druggist can dispense out of his own stock of standard drugs, in vehicles of his own making. And it may be said of these vehicles that although they do not contain the special flavourings, colourings, and superfluous drugs in homeopathic doses that are in the factory-made products, they are quite as effective and far less expensive.

But, it may be asked, what of the products that do not come within the scope of the Formulary and the Pharmacopoeia? What of the glandular extracts, the vitamin concentrates, the aniline dyes, and so forth? The value of many of these has already been proved, and the value of others is being proved daily. Are we to deprive our patients of the benefits of these products merely because the druggist cannot concoct them himself out of standard drugs? Not at all—but certainly let us help along the process whereby these new products can themselves become standard. Some new drugs now on the market are extremely expensive, and their efficacy is at best doubtful. Let us help by refraining from free-lance, unscientific, haphazard experimentation; by leaving the proving of new drugs to the people who have proper opportunities, facilities, time, equipment, and special training for the task. We may rest assured that as fast as the value of new products is clearly established, the wisdom of having them permanently in stock will become plain to the druggist, and all the more so because he will have lost his fear of ephemeral fads.

Clear, sensible and expedient, therefore, is our line of action: a movement toward the prescribing, wherever they are indicated, of plain standard drugs, under their uncommercial names, according to the method outlined in the *Canadian Formulary*. We can not go far wrong; we shall be on solid ground—and so will be the druggist.

1. Canadian Medical Association Journal, *Ready-Made Remedies*, pp. 176-179, 1935. (V. E. Henderson.) This article illuminates the subject excellently, and is well worth looking up.

D. M.

IT is good to be members of a profession that is marching forward into the light. For the last half-century each generation of doctors has cleaned up at least one of the major plagues of the world. The public has rewarded us for marching forward. They have given us honor. They have made us the heroes of their stories and song, have changed us from a butt-of-jokes into "Men in white".

There is a major plague before us now staring us in the eye, challenging and taunting us to a fight to the death. And it is naked to its own destruction.

Which of the major plagues is this?

With one voice the answer is *cancer*!

Wrong again!

In the fight with cancer we are still in the dark. We don't know the cause, we don't know how the thing is transmitted, or whether it is transmitted. We know pitifully little about it. And we have poor weapons with which to fight. We work in the dark with poor tools.

But of the other plague: Here we have light. We know and can see the cause, we know how the disease is transmitted, we have tests that can detect it, tests that can even anticipate it by years, and now we seem to have tests that can confirm our anticipation, and say which of the contacts is likely to develop the disease.

Which disease is this?

Tuberculosis, of course.

We found the stethoscope too slow. It could confirm the disaster after it was well established. We found the X-ray quicker, but with many infirmities. The tuberculin-test would anticipate, but in a general way, and not much more accurately than good common-sense would anticipate.

But now it would almost seem that we have a delightful new step forward to help us. The work of Cauldfeild, Ogden, Anglin, and others would seem to say that we have a serological test, on the complement-fixation order, for tuberculosis that can say which of the tuberculin-positive cases is likely to develop active disease; that can anticipate active tuberculosis by months. And that if moderate and reasonable care is exercised in this anticipatory stage active disease can be headed off almost entirely. Reference: Ogden, C.M.A. Journal, March 1939. This article is worth careful study.

Even if this new light should fail we could clean up tuberculosis now. We could clean it up with our present tools, perhaps in one generation. There is another world ahead of us to conquer. We could clean up this plague by clearing the stream at the fountain-head. We could clean up this pollution at its source. Almost every one of us in the profession will admit that we have been very lax in "Sherlocking" out the open cases of tuberculosis. We knew that they were here and there without doing much about it. Why the public doesn't even know the difference between an open and a closed case! It is no disgrace to have tuberculosis, but it is disgraceful for an open case to go about spreading the disease. The closed case, with reasonable care, is not a leper. There are only a few open cases. They pollute the stream at its source. If we and the public learn to make it our responsibility that no open case would go about undetected; if we and the public would get into the habit of being on the alert for open cases of tuberculosis we could soon make them as scarce as typhoid cases—and as disgraceful.

In a district ravished by foot-and-mouth disease a meeting was being held re its control. The scientists had their say, then one farmer said, "Well

the way I see it about this disease is, that where it isn't it aint." This is true of tuberculosis. Where the open case "isn't the new cases aint." So in that district they destroyed infected cattle and contacts. They even rounded up the deer for destruction, and cleaned up the plague. We can hardly destroy those infected with tuberculosis—although some of us who are sufferers might not object very strenuously—but we can segregate the spreaders. It might be possible to find and segregate *all* the spreaders. We should segregate the open case.

The ancient plague of tuberculosis is ready for the cleaning-up. It is ready to be wiped out. We have the light. We have had the experience. The preliminary work has been laboriously done. We have tools that will serve. Have we the energy and the brains to go forward?

T. W. McL.

CASE REPORTS

Two Primary Malignancies in One Patient

IN Nov. 2, 1934 this patient, age 38, had a hysterectomy on account of dysmenorrhoea and haemorrhage.

Her history reveals that previously, she always had good health. But on her mother's side many members of the family had suffered from carcinoma.

To the surprise of all the uterus was found to have, on section, a completely buried adenocarcinoma 1/2 inch in diameter. The haemorrhage had no connection with this cancer and had not a section of the uterus been made the growth would not have been found. As it appeared to be buried $\frac{1}{3}$ to $\frac{3}{8}$ of an inch it was thought that this operation would be curative. Deep X-ray therapy followed the operation.

Six months later a large polypoid mass was found in the vault of the vagina. This secondary cancer was cauterized and radium applied. Following this the patient had a very stormy time with intense vaginal pain, bladder symptoms etc. In an attempt to give relief alcohol was injected into the spinal canal, but without benefit to the patient.

Just at this time Dr. Connell's experiments were being carried out in Toronto and the spectacular results were heard almost around the world. Patients were crowding his clinic from near and far, and it was hoped that here was a serum which would be a discovery of the age. Dr. R. P. Smith, provincial pathologist for Nova Scotia visited Dr. Connell's clinic and studied his work. Pathologically, he reported, that he was not satisfied that this serum was a therapeutic agent. However, grasping at anything, I thought I'd at least try this serum on this case, but on forwarding the necessary \$75.00 I was informed that further treatments could not be shipped.

Had the serum been used it is possible that a case would have been reported of its curative value, for within a short time this suffering patient took a turn for the better. Her pain became less and general improvement developed, so much so that finally repeated examinations, both here and in Montreal, failed to show a trace of any pelvic pathology remaining. The patient became well and returned to work.

The tragic story of this case follows.

During the summer of 1938 she developed pain similar to renal colic and after two or three sudden attacks she was cystoscoped on two occasions but the cause for the pain was not found.

To get an independent examination she then went to Montreal and entering hospital was again cystoscoped, but not any abnormal condition could be found. On returning to N. S. her symptoms of renal pain continued and so again she had four or five cystoscopic examinations. Finally it was possible to say that there was some pathology within the kidney but not a calculus—probably a growth. Dr. Frank Mack who did this series of examinations made a fine diagnosis as the pathological report of the specimen after a nephrectomy shows:

Sept. 30, 1938.

"Report on tissue, kidney and suprarenal."

The large mass from adrenal region and the upper pole of the kidney with an extension into its pelvis is infiltrated with a whitish malignant growth, showing numerous yellow areas of necrosis.

The histological appearances have the characters of a diffuse carcinoma of the adrenal cortex with secondary involvement of the kidney. The latter also shows a few small abscesses (suppurative pyelonephritis). No adrenal tissue can be identified and much necrosis is seen. The cells have an epithelial character being rounded and spindle-shaped with an alveolar arrangement.

Examination of the old sections from the uterus show this to be an adenocarcinoma, which has no resemblance to the present adrenal neoplasm, i.e. the latter is not a metastasis of the uterine growth, but a second primary carcinoma in the same person."

Following this operation the patient had a very hard time of it. Finally she was able to leave the hospital, but she never became well. Her course followed that of many having such pathology but she had more pain than is usually met with. Morphine was used and gradually increased until she required grs. XXX per day, supplemented by nembutal grs. XII to XV, and then the pain was not all relieved. Cobra venom solution, put up by Hynson, Westcott and Dunning, Baltimore, U. S. A. was tried for the relief of pain but it was of little value, altho' reports from various clinics speak favorably of its analgesic properties in carcinoma. Like morphine it depresses pain areas in the cerebrum, but it differs from morphine in that its analgesia is slower in onset and longer in duration than that effected by the alkaloid.

Various courses of deep X-ray therapy were also used during the past six years.

The patient gradually lost out, until early in 1940 when the nursing profession of N. S. lost one of its most beloved and successful members, with a province-wide influence.

D. S. McCURDY, M. D.

Impetigo Contagiosa.

It has been noticed by physicians that impetigo in many instances is much more difficult to respond to treatment than some years ago. This early winter I had two severe cases in adults; the face, ears and some of the fingers were involved; the fingers were extremely ulcerated. Dagenan, (Sulphapyridine) in a dosage of 45 grains for 2 days and 30 grains, 2 remaining days,—the local treatment being continued,—cleared the cases up promptly and permanently.

[W. J. MACDONALD, M.D., TRURO, N. S.]

Malignancy of the Cervix Uteri Complicated by an early Pregnancy

I wish to report a case of malignancy of the cervix uteri, with ensuing pregnancy taking place, subsequent operation, and the condition of the patient, five years following total hysterectomy.

In late December, 1934, Mrs. L. D.,----, housewife, age 45 years, came to me complaining of frequent appearances of small amounts of blood stained vaginal discharge. Examination at that time by palpation and inspection

per vagina, revealed a slightly friable area of the cervix in one small section only,—which bled very readily. Marked induration, rather inflammatory in character, involved the remainder of the cervical region.

Bimanually, no enlargement of the body of the uterus could be recognized,—examination was difficult due to the excessive obesity of the patient.

Operation was advised at the earliest date, with the conclusion that an early malignancy was already present. However, the patient did not return for hospitalization until six weeks later, February 2, 1935, on which date she entered the Colechester County Hospital. At this time, re-examination of the cervix uteri showed conditions apparently not much changed—a bimanual was not done. Perhaps this was influenced by three facts. (1) The patient was sure no menstrual period had been missed, (2) that in February, 1934, (one year previous) she had been under my care due to an alarming and profuse uterine hemorrhage, complicating a pregnancy of 7½ months duration,—at that time hospitalization was necessary. The uterus was packed to control bleeding, and a slightly macerated “still born” delivered in a few hours. The convalescence was uneventful at that time; also and (thirdly) that the patient was of good intelligence and gave a clear history. Thus she went to operation without the diagnosis of a pregnancy having been made.

History and physical examinations follows:

Obstetrical and Gynecological. Menses began at twelve years. 4-28 type,—regular until the last year, slight metrorrhagia for one year. Previously the patient had nine pregnancies, all normal,—all the nine children resulting were living and in good health. No previous “still-borns” nor abortions.

General history was that of good health. Family history; Father died at 77 years, of cerebral hemorrhage; Mother died at 73 years, cause unknown. Nine brothers and sisters all living and enjoying good health.

The general physical examination—with the exception of the uterine condition, and the excessive obesity she was apparently normal. There had been no change of weight in the past two years. Urinalysis: normal findings.

Operation was done on February 3rd,—an abdominal panhysterectomy. An unsuspected pregnancy of over three months gestation was discovered. The upper portion of the vaginal vault was removed in a small area, making closure of the vaginal vault somewhat difficult. Convalescence of the patient was satisfactory, with the exception of a slight delay in the healing of the abdominal wall, due to a small area of fat necrosis.

The pathological report from Doctor Ralph Smith was as follows:

“Halifax, N. S., Feb. 15, 1935.

Report on tissue, Cervix Uterus, Entry No. 35-1054.

Patient's name, Mrs. J. D.,---. Age 45.

Dr. W. J. MacDonald, Truro.

Result of examination. The gross appearances here reveal a diffuse malignant infiltration of the cervix uteri. The histological appearances are those of a squamous epithelioma corresponding to Type 3, Broder's Classification. Signed, “Ralph P. Smith, M.D., D.P.H., Provincial Pathologist.”

Summary: The fact that the patient had a family of nine living children; also that one year previously she could not carry her pregnancy to term, and lost the infant—that a malignancy of the cervix uteri existed, all supported

the operation at this date. Treatment by radium would probably have caused an abortion. The history pointed strongly to the probability of a premature; and in any event, six month's delay for a Caesarean section and hysterectomy seems rather leaning backwards in conservative treatment.

The result has been entirely satisfactory to date and the patient is today, healthy,—does all her own housework in a farm household, and attends to her family of yet, comparatively, young children. It is slightly over five years since operation and there is no apparent recurrence to date. Malignancy of the uterine cervix, complicated by pregnancy, is relatively an uncommon condition, fortunately.

No "radiation" was used, as it was not easily possible in this particular case.

W. J. MacDONALD. M.D., Truro, N. S.

Carunculous Condition Treated by Estradiol

About a year ago I was consulted by a woman about 52 years old for a recurrent carunculous condition about the urethra. The orifice of the urethra and for a distance of $\frac{1}{2}$ an inch all around the urethral orifice was tender, reddened, bleeding on being touched, and poorly covered with mucous membrane, almost ulcerated. The woman was very uncomfortable. Twice she had been cauterized, once operated upon for this condition, but still it painfully recurred.

On consultation it was thought that her case was due essentially to degeneration of the mucosa in that area and that before any further excision surgically was attempted a trial of estrin should be made.

Estrin, as we know, has a regenerating and stimulating effect on vaginal mucous membrane. So she was given 2,000 rat units of Progynon—B, (Schering) intramuscularly twice a week with the intention of increasing the dose to every second day if improvement did not take place in two weeks.

By that time, however, the carunculous area felt more comfortable and was less painful. The epithelial cells were gradually covering the carunculous area, and by continuing the treatment the condition went on to a satisfactory ending without further surgery or other treatment.

There are many estrogenic preparations on the market, and being among the newer pharmaceuticals they are perhaps over-valuated in being used for many conditions with doubtful benefit; but one of these reliable preparations used when definitely indicated is a modern advance in medicine.

D. S. McCURDY, M.D.,
Truro, N. S.



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F. Hendrych and K. Klimesch, Arch.

Exptl. Path. Pharmacol 178, 178-88, 1935, regard ferrous chloride as the physiological form of iron. They find that it does not cause chronic poisoning when administered orally, but that ferrous carbonate and ferric citrate cause characteristic liver damage.

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

Province of Nova Scotia Division of Vital Statistics
Provisional Monthly Report—January 1940

	January 1940				Jan., 1939
	Total	Male	Female	Rate	Rate
No. of live births.....	980	499	481	21.1	21.7
No. of stillbirths.....	34	21	13	33.5**	28.8**
No. of deaths.....	609	310	299	13.1	12.3
No. of deaths under 1 year of age.....	80	42	38	81.6*	98.9*
No. of deaths from puerperal causes.....	5	...	5	5.1*	2.0*

Causes of Death	Int. List No.	January, 1940				Jan., 1939
		Total	Male	Female	Rate	Rate
Scarlet Fever.....	..	..	..	..	..	..
Whooping Cough.....	9	12	4	8	25.9	6.4
Diphtheria.....	..	..	..	..	..	..
Influenza.....	11	21	7	14	45.2	45.1
Infantile Paralysis.....	..	..	..	..	..	..
Cerebro Spinal Meningitis.....	18	1	..	..	..	..
Pulmonary Tuberculosis.....	23	43	19	24	92.6	55.9
Other forms of Tuberculosis.....	24-32	3	1	2	6.5	15.0
Cancer and other Malignant tumors.....	45-53	66	40	26	142.2	92.4
Cerebral hemorrhage, thrombosis and embolism.....	82	22	6	16	47.4	..
Diseases of the Heart.....	90-95	109	57	52	234.8	202.0
Diseases of the Arteries.....	96, 97, 99, 102	47	24	23	101.3	191.2
Pneumonia (all forms).....	107-109	48	20	28	103.4	156.8
Diarrhea and Enteritis under 2 yrs. of age.....	..	..	..	..	..	..
Nephritis.....	130-132	35	18	17	75.4	73.1
Diseases of Early Infancy.....	158-161	31	19	12	31.6*	31.7*
Accident.....	176-195	26	19	7	56.0	45.1

* Rate expressed as number of deaths per 1000 live births.
**Rate expressed as number of stillbirths per 1000 total births.

Provisional Monthly Report of Births and Deaths January, 1940.

	BIRTHS							DEATHS																					
	Total Births	Live Births					Still Births		Total	All Causes																			
		Total	Legit-imate		Illegit-imate		Total	M.		F.	M.	F.	Maternal	Under 1 year of Age	Whooping Cough	Influenza	Pulmonary Tbc.	Other forms of Tbc.	Cancer	Cere. hem. Embolism Thrombosis	Heart Disease	Disease of the Arteries	Pneumonia All Forms	Diarrhea under 2 years	Nephritis	Diseases of Infancy	Accident		
			M.	F.	M.	F.																						M.	F.
Nova Scotia	1014	980	466	452	33	29	34	21	13	609	310	299	5	80	12	21	43	3	66	22	109	47	48	..	..	35	21	26
Annapolis...	40	38	17	17	..	..	2	2	2	28	12	16	..	4	1	..	..	..	4	1	5	5	1	..	..	2	1	1
Antigonish...	30	29	13	13	..	..	1	1	1	19	9	10	..	..	..	..	..	..	..	..	4	..	..	..	..	1	1	4
Cape Breton	196	191	95	90	3	3	5	3	2	91	45	46	..	11	3	2	3	..	13	4	18	6	7	..	..	6	4	4
Colchester...	32	27	17	6	..	..	5	3	2	28	16	12	..	4	..	..	..	..	2	1	6	4	3	..	..	3	3	2
Cumberland	52	51	25	24	1	1	1	1	1	28	14	14	..	2	1	2	..	..	3	1	6	2	3	..	..	3	1	1
Digby.....	47	46	23	20	3	3	1	..	1	33	17	16	..	2	..	..	..	..	2	1	10	1	1	..	..	1	2	..
Guysboro...	20	20	8	9	1	..	..	..	..	17	7	10	..	1	1	1	..	..	1	1	1	1	3	..	..	6	1	..
Halifax.....	254	243	116	112	10	5	11	7	4	143	87	56	..	25	4	5	6	1	14	2	26	10	21	..	..	5	3	5
Hants.....	37	36	18	15	..	..	3	1	1	24	12	12	..	3	1	1	..	..	1	3	4	1	1	..	..	3	3	3
Inverness...	26	26	16	10	..	..	..	..	..	18	8	10	..	2	..	..	..	..	1	1	5	..	..	..	..	3	..	..
Kings.....	51	50	20	26	2	2	1	1	1	29	12	17	1	1	2	2	8	..	5	1	4	1	4	..	..	4	2	..
Lunenburg...	45	45	18	22	4	1	35	16	19	1	3	3	2	1	1	1	7	1	8	4	4	4	1	1
Pictou.....	73	72	33	38	..	..	1	1	1	38	13	25	..	1	3	1	8	..	3	4	5	4	2	..	..	4	1	1
Queens.....	22	20	10	8	1	1	2	2	..	8	6	2	..	3	1	1	..	..	1	1	1	1	..	..	..	1	..	..
Richmond...	16	16	9	6	..	..	..	..	..	15	10	5	..	3	3	1	..	..	2	1	..	..	..	..	..	2	3	3
Shelburne...	16	16	7	6	2	1	..	..	..	12	6	6	..	1	..	1	..	..	2	1	2	1	1	..	..	1	1	..
Victoria.....	15	15	7	7	..	..	1	..	..	11	6	5	..	..	1	..	..	..	1	1	1	1	..	..	..	..	..	..
Yarmouth...	42	39	14	23	..	..	2	3	2	32	14	18	..	3	2	2	3	..	3	..	4	5	..	..	..	1	1	4

Note: These figures are based on the Birth and Death certificates received by the Division of Vital Statistics, Halifax, N. S., up to and including February 10, 1940 and represent the number registered with the Division Registrars during the month of January, 1940.

Personal Interest Notes

Dr. W. J. MacDonald, of 22 Young Street, Truro, has purchased the residence of the late Mr. Martin Dickie, 605 Prince Street, and after making some alterations will have his residence and office there.

Dr. and Mrs. Hugh R. Peel of Truro are on a week's visit with Mr. Peel's uncle Mr. F. O. Ritchie, Melrose, Mass.

We regret to learn that Dr. L. R. Meech of North Sydney is confined to his home through illness.

Dr. and Mrs. R. E. Mathers of Halifax who have been spending some time in the Southern States are at present in South Carolina.

The BULLETIN extends congratulations to Dr. and Mrs. W. D. Rankin of Halifax on the birth of a son on March 4th; to Dr. and Mrs. J. S. Robertson of Yarmouth on the birth of a daughter on March 5th, and to Dr. and Mrs. G. D. Donaldson of Mahone Bay on the birth of a son on March 6th.

We are glad to learn that Dr. G. W. T. Farish of Yarmouth who entered the hospital for observation and rest is reported to be feeling much better.

The marriage took place at New Glasgow on March 2nd of Miss Elizabeth Ross Miller, only daughter of Dr. Clarence Miller and Dr. G. R. Douglas, only son of Mr. and Mrs. A. M. Douglas. Mrs. Douglas graduated in Arts from Dalhousie and Dr. Douglas in Medicine in 1939. Dr. Douglas practised his profession in New Glasgow until called up for war service in December and is at present a Lieutenant in the R.C.A.M.C. at Halifax.

Dr. and Mrs. B. F. Miller of New Waterford and their two sons, have taken up residence in Halifax, where Dr. Miller is Deputy District Medical Officer. Dr. Miller had the misfortune recently to fall and break his ankle and is at present a patient at the Halifax Infirmary.

We are glad to know that Dr. M. J. Carney of Halifax who has been ill in Hospital is now able to be out again.

Dr. and Mrs. Allister Calder of Glace Bay have returned home from a holiday trip to Montreal and Halifax.

Dr. J. K. McLeod, City Medical Officer of Sydney, has announced that the toxoid immunization against diphtheria which proved very successful last year in combating the disease not only in Sydney but throughout surrounding industrial centres, will again be carried out this year.

A toxoid clinic for school age and pre-school age children is also being carried out in North Sydney, where three clinics are to be held.

Five doctors examined a man in Buffalo who has five wives, and found him sane. The meds may be right, but there's a big doubt of any man's sanity who thinks he can manage five wives—Guelph Mercury.

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In convenient vaginal tablets, each containing 0.25 Gm. Stovarsol. Boxes of 20 and 100 vaginal tablets.

In dry powder for use by insufflation (1 gram containing 0.25 Gm. Stovarsol). Bottles of 30, and 200 grams.

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A quartz lamp, ultra-violet, property of the late Dr. J. J. MacDonald—in excellent condition—no reasonable offer refused. Apply to Mrs. J. J. MacDonald, New Glasgow, or Dr. J. C. Ballem.

Indians' Medical Herb Lore Studied by Smithsonian Scientist

Indian medicine men that treated early white settlers with herb medicines of their own concocting had some valid ideas behind their hocus-pocus, declares Dr. William N. Fenton, ethnologist of the Smithsonian Institution, who is now conducting a study of the medicinal plants in use among the Senecas of central New York. Early settlers usually had to depend on Indian medical lore, since European-trained doctors were few and far apart, and also because they were newcomers and did not know the possible medicinal values of the herbs growing in the woods.

The Indian medicine men, however, usually mixed with their really useful drugs other plants of no medical value, because of certain preconceived and traditional notions. Thus, a fast-growing plant was supposed to speed the growth of backward children, and a plant with a brilliant red blossom might have been considered good for those "pale people". It was very much like the ancient European medical doctrine of "signatures".

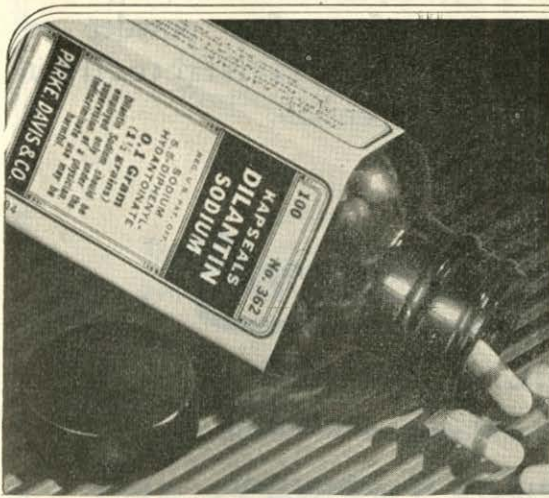
Indian medical secrets were jealously guarded and were not often handed down even from father to son. The medicine man's social status was somewhat ambiguous. He was a sorcerer and magician as well as a medical practitioner.—*The Diplomat*, February, 1940.

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DILANTIN SODIUM (sodium 5,5-diphenylhydantoinate), an anticonvulsant with little or no hypnotic effect, is supplied for the treatment of epileptics not responsive to other medication. Extensive clinical use indicates that Dilantin Sodium will prevent, or greatly decrease the frequency and severity of, convulsive seizures in a majority of epileptics. However, since the significance of observed reactions to Dilantin Sodium is not fully established, patients receiving the drug should be closely observed.

Dilantin Sodium is accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies.



* The name 'Dilantin' Sodium designates the sodium salt of diphenyl hydantoin. 'Dilantin' Sodium was formerly known as 'Dilantin,' a term now designating the basic substance, diphenyl hydantoin. Dilantin Sodium is available as 0.1 Gram (1 1/2-grains) and 0.03 Gram (1/2-grain) Kapseals, in bottles of 100, 500 and 1000.

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Vascular spasms, hypertonia, nervous dyspepsia,
ulcer pains,
Climacteric disturbances, dysmenorrhoea,
Pruritus, hyperthyreosis, etc.

ISSUED:

Tablets, in bottles of 30 and 100; also in bottles of 500 for hospital use.

DOSAGE:

As a sedative and antispasmodic: 1 tablet 3 to 6 times during the day.

As a hypnotic: 2 to 3 tablets half an hour before retiring.

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Old Way . . .

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: *The Golden Bough*, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

New Way . . .

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*Booklet discussing in detail the clinical application
of Torantil will be sent to physicians on request.*

HOW SUPPLIED: Torantil is supplied in tablets of 5 units, bottles of 50 tablets. One unit is the amount which will inactivate 1 mg. of histamine hydrochloride during incubation at 37.5° C for twenty-four hours.



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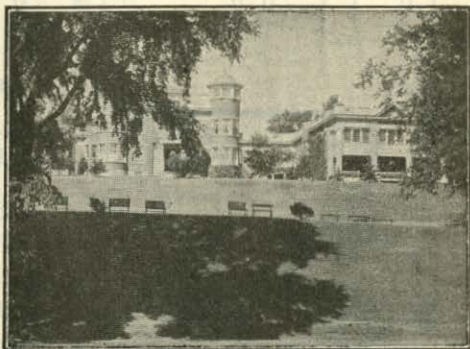


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