The Nova Scotia Medical Bulletin

MAY 1929

Leading Features This Issue:

ANAESTHESIA—DR. ARCHIBALD

THE 76TH ANNUAL MEETING

PICTOU LODGE CUTS

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PRINTED BY
IMPERIAL PUBLISHING CO., LIMITED
HALIFAX, CANADA

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Anaesthesia*

DR. M. G. ARCHIBALD, Kamloops, B. C.

WHEN the "Lord God caused a deep sleep to fall upon Adam and he slept; and He took one of his ribs and closed up the flesh instead thereof" the first operation under general anaesthesia was performed.

Ever since man has endeavored to imitate the anaesthesia, but has never assayed to attain to the excellence or beauty of the operative results.

In these attempts at anaesthesia many methods and diverse agents have been employed. A year or two back many of us were presented with a Frosst's Calendar in which Dingbat anaesthesia was depicted. The victim was first bound down, the anaesthetist with a maul brought about unconsciousness and the operation proceeded. Who knows but that a similar procedure was the common practice in the stone age or other periods before the ken of the historian? During the classical era of Grecian Literature Homer in his "Odyssey" caused Helen of Troy to put some drug into wine to "lull all pain and anger, and bring forgetfulness of every sorrow". Five hundred years after Homer, Herodotus, the Great Historian of Greece, tells of a custom among the Scythians of inhaling the fumes of a variety of hemp which produced an exalted mental state followed by sleep. The Chronicles of ancient Rome furnish similar evidence. The use of Mandragora was well known at the beginning of the Christian era for many references to it are made by the writers of that period. Galen mentions its powers to paralyse sensation and motion and Pliny tells of its use by the people of Rome to relieve the sufferings of the victims of crucifixion.

Shakespeare makes Cornelius, the Court physician, prescribe a drug which:

> "Will stupify and dull the sense awhile; but there is
> No danger in what show of death it makes
> More than the locking up the spirits a time
> To be more fresh, reviving."

It is thus seen that ancient medieval and modern history furnishes us with many examples of the use of drugs and other media to bring about partial or complete unconsciousness.

It was not, however, till near the close of the 18th century when hydrogen, nitrogen, oxygen and nitrous oxide were discovered that

* (Read at the 75th Anniversary meeting of the Medical Society of Nova Scotia at Halifax, October 15th, 1928.)

modern anaesthesia was foreshadowed. "Pneumatic Chemistry", so called, opened up a field of experimentation which made possible surgical operations under conditions which Humphrey Davy described as "Uneasiness being swallowed for a few minutes by pleasure." It is not possible in a brief address to go further into the History of Anaesthesia, nor to trace its progress during the 19th and 20th centuries. Suffice it to say we have not yet reached the millenium in anaesthesia. In spite of our boasted 20th century progress it is far from perfection. In fact in some respects we are not much ahead of Crawford W. Long when he first administered sulphuric ether for a surgical operation in Georgia in the year 1842. In other respects we have learned a few things, e. g. No medical man in his right mind would now administer chloroform as it was administered to a strong and vigorous girl by Dr. Meggison in 1848. The operation was for ingrown toe nail, the girl was seated in a chair and only a few whiffs of CHCL were given, when she died, the first recorded fatal case under this anaesthetic. Many of the physiological principles as we know them to-day, were outraged in this case.

1. It was administered with patient in upright position.
2. It was administered for a minor operation.
3. It was administered to a patient with high nervous tension.
4. It was probably administered in concentrated dose.
5. And to a young vigorous woman.

There would be no justification for such a fatality with our present knowledge.

From that day to this various committees and commissions have alternately condemned and recommended the use of chloroform, and, to read the literature on this subject one is lost in a maze of conflicting opinions.

Out of this maze however, come these facts regarding this anaesthetic: Besides the dangers occuring during actual administration, of which we all are cognizant, there is a delayed chloroform poisoning. In some cases after only twenty to thirty minutes of anaesthesia the patient develops in a few hours or at the most, from three to four days, weakness, pallor or cyanosis, restlessness, vomiting, soon followed by delirium convulsions, stupor, coma and death.

Post mortem the lesions observed are chiefly in the liver and kidneys. The former is yellow and fatty with hemorrhages under the capsule and throughout its substance. There is a central necrosis.

The kidneys are swollen, markedly congested with occasional hemorrhages under the capsule, about the tubules and in the pelvis. The heart muscle, too, shows some fatty degeneration. In the light of these established facts with regard to chloroform, numerous experiments have been carried out with ether as the anaesthetic. Although anaesthesia was pressed to deep narcosis and prolonged no such lesions were found in liver, kidneys nor heart; there was no suggestion of necrosis at any point.

From personal experience and from the records of the experience of others, I am compelled to agree with Flagg, who in his latest book states: "Chloroform is a dangerous anaesthetic. Its use in major operations is no longer justifiable." Its use even in obstetrics should cease.

Some here who were my contemporaries as internes will recall the days when we gave chloroform for all minor operations because in many cases only a whiff was required. When I think of those days, I shudder and utter a prayer of thankfulness that, inexperienced as we were, no dire accident overtook us. I can hear some of my venerable confreres exclaim "what nonsense" or "I always give it in obstetrics and find it most safe and convenient".

True, they have become accustomed to chloroform, and will be prone to yield to its charms and to feel that because clinical distress seldom appears, pathological damage has not occured.

They will recall particularly their rather extensive experience in obstetric cases, the delightful and efficient anaesthesia which they have so often obtained, the freedom from excitement in induction, the absence of vomiting and of other symptoms on recovery. They will recall the many instances in which they have anaesthetized children large and small. They are prone to smile when the pathologist condemns their most valuable agent, "chloroform".

They will not abandon it, but will use it less frequently and with more respect. This is a most dangerous attitude and eventually will lead to trouble. Why not substitute for it the far more safe agent and be free of worry, not only in administration, but also in subsequent results.

Perhaps, at this stage I might relate some of my personal experiences, not that these have been so extensive, but that they might be of some help to those who do general work and have to give anaesthetics frequently

In the last fifteen years I have probably given eight to nine thousand general anaesthetics and for the past four years have kept very complete records of all cases. These eight thousand or more cases include a large variety of surgical conditions from the simplest type, such as amputations of fingers, to the most serious operations of surgery, e. g. Thyroidectomy in toxic goitre and thoracoplasty for advanced and otherwise hopeless Pulmonary tuberculosis. During this period you will understand I have tried various anaesthetics and sequences of anaesthetics. In those first years inductions were carried out with chloroform, followed by ether by the open method. This procedure was abandoned on account of the frequent collapses or near collapses due to the use of chloroform, and also to shock after prolonged narcosis with ether given by the open method.

For a time Ethanesal was used with Chloroform induction.

Laterly, however, I have used ethyl chloride for induction with a sequence of ether and found this most satisfactory. We have been told that ethyl chloride is a dangerous anaesthetic. It may be, and

according to Gwathmey, it comes fourth in the matter of safety (15,000 cases in Guys without a death), while chloroform is eleventh, that is at the very bottom of his list. True, the margin of safety as between what is sufficient anaesthesia and the lethal dose is narrow, but so it is with nitrous oxide and oxygen which Gwathmey places No. 1 on his list. For simple operations such as extraction of a tooth, or opening an abscess, etc., for the general practitioner who is a busy man, I know of no better or safer anaesthetic. It is quickly administered, quickly recovered from and has very mild after effects. Very infrequently is there vomiting and if it occurs is never serious and seldom lasts beyond fifteen minutes. To make it perfectly safe, I usually administer a small amount of ether, which relieves the massiter spasm and ensures a smoother narcosis, nor does it prolong the recovery to any appreciable extent.

With the patient properly prepared for anaesthesia, a protecting damp piece of lint or several layers of gauze are placed over the eyes, the ordinary chloroform mask—we use the Tankauer Gwathmey drop and vapor mask, with perforated hollow frame—is placed in position. With the patient counting slowly, the ethyl-chloride is dropped on the mask at the rate of a drop or two a second. When patient has counted to 25 or 30, he will begin to be somewhat mixed, but there will be no spasm;—then begin to add ether and continue ether and ethyl chloride drop by drop together. At this stage a roll of lint wrung out of hot water is applied over mask by the nurse, leaving space for dropping on anaesthetic. By this time the patient has ceased counting, which normally occurs at 45 to 50. Another small roll is applied making the mask thicker, and continue both anaesthetics till breathing becomes regular. Then discontinue the ethyl chloride and increase the amount of ether till there is a complete narcocis.

If properly carried out this will give a smooth induction free from struggling and, if there has been premedication of morp. and atrop, free from cough and mucus. This induction too, will not be altogether unpleasant to the patient. Actually, of course, not as pleasant as nitrous oxide induction, but much simpler in administration and much less expensive, and with all not far below it in time saving and absence of distress to the patient.

This is our method for simple operations of only a few minutes duration. For longer cases of major surgery, abdominal cases for example;—We use the premedication of morp.and atrop. ¼-1/150 for adult males and 1/6-1/150 for females, one-half to three-quarters of an hour before operation is commenced. Induction is carried out as described with ethyl chloride and ether, except that as soon as patient is breathing regularly and shows fairly deep narcosis, a vapor of ether is turned on and for this we use what we know as the "Sister Chas. Apparatus."

With the piece of oiled silk we are able to construct a mask which gives us sufficient rebreathing to keep the patient's skin pink and reduce shock to a minimum.

Regarding the matter of rebreathing, I would direct your attention to a most interesting lecture by Prof. Yandell Henderson of Yale, delivered under Dental Board of the United Kingdom and given in full in the *British Medical Journal*, December 19th, 1925. To quote one paragraph only, he says:

"Our lungs are themselves a rebreathing apparatus, especially fitted to prevent fresh atmospheric air from coming in contact with the blood as it flows through the pulmonary vessels. Suppose that the lungs had only the capacity of the breath and were emptied by each expiration; then at each inspiration the gaseous contents of the lungs would be virtually atmospheric air, and the blood would be momentarily greatly over-aerated. Similarly by the end of each expiration the air in the lungs would be so vitiated that the blood would be inadequately aerated. The faces of our friends would go blue and pink a dozen times a minute. Instead of this truly alarming spectacle, Nature has arranged that the lungs constantly contain 3 to 5 litres or more of air, of which only about a tenth is thrown off at each respiratory tide. This fraction is replaced by the same quantity of fresh air, which is immediately mixed with the stationary air. Accordingly, in the successive phases of each breath, the composition of the air in the lungs normally varies so little that the oxygen and carbon dioxide rise and fall by only two or three tenths of 1 per cent."

Dr. Henderson also points out that the blood alkali, after a prolonged and difficult anaesthesia, may be reduced to an extent which is recognized as a serious departure from the normal for health. This is the condition which we call acidosis. In other words the acid base equilibrium is disturbed. If, in the process of anaesthesia, the normal content of carbon dioxide in the lung air is retained and more than this, if it is increased by rebreathing, it tends to restore the normal acid base balance and relieves acidosis and tends also to prevent post anaesthetic pneumonia.

By the apparatus shown—over ventilation is prevented—the amount of stationary air in the lungs is, as it were, increased, the volatilized vapor of ether is warmed and fed under the mask in sufficient quantity to produce a steady smooth narcosis.

We have found that following such narcosis, even if prolonged to two or more hours, there is very seldom any persistent vomiting in convalescence, nor does the patient suffer shock, unless, of course, shock is the direct result of operative procedure.

In case the Sister Chas. apparatus is not at hand, and we use it only in Hospital, we improvise a mask by using the oil silk as above and apply it as before, cutting a hole over the top through which ether is poured at intervals. Between the intervals of pouring ether on mask the hole is covered by the hand and more or less rebreathing is obtained.

If the above described procedure is carefully carried out a good anaesthesia is obtained, i. e., a rapid and pleasant loss of consciousness, a short period of excitement, a relaxation which comes on quickly and which does not unduly delay the surgeon's work, a stage of maintenance under the complete and ready control of the anaesthetist and a knowledge on the part of the anaesthetist of the exact depth of the anaesthesia at any given time. Under the circumstances with the

face completely covered, how is one to know just where the patient is in the depth of anaesthesia? Simply by observation of the color of the exposed ear and by the respiration. While the color is pink (and when rebreathing is maintained even to a small extent, it is distinctly so), and the respirations are regular and of full volume—the pulse normal or slightly accellerated, one needs no further information as to the well being of the patient.

In case of doubt it is an easy matter to remove the mask and examine the condition of the eye and the reaction of the pupil.

If anaesthesia is advanced beyond what is perfectly safe—the pupil becomes dilated and fixed i. e., does not react at all to light. Very soon, if not at once, respirations begin to be spasmodic, irregular and may stop altogether. These latter are the signs that indicate an over dosage, but need excite no alarm for if the anaesthetic is withdrawn at once—and the chest is compressed a few times—normal breathing is soon re-established.

Complications during administration.

Perhaps the chief of these is respiratory obstruction, vital, of course, to the anaesthist as well as the surgeon, especially the throat surgeon. There are the minor crises, which arise during the course of anaesthesia, and are overcome by such simple, but yet all important manipulations as forcing apart the clenched teeth, gagging open the mouth, holding jaw forward, pulling out the tongue, swabbing mucus or blood from the throat and performing artificial respiration.

But there is another cause of obstruction drawn to our attention by H. M. Wharry in the *British Medical Journal* of May 21, 1927. This is impaction of the epiglottis over the larnyx, causing complete obstruction. He shows the variety in form and structure of the epiglottis and demonstrates the liability for an unusually long epiglottis to become tightly impacted over the laryngeal aperture with its extreme end curved up and closely applied to the posterior pharyngeal wall. A striking feature of the epiglottic obstruction is the silence of the process. Before anything amiss is noticed the obstruction is accomplished. There is no sound of active respiration, no movement of the diaphragm, no abdomenal excursion, no convulsive effort to breathe. The patient goes from bad to worse, with increasing cyanosi and failing pulse.

For relief a finger must be passed to the back of the throat and the epiglottis raised and pressed against the back of the tongue. Until this is done artificial respiration is useless. If the finger is not long enough a closed sponge forceps or a spatula can be used. In the event that the condition is not recognized until the patient is "in extremis" after the obstruction is relieved, the various methods of resusitation, artificial respiration, inflation of lungs with oxygen may be carried out.

Such an emergency calls for the very best team work on the part of the surgeon, anaesthetist and their assistants, if the patient is to be saved.

I wonder just how many deaths from this unrecognized condition have occurred, which have been attributed to status lymphaticus, heart failure, etc.

Another and rare complication of ether administration is the occurrence of severe spasmodic muscular contractions described sometimes as Jactitations and sometimes as convulsions. This phenomenon has not always been associated with a fatal issue, but death has occasionally occurred, either on the table or after patient is returned to bed. It is said by some authorities to be due to atropine, by others to impurities in the ether, still others state that it only occurs when ether is administrated by the "bomb" method. The practical lesson would seem to be to take every precaution, first to use ether that is pure, second to limit the amount inhaled to what is reasonable, third to avoid all oxygen deprivation.

In a recent article, Z. Mennell, M.B., London, Eng., reports four deaths under ether anaesthesia. One of these proved to be due to fat embolism and which we will not consider. The other three were anaesthetized by expert men, who used the purest ether vaporized by passing oxygen through Junker bottle. All these showed the same pathological condition, namely—profound dilatation of all the minute vessels and with capillaries full of red cells, virtually death due to "shock". Dr. Mennell suggests that there was over oxidation due to unnaturally clear airway and excessive use of oxygen, thus setting free "histamin", normally present in the body, into the circulation. Be that as it may; at any rate, the pathological picture was the same as that produced by Dale when he injected histamin into animals.

To sum up I would emphasize:

1. That the anaesthetic to be used should be the best possible and the safest for that particular case.

2. That chloroform and mixtures containing it should be avoided altogether.

3. That for the busy general practitioner, ethyl chloride for induction with a sequence of ether, is most safe, convenient and the least liable, if properly administered, to have serious after effects.

4. That more or less rebreathing is a most important element in securing an even narcosis, in lessening the amount of shock and in preventing such after effects as the lung complications, and acidosis.

Finally let me remind you that anaesthesia is one of the most beneficial of the applications of science and one of the greatest achievements of modern medicine.

In the hands of the careless, however, or of those unskilled, it may be fraught with very serious and dangerous consequences. The day is passed when its administration can be given over to the nurse or an untrained interne.

No one should approach such a task without the full realization of the fact that in the process a living being is brought to that borderland in which life in many respects so simulates death.

Tumors of the Breast*

DR. A. PRIMROSE, Toronto.

THE public should be first instructed to consult the physician whenever there arises in the patient's mind the slightest suspicion of malignancy.

Malignancy is very rare before the third decade, but it should be remembered that the younger the patient the more malignant a growth becomes if carcinoma does develop. In young patients medullary carcinoma is the type which so often develops and it is this form of growth which becomes so intensely malignant.

The adenoma, an encapsulated tumor which shows normal breast tissue on histological examination is not uncommon, and these very often undergo cystic changes, become fibrous, or both, so forming a fibro-cystic adenoma. Simple cysts in the breast are exceedingly common.

A well known authority, Dr. Bloodwood, of Baltimore, is of the opinion that too many breasts are operated on unnecessarily, especially some of these cystic breasts, but his colleague, Dr. Jennie, thinks that it is better to operate on all women over 25 years of age with a lump in the breast.

Sir G. Chettlewood was definitely able to show that malignancy, evinced by the loss of polarity of the cells, their breaking through the basement membrane, and the presence of abundant mitotic figures often occur in a simple cystic breast.

That little reliance is to be placed on the statement that multiple breast tumors seldom become malignant is shown by the history of a woman with multiple tumors in both breasts, one side being malignant while the other proved to be benign.

Method of Diagnosis

Firstly—A clinical diagnosis should always be made and purely clinical methods be encouraged. If the clinical picture points to malignancy, without doubt, and the microscopic picture is negative operation should not be postponed. There may be only a small focus of malignancy present which may escape section altogether. If the clinical picture is doubtful the action to be taken may be modified if a quick section is negative.

*(Being a synopsis of an address by Dr. Primrose at the 75th Anniversary Meeting of the Medical Society of Nova Scotia, October, 1928.)

1. Use every gentleness—never rub hard, squeeze or massage. In preparing for operation the nurse should not scrub the breast vigorously or irritate any more than at all possible.

2. The flat of the hand is to be used for palpation and with practice the outline of the tumor can be accurately defined. This method avoids unnecessary handling.

3. The skin over the tumor does not move as freely over it as over the healthy tissue. This is a very early and a very important sign.

4. There is an early loss of elasticity of the skin over the tumor due to changes in the ligaments of Cooper. This too is an early sign.

5. The glands in the axilla are soon involved becoming palpable. It is again to be emphasized that in early cases a section is not reliable.

Results—

In a series of 100 cases over 5 years:

Cures—44% and of these—
91% cures in favorable cases without glands.
61% cures in less favorable cases with slight glands.
9% cures in still less favorable cases with large glandular involvement.

The glands most frequently involved are those along the subscapular vessels, and then the glands situated along the internal mammary artery are less frequently involved, the explanation being that the lymphatic circulation is closed off at puberty. The liver is early affected in malignancy of the breast due to the migration of cancer cells down the lymphatics of the anterior thoracic and abdominal wall to the umbilicus thence along the ligamentum teres to the liver.

In a radical operation anatomical considerations govern the choice of an incision, which should be carried over the medial aspect of the upper arm, encircle the breast, and be continued down to the epigastrium. The pectoralis major muscle is defined and the clavicular separated from the costal part. Strip off the latter and turn it back, then expose the pectoral minor which is cut thus displaying the axilla. The breast and axillary contents are removed en masse.

Metastases to bone from breast carcinoma is very common, and these may be very diffuse before producing symptoms. They do not extend beyond the compact bone unless stirred up by manipulation or cutting.

Very widely occurring metastases may occur from a very small cancerous growth, the symptoms produced by them being of greater importance than those of the original growth.

Intestinal Obstruction*

DR. A. PRIMROSE, Toronto.

Classification:

1. Small intestine	Mechanical	Acute and Chronic.
	Non-mechanical	
2. Large intestine	Mechanical	Acute and Chronic.
	Non-mechanical	

Paralytic ileus constitutes 60%-70% of the cases of intestinal obstruction.

Breaking the reflex arcs by spinal anaesthesia will at times effect a cure. Paralytic ileus often constitutes a severe and fatal form of obstruction without mechanical cause.

Acute:

Still possesses a very high mortality, 40-60%, and is produced by some disturbance of innervation, though the exciting cause may be outside of the abdomen altogether. Obstruction is the ultimate cause of death in acute abdomen.

Irritation of bowel causes an impulse through the sympathetic which is referred back along the efferent pathway supplying corresponding abdominal segment causing immobility of the bowels and splinting of the abdominal muscles.

The pathway through which the inhibitory impulses reach the intestines is totally within the sympathetic system.

Spinal anaesthesia is a valuable therapeutic agent in treating paralytic ileus. It breaks the chain of inhibitory impulses causing immobility and allows normal peristalis to go on.

In appendicitis referred epigastric pain is caused by reflex pylorospasm.

Purgatives in obstruction from any cause are dangerous.

Mechanical Obstruction:

Cause—Tumor, hernia, adhesions, foreign bodies, visceroptosis.

Usually in acute obstruction the small bowel is involved. All hernial orifices should be examined as routine.

Symptoms—Pain, paroxysmal, constipation, severe vomiting of gastric contents, bile, etc. Pain becomes less. Patient becomes very toxic.

* Being a synopsis of an address by Dr. Primrose at the 75th Annual Meeting of the Medical Society of Nova Scotia.

Inspection—Distention, visible peristalsis.
Palpation—Rectal and abdominal. Tumor may be felt.
Percussion—Liver dullness, fluid tumor.
Auscultation—Heart sounds may be transmitted.
With vomiting alkalosis is present.
Blood—Fall in chlorides—rise in N.P.N.—rise in CO_2 combining power.

Chlorides exercise a protective agency. Tissue destruction and toxaemia may be averted by raising the chlorides in the blood. The higher the obstruction the more acute are the symptoms. Percentage of blood chlorides indicates severity of toxaemia. After twelve hours there is a great increase in mortality, and after thirty-six hours to forty-five hours condition is almost hopeless.

Treatment:

1. Determine chlorides and raise the same in blood if depleted
2. Determine N.P.N. and CO2 combining power.
3. Give glucose and saline—10% glucose in normal saline 600cc.
4. Chlorides per mouth and rectum. By mouth give Frosst's (Na cl) gelatine coated capsules. Chlorides may be given at onset and may also be given by interstitial. This prevents or delays toxaemia.
5. Enterostomy and flush bowel.
6. Spinal anaesthesia—Novocaine.

Chronic Obstruction:

In these cases a tumor is frequently felt.
Great care should be exercised in history taking: Blood in stools, loss of weight, etc.
Digital exam. of rectum should never be omitted.
There may or may not be vomiting present with inability to pass flatus. Vomiting usually absent in obstruction of large bowel.
Prognosis depends on cause—(1) Malignancy; (2) Obstruction Benign.
Operation is the only method of giving relief. A long incision is made and the bowel brought out with greatest care possible. Two stages—(1) Colostomy; (2) Caecostomy.

An Exploded Idea. The introduction of the Public Health Nursing Service met at first considerable resentment among many physicians who felt that their *Private practice* was being interfered with. To-day it is recognised that this service is of distinct monetary advantage to the local doctor. The principle of the service was never questioned by intelligent people.

Brucella Abortus Infections in Man

DR. D. J. MACKENZIE, Halifax, N. S.

IN the last two or three years a rapidly increasing number of case reports of Br. abortus infections have been published in various medical journals These cases have been reported from almost every section of Canada and the United States, and show that Undulant fever is a much more common and wide spread disease than was thought a few years ago. The recent discovery of two cases in this province has prompted the writing of this brief note.

When in 1897 Bang demonstrated the Microorganism, which is now known as Brucella abortus, to be the specific cause of epidemics of Infectious abortion of cattle, it was thought that the pathogenicity of the organism was directed against cattle alone; that man was not susceptible to infection. The possibility that such was not the case, and that Br. abortus could readily set up a rather modified form of the disease in man was suggested in 1913 by Larson and Sedgewick. A very important contribution to the subject was presented by Evans in 1918 when she pointed out that an exceedingly close relationship existed between Br. abortus and Br. Melitensis, the organism which for many years had been recognized as the specific cause of Malta fever, now better known as Undulant fever. It was not until 1926 that Carpenter reported the first case of Undulant fever in America which was definitely proven to be due to Br. abortus, and the route of infection clearly established by showing that the patient had consumed large quantities of non-pasteurized milk which was heavily infected with Br. abortus. Since that date, the prevalence of Undulant fever has been studied more intensively, and many cases have been reported from the Eastern United States, Ontario and Quebec. Two cases have been demonstrated in Nova Scotia, from Colchester and Lunenburg Counties.

Further study of this microorganism has shown that Br. abortus is but the bovine strain of a large family of very closely related organisms, of which the caprine, bovine, and porcine strains, though primarily infecting goats, cattle and hogs respectively, are also pathogenic to man.

As seen in cattle, Br. abortus sets up an inflammatory process in the placental tissues, which usually results in a premature expulsion of the foetus. The most important characteristic of the disease, from an epidemiological or Public Health standpoint, is the frequency with which the disease becomes localized in the udder; in which case the

milk becomes heavily infected and may remain so over a period of years, the animal showing no obvious results of the continued infection.

As seen in man, the symptoms described in the reported cases are rather variable. In its onset, Undulant fever resembles Typhoid fever or in some cases "grippe" more closely than any other condition. The symptom complex is usually an onset with severe headache, painful muscles and joints, malaise, chills followed by drenching sweats and gastro intestinal disturbances. The temperature is usually of the undulant type, often reaching 104 F. in the afternoon. It may remain normal for a few days only to have one or more recrudescences later. This feature has caused the disease to be confused with typhoid fever followed by one or more relapses. A rash and enlarged spleen has been reported in several cases, but they seem to be the exception rather than the rule. A slight leucopoenia with a relative lymphocytosis and secondary anaemia are the only cytological blood changes. Arthritis is common late in the course of the disease. In the more severe cases the infection may persist several months, but the mortality rate, as reported from almost 200 cases in Canada and the United States, is very low.

As regards Laboratory aid in the diagnosis of this disease, there are few, if any, conditions in which Laboratory procedures are as necessary as they are in enabling the physicians to make a positive diagnosis of Undulant fever. The Widal agglutination test is the most helpful as well as the most convenient, and should certainly be carried out on all cases of obscure or long continued fevers. To carry out the test properly about 3 cc of blood, the quantity usually submitted for a Kahn or Wasserman test, are necessary. All such specimens sent in to the Public Health Laboratory for a Widal agglutination test are always examined for evidence of Br. abortus or Br. melitensis infection as a routine procedure. Blood culture is also helpful, but Br. abortus is a difficult organism to isolate from the blood stream, usually requiring two or three weeks to obtain a definite growth. Br. Melitensis is much more easily recovered from the blood stream. The Urine may also be examined for Br. abortus, but this usually involves inoculation into guinea pigs, animals which are very susceptible to this infection.

Pending the erection and equipment of a Hospital in Wolfville to be known as the Eastern Kings County Hospital, Westwood Hospital, which has been operated by Dr. C. E. A. deWitt as a private institution, will, after May first, be operated under the directions of Doctors Elliott, Cochrane, Chase and deWitt, Miss Bingston, and Mr. George Boggs. In this connection we note newspaper references to the presentation of property by Mr. Geo. E. Calkin to the town of Kentville for hospital purposes. Perhaps we had better go slowly in this matter of hospital construction.

Medical Organization*

E. J. BOARDMAN, M. D., Winnipeg.

ONE needs only a casual glance at the general medical literature of to-day to be aware of a leaven of uneasiness working through the profession. Its aetiology is vague and as yet intangible, to the many it is sensed and not explained. Deeper study, however, reveals a very general impression that we are more or less precariously balanced on the edge of a crisis, and that from the viewpoint, both of the individual practitioner as well as medical organization, we are being pressed toward a brink over which we must inevitably fall into the abyss of the uncertainties of state and industrial medicine.

We are in actual practice a relatively small group of individuals, especially trained to treat individuals, each case a separate individual contract between doctor and patient, each man running his own private show with more or less success as the case may be, just the same now as we did fifty years ago.

Being so engrossed in private enterprise, many of us have utterly failed to lift our eyes high enough to note the clouds bordering the horizon, or the faint rumbles of discontent and dissatisfaction that should from time to time have been audible to the attentive ear. They have indicated a changing attitude on the part of the general public toward physicians in general and medicine in particular. Toward medicine there is an ever increasing trend toward more hospitals, more hospitalization, more lay organizations, more public interest in the care of the sick, and greater public interest in the prevention of disease. Toward the physician the change lies in his loss of popularity and waning social status. We look back on the prestige of the physician of thirty or forty years ago and turning our attention to the doctor of to-day find him the competitor of quacks and charlatans and a poor competitor financially at that. It is useless to shut our eyes to the fact that a large section of the general public would just as soon be treated by the one as the other, and that a still larger section cannot differentiate between us. How are the mighty fallen!

Hitherto we have been at the beck and call of individuals, but these have been so numerous that those we did not like or who were incompatible with us we could afford to forget about, without injury to our prestige, our self-esteem or our pocket. But more and more and in larger numbers we are beginning to be at the beck and call of hospital boards, lay organizations, municipal authorities and governmental

* Taken from the March issue of the *Manitoba Medical Bulletin.*

departments; the ignoring of which is likely to cost us something considerable financially.

What is the future of the profession to be?

Must we, one of the most learned of the professions, as the years roll by, continue to approach lay organizations and hospital boards with an ever increasing attitude of humility, and with please and thank you, beg for what we should demand, follow where we should be leading the way? If we do, the fault is entirely our own.

By the docility with which we have carried out the instructions of lay organizations, by the servility with which we are obeying the orders of hospital boards, by the obsequiousness with which we have sought appointments, we have dug a pit into which we have fallen and from which we may escape but only with great difficulty.

We speak of medical organization, but gentlemen, it is to laugh; we have no such thing. It is true we have a loose co-ordination of a certain number of the profession into societies largely for clinical and scientific purposes but there is almost no element of cohesion in them. For years the medical profession has been pushed and prodded this way and that like so many driven cattle, by whatever group of upstarts with a little money and some spare time who may have taken a notion to try out some fantastic health scheme, and we have stood for it quietly, and even turned our other cheek, because there was nothing else to do. We could merely draw our cloak of dignity and honor and prestige about ourselves more tightly, but that is a very inefficient weapon with which to combat organization. So long as we were dealing solely with individuals, it was sufficient and we were safe, but now it is organization we are up against, trained skilful organizers we are dealing with, and it is because as a profession we are without adequate organization that we are inarticulate in times of stress. It is not that we are afraid to speak but that we have no voice, not even the vocal chords.

The greatest need of the medical profession to-day, in my opinion, is the development of a class consciousness, beginning with the medical student in his first year and on through his career carrying out instruction in his duty to his profession as well as to the public. The public is showing an ever-increasing ability to take care of itself, and it has also demonstrated repeatedly that it is not losing any sleep over the troubles of the medical profession.

Our troubles and difficulties are peculiarly our own and we can expect no help except as the result of our own efforts.

We must develop a class consciousness and an efficient organization to go with it that can speak with a single emphatic voice for the whole profession. The power we can wield is tremendous if we have sufficient cohesion to stick together. Then when the crises come, we will be consulted. There will be conferences, and affairs will be arranged to the mutual satisfaction of all concerned, and no more shall we be told, gentlemen, this is the arrangement, take it or leave it.

We have the skeleton for this organization in the Manitoba Medical Association and the local societies, but the members are either so ignorant of the trend of events, or so indifferent as to the future, that by the time each individual receives a sufficiently severe jolt to his own private enterprise to arouse him to a consciousness, it will be too late to save very much from the wreck, and as a profession we will be reduced to selling our time at so much per, to various contractors, much like the bricklayers and the carpenters. In the past we have occupied a peculiar position, we have been freemen, almost dictators, and personally I have no hankering to have to be compelled to adopt the idea and attitude of an ordinary paid servant. However, we have the skeleton for the organization which properly directed may do much to save the situation, but it must be very greatly extended to be of real service to us. And since we must all continue, each to make his living in his own private enterprise, it follows that some one or more who can think and see and feel for the profession as a whole, who has lived its life and knows its problems, must undertake the task of giving this association a voice and teaching it to talk.

We want a man, an organizer, a secretary, a manager, a promoter, call him what you will, who will devote his whole time to the development of the association; a man old enough to have gathered experience, but not old enough to have grown stale. Not a hail fellow well met who can go out and make a lot of personal friends, but one who can build a spirit of earnest co-operation into the organization. A man who, as the Good Book says, "is as wise as a serpent and as harmless as a dove," who can arouse enthusiasm with a minimum of antagonism, who can secure co-operation in urban and rural districts and exclude petty jealousies; a man with vision and imagination to think and plan. A pilot who, knowing well the course, can skillfully guide us past the shoals, and in addition he must be able to speak, to say something when he talks and to talk convincingly.

But we must not expect him to perform miracles. The thoughts, ideas, and prejudices, a hundred generations of individualists, may not be completely altered in a single lifetime. And if it is too late to stem the tide that is set against us, we may at least find a safe enchorage.

(Address delivered before Winnipeg Medical Society, February 15th, 1929)

A local newspaper says there are about 135 doctors for every 1,000 persons in this country. We are certainly very much misled regarding physicians in Nova Scotia by the list as published in the medical registration. The General Secretary of The Medical Society of Nova Scotia, has never been able to locate more than 400 doctors who may be regarded as being in actual practice in this Province. The newspaper intimation would indicate that we had about 775. The actual number does not exceed 400.

The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

Confined to, and Covering every Practising Physician in Nova Scotia. Published on the 5th of each month. Advertising Forms close on the 20th. of the preceding month. Subscription Price:—$3.00 per year.

VOL. VIII. MAY 1929 No. 5

76th Annual Meeting

THE MEDICAL SOCIETY OF NOVA SCOTIA.

Pictou, N. S. C. N. R. Hotel, Pictou Lodge, Headquarters.

June 25th, 26th and 27th, 1929.

Tuesday, June 25th, 1929

3.00 P. M. Meeting of the Executive of the Medical Society of Nova Scotia.
Presentation of reports and their disposition.
Approval of the Programme.

5.00 P. M. Special Golf Tourney.
1st and 2nd prizes to be awarded. Entries to be made at once.

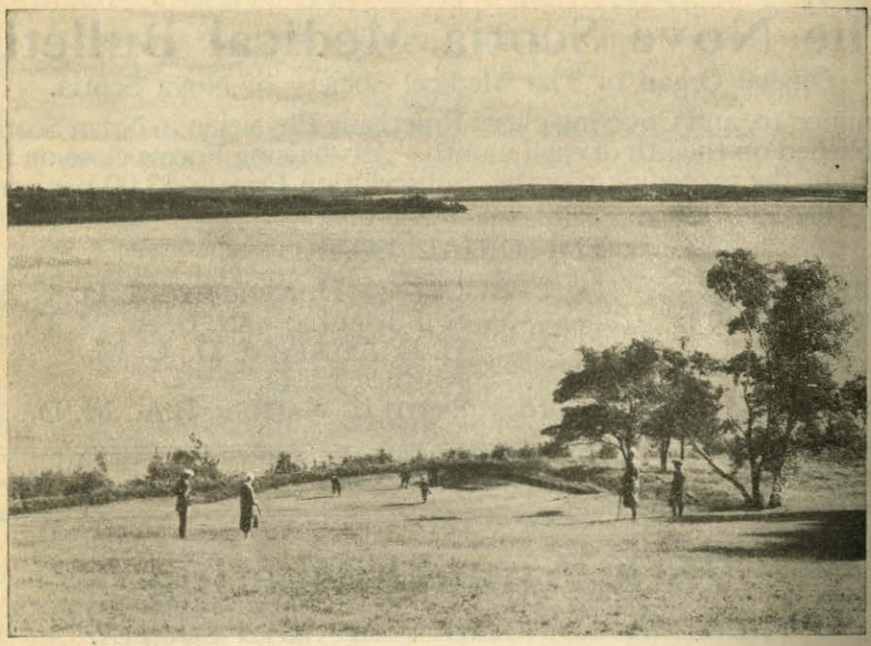
7.00 P. M. Dinner. Followed by meetings of special committees of the Executive.

7.30 P. M. Annual Business Meeting of the Medical Health Officers' Association.

11.30 P. M. Reception to the arriving members.

Wednesday, June 26th, 1929

Reveille calls from 7 A. M. to 8.30 A. M. at 15 minute intervals unless satisfactory acknowledgment of a call is received from each Lodge.



View of Golf Links adjacent to Pictou Lodge, Pictou, N. S.

Another View of Golf Links Adjacent to Pictou Lodge, Pictou, N. S.

9.00 A. M. Breakfast. Roll call. No meals served in cottages this morning.

10.00 A. M. Registration.

10.30 A. M. Meeting called to order and reading of Minutes.

10.45 A. M. Unanimous consent requested to consider the report of the Executive Committee, which will carry with it recommendations of the procedure during the next two days. This will also include the appointment of the Nominating Committee and the Auditors, together with any proposals for any business.

11.30 A. M. Scientific paper—title:—"The Hospital situation in Nova Scotia". Dr. H. A. Agnew, introducing the subject, followed by a round table discussion.

12.30 P. M. Luncheon. Official announcements.

2.30 P. M. Scientific session. Papers presented by Dr. Fitzgerald, Toronto, Dr. M. A. B. Smith, of Dartmouth, N. S., Prof. Smith of Dalhousie University, Prof. Gibbs of Dalhousie University, Dr. L. R. Meech, North Sydney.

5.00 P. M. Golf and Swimming Contests.

6.30 P. M. Dinner.

There will be a special dinner party composed of Ex C. A. M. C. members which will be presided over by the President, on account of his having recently received a special military decoration. A special issue of Mulligatawny will be served. The other guests will watch you sop it up while they will enjoy a particularly good menu of an entirely different nature. Lest we Forget!

8.00 P. M. General Session. Nursing Education. The speaker being Miss Beard, of the Rockefeller Foundation, New York.

9.00 P. M. X-Ray Plates in Tuberculosis, Dr. A. F. Miller of Kentville, Nova Scotia.

The Relations between the Ex-soldier and the Medical Profession, Dr. Ross Millar, Ottawa.

Thursday, June 27th, 1929

8.30 A. M. Reveille followed by breakfast when and how you can get it.

10.00 A. M. Business and scientific session. Reports of Commitees 1st. The Nominating Committee.

11.00 A. M. Scientific papers—Dr. Fitzgerald, of Toronto, Dr. J. G. D. Campbell, of Halifax, Dr. H. R. Corbett, of Kentville, Dr. W. N. Rehfuss, of Bridgewater, Dr. I. R. Sutherland, Annapolis, Dr. W. F. McKinnon, Antigonish and others.

View from one of the Bungalows, Pictou Lodge, Pictou, N. S.

Some of the Bungalows, Pictou Lodge, Pictou, N. S.

1.00 P. M. Luncheon. (P. E. I. Doctors as Guests).
2.30 P. M. Scientific programme and business session.
Prof. Bean of Dalhousie University.
G. Kerr Thomson, D. D. S., Dr. M. E. McGarry.
4.00 P. M. Conclusion of Business.
7.00 P. M. Dinner Dance.

The meeting will be bigger and better than this tentative programme suggests. Please note some of the views of Pictou Lodge. Plan to be present.

S. L. WALKER,
Secretary.

A Health Officer's Story.

It happened a few years ago that a Health Officer in Truro took his duties seriously, as, of course, they all do now, and, when visiting patients, was accustomed to make an inspection of the local sanitary conditions. One day he looked over several places, finally coming through the premises of a colored couple he knew very well. The husband was steady, sober and honest, but was slow of action and speech. His wife, however, was also of good character, a fine housekeeper, but possessed of a very ready wit. At the same time she possessed a face that was a work of art for homeliness.

Ruth: "You needn't come snoopin' 'round here, everything is clean inside and out. The house is well aired an' I sleeps with the window full up every night."

H. O.: "Yes, Ruth, I know all that, but as your bedroom is on the ground floor, are you not afraid some one will come in some night and carry you off?"

Ruth: "Ah, Doctor deah, ah's not afraid; jest as soon as it came daylight he'd bring me right back."

Incidentally it may be added that a few years ago Providence made Ruth a widow, and since then many lines on that dark face have smoothed out and, altho not pretty, she is now good looking.

Volume 3, No. 5 of the Bulletin, the official organ of the Canadian National Committee for Mental Hygiene, came to our desk some time ago. This Committee is a combination lay and professional organization, but Dr. C. L. Martin of Montreal is President and Dr. C. M. Hincks is chief executive officer. In this health educational work we need lay organizations, but this Committee is so largely medical that we are impelled to ask why all its obligations could not be assumed by a Committee of the C. M. A.? Surely its recommendations, and that is about all it can do anyway, would have greater force with the entire medical profession in Canada its sponsor.

Royal College of Physicians and Surgeons

An Act to Incorporate the Royal College of Physicians and Surgeons of Canada.

Whereas the Canadian Medical Association, a body corporate duly incorporated by virtue of Chapter 62 of the Statutes of Canada, passed and enacted in the year of Our Lord Nineteen Hundred and Nine, has by its petition prayed that certain of its present members and others to be hereafter selected may be incorporated under the name of THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA.

And whereas it is expedient to grant the prayer of the said petition.

Therefore His Majesty by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:—

1. In this Act unless the context otherwise requires—
   (a) "The College" means the Royal College of Physicians and Surgeons of Canada, constituted under the provisions of this Act.
   (b) "The Council" means the Council of the said College.
   (c) "Fellows" means members of the College.
   (d) "Charter Fellows" means members of the College who become such upon the coming into force of this Act, together with those persons selected and admitted as Fellows within two years thereafter.

2. Those persons holding, at the date of the coming into force of this Act, appointments as professors in medicine, surgery, gynaecology or obstetrics in a Canadian University together with the persons from time to time selected and admitted as, or otherwise being, Fellows of the College pursuant to this Act, upon their consent so to act, are hereby constituted a corporation under the name of The Royal College of Physicians and Surgeons of Canada.

3. The Council may, at any time within two years after the coming into force of this Act and without examination, select and admit as Fellows any duly qualified persons who have in their opinion given evidence of high ability in one or more departments of medicine;

4. The Council may, without examination, select and admit as Fellows, physicians and surgeons practising in Canada and licensed to practise in at least one of the Provinces thereof, and holding a diploma or fellowship issued or granted after examination by a recognized Medical or Surgical organization constituted by the laws of Great Britain and Northern Ireland, of the Republic of India, or of any of

the British Dominions, or of such other countries as the Council may direct, if in the opinion of the Council, such diploma or fellowship is of equal status to fellowship in the College;

5. The Council may, without examination, select and admit as Honorary Fellows such distinguished physicians, surgeons or other persons resident within or without Canada as the Council may deem fit.

6. (a) Except as hereinbefore mentioned, no person shall become or be admitted as a Fellow of the College until he shall have complied with such by laws and regulations as the Council shall from time to time consider expedient, and unless he shall have passed such special examinations by the Examiners of the College as the Council shall from time to time prescribe and direct for candidates for fellowship, but every fit and proper person, qualified as hereinafter set forth and having complied with such rules and regulations and passed such special examination as hereinbefore set out, shall be entitled to be admitted as a Fellow of the College.

(b) All candidates wishing to be examined for fellowship in the College shall be graduates of not less than three years standing of a Medical School or University approved by the Council, and shall hold licence to practise medicine in at least one of the Provinces of Canada.

(c) The Council may by by-laws provide for the organization of the College into Medical and Surgical Divisions and for admission into fellowship in the College in one or other of such divisions in which event a Fellow of the Surgical Division may be known and designated as a Fellow of the Royal College of Surgeons of Canada and a Fellow of the Medical Division may be known and designated as a Fellow of the Royal College of Physicians of Canada.

7. (a) The admittance of every Fellow or Honorary Fellow of the said College shall be by diploma under the Seal of the said College in such form as the Council shall from time to time think fit, provided that one or more general diplomas may be granted or issued covering the admittance to the College of such Charter Fellow;

(b) The Council shall cause the name of every Fellow or Honorary Fellow for the time being of the College to be entered, according to the priority of admittance or otherwise as the Council may direct, in a book or register to be kept for that purpose at the headquarters of the College or such other place as the Council shall direct, and such book or register, subject to such reasonable and proper regulations as the Council for the time being may direct shall be open to the inspection of any Fellow of the College.

8. (a) The business and affairs of the College shall be administered by a Committee of the Fellows to be known as "The Council" of the College;

9. The Council may make such by-laws, rules and regulations not inconsistent with the provisions of this Act as it may deem necessary or advisable for the government and management of its business

and affairs and especially with respect to the qualifications, classification, admission and expulsion of Fellows, the fees and dues which it may deem advisable to impose, and the number, constitution, powers, duties and mode of election of the Council or any sub-committees thereof, and of the officers of the College, and may from time to time alter or repeal all or any of such by-laws or rules as it may see fit.

10. The College may receive, acquire, accept and hold real and personal property by gift, purchase, legacy, lease or otherwise, for the purposes of the College, and may sell, lease, invest or otherwise dispose thereof in such manner as it may deem advisable for such purposes; provided, however, that the annual value of the real estate held by the College shall not exceed the sum of Dollars.

11. No member or Fellow of the College shall merely by reason of such Fellowship be or become personally liable for any of its debts or obligations.

12. The General Secretary of the Canadian Medical Association shall call together, within six months of the passing of this Act, all those entitled to become Fellows of the College, as set out in Section Two of this Act. All those present at such meeting shall constitute a provisional Council. It shall be their duty at this meeting to elect a Council with such officers and officials as they deem necessary. The elected Council officers and officials shall hold office in accordance with the provisions of this Act and with the by-laws, rules and regulations of the College.

13. The Council shall hold office for a period of four years, and (or) until their successors are elected and hold their first meeting.

To His Excellency The Right Honourable Viscount Willingdon, Knight Grand Commander of the Most exalted Order of the Star of India, Knight Grand Cross of the Most Distinguished Order of Saint Michael and Saint George, Knight Grand Commander of the Most Eminent Order of the Indian Empire, Knight Grand Cross of the Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief of the Dominion of Canada.

IN COUNCIL.

The petition of The Canadian Medical Association, a corporate body duly incorporated under Chapter 62 of the Statutes of Canada passed and enacted in the year of Our Lord 1909.

HUMBLY SHEWETH:

1.—*That* your Petitioner is desirous that certain of its members and others who have achieved distinction in some branch of the medical profession as evidenced by their holding professorships in recognized Canadian Medical Schools or displaying high ability in one or more special departments of the medical profession, should be incorporated under the name of THE ROYAL COLLEGE OF PHYSICIANS AND

SURGEONS OF CANADA (hereinafter referred to as the College) and should be designated and known as FELLOWS of the said College.

2.—*That* your Petitioner contemplates that the original members of the said College (herein referred to as the Charter Fellows) should include and be limited to the professors in medicine, surgery, gynaecology and obstetrics, at the present time actively engaged in teaching in a Canadian University within the meaning of the Canada Medical Act, together with such other persons whom the Council of the College may at any time within two years after the incorporation of the College select and admit as Charter Fellows of the College.

3.—*That* your Petitioner contemplates that except for:—

(a) The Charter Fellows to be selected as aforesaid.

(b) Honorary Fellows to be selected by the Council of the College without examination from among physicians, surgeons or other persons distinguished by their ability.

(c) Duly qualified physicians and surgeons practising in Canada, and licensed to practice in at least one of the Provinces thereof holding a degree, diploma or fellowship issued or granted by a recognized University of Medical or Surgical organization of equal status to a Fellowship in the College, to be selected and admitted without examination, admission to the College should be by examination and should be open to all physicians or surgeons being graduates of not less than three years standing of any Medical School or University within the meaning of the Canada Medical Act and being duly licensed and authorized to practice the profession of medicine in at least one of the provinces of Canada.

4.—*That* your Petitioner is desirous that the College may be authorized to acquire and hold such real and personal property as is necessary or expedient for its purposes and to sell, lease or otherwise dispose of the same.

5.—*That* your Petitioner contemplates that the affairs of the College shall be administered by a Committee of the Fellows to be known and designated as the Council of the College to be elected from time to time by the Fellows thereof and that the said Council be authorized to make and pass by-laws and regulations for conducting and controlling the selection and admission of Fellows and the examination therefor, for the election of the Council and officers thereof and for the doing of all other lawful acts and things that may be deemed expedient for the exercise of its corporate powers.

Wherefore your Petitioner humbly prays that your Excellency may be pleased to sanction the passing of an Act for the purposes above mentioned in the form hereunto annexed or in such other form or with such modifications as your Excellency may be pleased to approve.

And as in duty bound your petitioner will ever pray.

Dated at Toronto this day of 1929.

Post Graduate Lectures

A Statistical Summary of the Canadian Medical Association Post Graduate Lectures given from October 1st, 1927, to September 30th, 1928.

In furnishing this statement the General Secretary writes as follows regarding the work made possible by the Sun Life Assurance Company.

"Dear Doctor:—

Herewith enclosed, you will please find a recapitulation of the extra mural post graduate work conducted by the Canadian Medical Association during the past year. As one of the speakers who contributed towards this undertaking, I think you will be interested in seeing just what has been accomplished.

On behalf of the officers and members of the Association, may I take this opportunity of thanking you most sincerely for the part which you played in making the past year's work so successful."

This statement is as follows:—

Province	Number of Speakers	Number of Addresses	Attendance	Total Cost
British Columbia	12	118	7,289	$6,217.52
Alberta	15	152	4,465	4,829.03
Saskatchewan	13	82	2,009	3,573.45
Manitoba	35	50	3,026	2,144.78
Ontario	173	210	5,491	5,045.03
Quebec	49	91	1,010	5,523.52
New Brunswick	10	34	478	1,807.53
Nova Scotia	9	31	680	1,844.02
Prince Edward Island	11	23	502	1,530.77
Newfoundland	2	11	473	820.80
	329	802	25,423	$33,336.45

Comparative Statement Covering Three Years of Post Graduate Work.

	1926	1927	1928
Number of Speakers	169	269	329
Number of addresses	513	729	802
Average Attendance per lecture	29	27	31.7
Total Attendance	17,264	19,683	25,423
Total Cost	$30,100.27	$28,831.66	$33,336.45
Cost per lecture per Doctor	$1.74	$1.46	$1.31

Some Aspects of Preventive Medicine

TO the writer it has always appeared that Medical Societies barely tolerate papers and addresses at Society meetings dealing with topics concerned with the promotion of health, the prevention of disease and the prolongation of life. The striking feature of this is that these aims have the ardent support of every practitioner in the Province. To them it appears useless to waste time, with papers and addresses before medical audiences, along these lines. We believe, however, that this is a very grave mistake.

To develop a line of thought we would suggest that the Medical Society of Nova Scotia pay more attention at its Annual Meetings to Preventive Medicine, not in general or indefinitely, but as it might be effective in Nova Scotia. We have been impressed of a certain characteristic of Nova Scotians (it may apply to the Maritime Provinces) to concentrate on their own special organization, ignoring all others. Time and time again we have stood for the proposition that our territory, our population and wealth is too limited to allow us to carry on all lines of activity without practical co-operation. In little Nova Scotia and little Halifax we have as many varieties of organizations as larger provinces and larger cities, each being possessed with the provincial idea of its own importance and independence. There is a wrong principle in operation here. No one city, town, or county knows, what is best for the Province as a whole. Likewise no one society or welfare organization can do all the work that the people in Nova Scotia require. Yet each Society does all it can and exploits itself in annual meetings. Something is going to drop some day and then various organizations must co-operate along certain lines or else be plainly told to quit. In Nova Scotia we cannot afford any more duplication or over lapping of philanthropic effort.

It is recognized by all that there is ample field for the activities of the Public Health Nurse, the School Nurse, the Victorian Order Nurse, the Tuberculosis Nurse, the Red Cross Nurse, the Welfare Nurse, the Health Committee of various Societies, etc. At the same time we all know there is a surfeit of their activities in some localities and an absence in others.

We have in mind also the Medical Society of Nova Scotia, the Health Officers' Association, the Mental Hygiene and Social Hygiene Councils, etc., all working out their own plans, without any reference to each other. To be specific one would think that the problem of the mental defective was not of concern to the profession generally, but only to the Psychiatrist and the Social Workers.

The title of this comment was suggested by seeing an address by Dr. FitzGerald of Toronto, published in the February issue of the

C. M. A. Journal, which every practitioner should read. It indicates the broad field of preventive medicine, which is why we make our plea for co-operation of our many agencies. In view of our limited resources we must centralize and co-ordinate all our health agencies. As to the extent of this work the address states:—

"In the evolution of preventive medicine the scope of the subject has been constantly extended. The practice of this branch is carried on by medical practitioners in the routine of general medical work, and by those employed in departments of public health; also by private practitioners who undertake certain tasks (e. g., school health-service), upon a part-time basis, for local or central health authorities. As a part of the work of the health departments, measures designed to ameliorate unfavourable social conditions may be organized supervised, co-ordinated or actually carried out by such departments. Similarly, community undertakings for the promotion of social welfare frequently are closely integrated with the work of the public health authority."

Later in his address Dr. FitzGerald asks the very pertinent question as to whether or no our present methods are the best that can be devised for the prevention of sickness and the provision of medical care. His very question brings up the matter of State Medicine. He says:—

"It has frequently been stated that 'well-to-do' persons in any community and those who are poverty-stricken or destitute receive the best and most satisfactory care when sick and, also, such preventive services as can be provided at present. This may or may not be true. In any event it need not deter us in our endeavour to answer this simple question: Is the present system for the prevention of sickness and the provision of medical care in this country the best that can be devised? If not, the first essential is an inquiry into the facts of the situation. Such an investigation might be undertaken by a group representing the organized medical profession, the federal and provincial departments of health, and, perhaps, representatives of other interested bodies. The Committee on the Cost of Medical Care, recently (1927) set out to explore this field in the United States, illustrates how some of these questions might be approached by a suitable committee. The investigation of Canadian conditions should be made by Canadians. The remedies which might be proposed should be designed primarily to meet our own needs."

We venture to suggest that the concluding paragraphs of his address would be reason enough to have the Medical Society of Nova Scotia make some effort, at each annual meeting and throughout the year, to secure the co-ordination of effort necessary to actually conserve our energies and make progress in Health Work. He said:—

"I should like to suggest that a splendid opportunity is afforded the organized medical profession of this country, to undertake a task of national interest and importance as follows: to ascertain whether adequate and satisfactory medical service, preventive and curative, is within the reach of all persons in need thereof; to learn whether the

present volume of sickness with its attendant economic loss may be lessened; if so, to suggest ways by which this might be achieved; to study the remedies already introduced elsewhere for the aleviation of analogous conditions; and, finally, to bring forward specific recommendations to the proper bodies, governmental and voluntary, so that appropriate action may be taken.

The spirit of scientific enquiry should animate such an undertaking. A dispassionate and wholly objective attitude of mind is essential if information of any value is to be obtained. The responsibility cannot be evaded, nor can the work involved be delegated to others."

S. L. W.

MEDICAL RADIO BROADCASTING.

WHILE we are of the opinion that there has been no abuse of ethics in medical broadcasting in Nova Scotia yet the matter is under the control of the various broadcasting stations and abuses may develop. It appears the danger would arise largely as a medium of advertising procedures or preparations whose value was open to question. In this Province we feel the Department of the Public Health should interest itself to see that this means of publicity is not prostituted by any such advertising.

Radio Advertising has been abused but steps are being taken to see that it is placed on the same basis as newspaper advertising. Just here we must call attention to the much higher standard of newspaper advertising as compared with a large number of the magazines on sale in Nova Scotia. *The American Medical Association Journal* in a recent number says:—

"The harm done by radio advertising is more serious than anything possible through newspaper advertising. The fact that radio broadcasting is controlled by a federal commission lends credence to the statements that come over the air. The persuasiveness of the human voice and the direct personal appeal are likely to sway the mind of the listener more than does a printed statement. The promoters who travel the borderland between honesty and quackery, raking in the shekels of the unwary, have found in radio broadcasting a glorious accessory for their manipulations. The mutterings of mystics from India and of fortune tellers from France, the claims for hair growers from Austria, for magic horse collars, for radium drinking waters, for antiseptics, cosmetics, influenza and cancer cures, the sexual appeals of rejuvenationists, the mouthings of evangelistic and faith healers, and preposterous dietary schemes come pouring from the loud speakers like noisome effluvia from the great sewer that drains away the by-products of human physiology in a metropolis. The combined action of the radio broadcasting industry and of the Better Business Bureaus of the nation should lead promptly to control, indeed, to actual sanitation, of this situation."

Correspondence

409 Medical Arts Bldg., Guy & Sherbrooke Sts., Montreal.
31 March, 1929.

Dear Doctor Walker:—

I write to thank you very sincerely for the kindness and courtesy shown to me during my visit to Halifax and New Glasgow. When I say 'you' I mean all those who were so good as to attend the meetings and expressed approval of what I presented and especially yourself, who took so much trouble to make everything go so smoothly and comfortably. It gives me a wonderful sensation to know that one is amongst friends and that sensation was strong in me during both my visits (previous and recent) to Halifax and also in New Glasgow. I thoroughly enjoyed my short visit even though it was so strenuous. I like the men I met, both old friends and new, and admire the earnestness which was evident in graduates as well as in students. My opinion of Halifax medical school is higher than ever—and I am more convinced from what I saw and heard, that the teaching there is conducted on sound lines, that good seed is put into good soil.

With my kindest regards, good wishes and thanks to you all.

Yours faithfully,

(Signed) HENRY M. W. GRAY.

London Truth a few years ago said:—"It was easier to start a University in the United States than it was a grog shop in England."

Father and Son Day. At a service club luncheon recently we were reminded of a little note we read from a letter a father wrote to his son during the war. While looking at his boy's picture in khaki Dad wrote a letter that ended thusly:—

"Let me whisper a secret.—While it has tickled my vanity to know how proud you are of the old man's little successes, and it has been a real spur to me, yet all the while I know and so should you, that you are my real success. All that I ever dreamed of doing, or being, I know you will accomplish, if you come through this war alive. —Dad."

With Our Advertisers

Just a word to every reader of the BULLETIN.

It takes two things to make a consistent advertiser. One is a strong conviction that he has a product that will hold its place in public favor despite competition. The other is the actual proof of that—the increasing popularity of his product.

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Read the advertising here in your BULLETIN It will guide you to the buying of worthy merchandise and making wise investments.

The Toast.

The idea of a "Toast" is derived from the toasted bread or biscuit that was at one time put into the tankard, and which still floats in the loving cups of the Universities and the Inns of Court. To toast a person is to drink to his good health. Then it came to mean that person himself. Of course, the ladies are responsible for the first use of the word in this latter sense. In the days of Charles II it happened that on a public day a celebrated beauty was in the Cross Bath and one of the crowd of her admirers took a glass of the water in which the fair one stood and drank her health to the company. There was in the place a gay fellow, half-fuddled, who offered to jump in, and swore, though he liked not the liquor, he would have the toast. He was opposed in his resolution, yet this whim gave foundation to the present honor, which is done to the lady we mention in our liquors, who has has ever since been called a "Toast".

"**To the Ladies**"—A man intent on putting a little sting into the tail of his compliment, gave this toast:—"To the first woman, the mother of us all; even though she was according to the old story, only a side issue."

Another man got off the first line and forgot the rest and thus cast a reflection on the sex, he stammered and broke down:—

"Here's to the Love that lies in woman's eyes,
And lies—and lies—and lies!"

OBITUARY

FITZGERALD UNIACKE ANDERSON, L. R. C. S. Edinburgh, 1883, L. R. C. P. Edinburgh, 1883, M. R. C. S. England, 1884, Halifax, N. S.

Following an illness that extended over two years, Dr. F. U. Anderson passed away April 14th, at his home at No. 7 Hollis Street, Halifax, aged 72 years. The following obituary appeared in the local newspapers:—

The death occurred yesterday morning of Dr. Fitzgerald Uniacke Anderson, who had just entered his seventy-second year. Two years ago he was operated upon by Dr. Harvey Cushing of Boston for a tumor on the brain. For a few months afterwards he enjoyed fairly good health, but for the last year he had been confined to his bed with a gradually increasing paralysis.

He was born in Halifax. His grandfather had come from Scotland to an important position in the Dockyard. Dr. Anderson studied medicine in Edinburgh and in 1883 gained the diploma of the Royal College of Surgeons there. He also became a member of the Royal College of Surgeons, England. On his return to Nova Scotia he settled in Yarmouth, but came to Halifax about 1890, where he soon took a leading place in his profession. He was regarded as a wise counsellor, a faithful and cheerful colleague, and enjoyed in a high degree the confidence and affection of his patients. He was esteemed as a man of sterling character and strong opinions, but modest and somewhat retiring in disposition. He was an unusually good anatomist and for years assisted the late Dr. Lindsay, Professor of Anatomy in the Medical School. The increasing strain of a large practice affected his health and he retired from active practice in 1905.

Dr. Anderson was a great lover of outdoor life. He was an expert angler and also a very good shot. He was also an accomplished yachtsman, and on his retiring from practice had a fine yacht built, the well-known *Wawa*. Few men knew the coast of Nova Scotia as he did. He made frequent cruises with a south shore fisherman for crew and occasionally a friend or two, all round Nova Scotia and up the Gulf of St. Lawrence as far as Gaspe, and could tell of some thrilling experiences. He was at one time Vice-Commodore of R. N. S. Y. S., and last year was made an honorary member of R. N. S. Y. S.

But when the war broke out in 1914 he sold his yacht and devoted himself to war work. At the time of the Explosion he did a great deal of valuable service, not only in the overwhelming amount of surgical work which taxed the energies of all the doctors in the city, but in an executive capacity, organizing and directing relief work.

In recent years he took pleasure in his motor car and travelled all over the Province. Among his many accomplishments he was an excellent amateur mechanic and had imported from England a very fine lathe with which he amused himself in the winter months, grinding and polishing castings for the repair works in the machinery of his car.

That he had been retired for twenty years from the active practice of his profession will account for the fact that he was probably unknown to one-half of the doctors of the day.

But there are still a goodly number of doctors and a very great number of old patients who will learn of his passing with great regret but with happy memories of days that are gone, a prominent member of the profession said last night.

The death occurred of a well known Nova Scotian in the passing of Capt. Amos Burns, on March 31st, 1929, at the home of his daughter in Annapolis Royal, after a very considerable illness. He was 87 years old and spent many years of his life on the sea. He is survived by two daughters and three sons, one of whom is Dr. A. S. Burns of Kentville, to whom we extend sympathy.

The death occurred on March 13th, 1929, at Burnside, Pictou County, of Geo. W. MacLeod, aged 61 years. He was acutely ill only one week. He had cardio-vascular conditions which had more or less invalided him for the past 15 years. He was unmarried and is survived by one sister and four brothers. Two of these brothers are Dr. R. H. MacLeod of Middle Musquodoboit, and Dr. F. T. MacLeod, of New Waterford, to whom we extend sympathy.

The death occurred recently in Pictou of Mr. D. L. Trites, father of Dr. C. B. Trites, of Bridgewater. He was possessed of good business ability and the soul of honesty and for some 15 years the efficient Secretary of the local Telephone Company.

The death occurred at Port Mouton, on April 2nd, of Mrs. H. Homans, at the age of 65 years. She had been in failing health for several years. Dr. C. O. Homans of Sheet Harbor, is a son of the deceased.

On April 22nd, 1929, Captain Albert Lawrence, a prominent and respected citizen of Hantsport for many years, passed away following a cerebral hemorrhage which occurred five days previously. He was one of many men in Hants County who were engaged in building and sailing the wooden ships of former days. Mrs. Sutherland, wife of Dr. R. H. Sutherland, of Pictou, President of the Medical Society of Nova Scotia, to whom we extend sympathy, is a daughter of the deceased.

The death occurred in March last at his home in Oxford, Nova Scotia, of the father of Dr. W. W. Patton of Port Morien.

The death occurred April 24th, 1929, at her home, 323 Brunswick Street, Halifax, of Mrs. Barton, wife of Dr. W. J. Barton, after an illness extending over six years. Her husband and five children survive her. Until her illness she was very prominent in many spheres of church, educational and social activities. Rev. Father Penny of Bridgewater and Prof. John H. Penny of Harvard University are brothers of the deceased and Sister Claire of the Mother House in Boston of the Convent of the Sacred Heart is a sister. To Dr. Barton and family the BULLETIN extends sincere sympathy.

The local daily newspaper in about the largest town in Nova Scotia gave very considerable prominence to the appointment of a local Health Officer. Following this account of the incident the same report dealt with the appointment of Dump Tenders. We are wondering if perhaps in these very essential but insufficiently paid positions we are not inclined to cheapen ourselves by not avoiding competition.

Locals and Personals

IN 1792 Neil MacNeil established himself in Mabou, Cape Breton, the first of a distinguished family. The Glace Bay *Gazette* recently published a very interesting account of this family many of whom became prominent in Church and State. We note that only two descendants are members of the Medical profession. One is Dr. Alexander John MacNeil a graduate of Baltimore in 1904, now residing at Mabou. The other is Dr. Daniel MacNeil, Dalhousie 1913, now in practice in Glace Bay.

The BULLETIN is very glad to acknowledge receipt on its exchange list of the *Medical Journal* of the University of Toronto for the month of April, 1929. It is an exceedingly interesting number and is very creditable to the student body who publishes it.

Supplementing recent notes on early practitioners in Lunenburg please see 1925 BULLETIN for June giving minutes of their early Society formed September 21st, 1867.

The Provincial Officer of Health has issued the following statement regarding the number of Smallpox cases in the several provinces of Canada from October, 1928, to March 9th, 1929:—

Prince Edward Island	4
New Brunswick	0
Quebec	289
Ontario	239
Manitoba	95
Saskatchewan	140
Alberta	46
British Columbia	68
	— 888

There should be no let up in the matter of vaccination in Nova Scotia and in Halifax in particular.

Heard at a Medical Banquet not so long ago:—"Like Lot's wife, above suspicion." "Standing by the bier of Cleopatra—I come not to talk but to bury Mark Anthony."

When will this building up of words ever stop? A certain drug firm described its phararmaceutical product as follows:—"An equimolecular compound of sodium aminopyrinsulphonate with dimethylaminophenyldimethylpyrazolon."

Mrs. Balcom, wife of Dr. P. P. Balcom, recently returned from a short visit to her friends in Boston.

Dr. A. R. Melanson, of Eel Brook, Pictou County, was a patient for a time in March in the Halifax Infirmary.

Dr. Eva Mader, of Halifax, who has been doing Post Graduate work in Toronto, was unfortunate enough in the month of March to be laid up with an attack of Scarlet Fever.

A property that for a considerable number of years has been identified with the medical men of Kentville is about to pass over to the control of the Canadian Pacific Railway, who will construct a new hotel on the site of the old Webster properties in that town. Dr. H. B. Webster is the last surviving medical man of this name living in the town.

When the 17th of March comes around there are always some doctors who grace the occasion. In this instance, we have in mind Dr. W. J. Egan, of Sydney, who on that date addressed an audience in Reserve.

Dr. W. W. Patton, of Glace Bay, gave an address recently on Pensions to the Glace Bay Branch of the Canadian Legion.

It is understood that Prince Edward Island is again to have a Tuberculosis Sanatorium. When the Dalton institution was abandoned by the D. S. C. R., it was felt that the resources of the Province were not sufficient to warrant its continuance as a Provincial Institution. The activity of local agencies assisted by the Canadian Tuberculosis Association, is apparently responsible for this further effort.

Among recent visitors to Halifax who called on the General Secretary were Doctors C. L. MacMillan of Baddeck, K. A. Baird, of Canning, and C. E. A. deWitt, of Wolfville.

A woman is as old as she looks and a man is old when he stops looking.

Apparently Dr. A. E. Blackett of New Glasgow intends to develop some specialty in Dietetics, besides X-Ray work, as witness his very entertaining address given recently to the Local Council of Women on Food.

Mrs. Robbins, wife of Dr. W. H. Robbins of New Glasgow, was operated on in the Aberdeen Hospital the latter part of March and has made a very satisfactory recovery.

"If you were my husband," said the woman, "I'd give you poison."
"And if you were my wife," retorted the man, "I'd take it."

A bill has recently been passed by the Delaware State Legislature which requires the recorder of deeds in each County to deliver to the state board of health all books, including indexes and loose leaf binders, relating to births, deaths and marriages.

Evidently the matter of Vital Statistics for which Dr. Jost did so much for Nova Scotia still occupies a large place in the administration of the Delaware State Department according to Dr. Jost their present secretary.

Dr. Hugh Ross of Sydney spent a few days in Halifax early in April.

Dr. E. I. Glenister, Dartmouth, was in the Victoria General Hospital early in April on account of an infected finger.

Dr. D. W. N. and Mrs. Zwicker of Chester spent a couple of days in Halifax last month.

Dr. G. M. L. Hatfield of Yarmouth spent a few days in Halifax recently and was thoughtful enough to call on the General Secretary. If more of the doctors would do this when in the City it would help our organization materially.

Doctors Gouthro, Roy, N. McDonald, and McKeough of North Sydney, by the close margin of one point, managed to defeat some fisherman curlers sometime in February last. Of course, the fishermen were handicapped in being used to water while, we note, the ice at the time was very keen.

After 43 years of steady work Dr. John W. McLean of North Sydney is taking a long delayed vacation. He is now visiting in England and Scotland. While in London he will visit his daughter, Mrs. (Dr.) Joseph Hunter, formerly Dr. Jean McLean, Dalhousie, 1914. We think Dr. McLean, who is an Honorary Member of the Medical Society of Nova Scotia, has attended a few sessions of the Presbyterian Synod in these many years, but they could not be regarded as vacations. We trust he will have a very pleasant trip.

Dr. H. R. Corbett of the staff of the Nova Scotia Sanatorium, was in attendance recently at an X-Ray conference in Michigan.

Dr. Hubert A. Lyons of Dalhousie, 1923, formerly of Kentville, now of New York, has sailed for Paris to spend a number of months in Europe and Great Britain.

Dr. M. G. Tompkins of Dominion recently returned from a two months' stay in Toronto.

Dr. W. B. Moore, formerly of Kentville, has been residing in Italy for much of the past winter. Recently he sent the Kentville *Advertiser* some newspaper clippings regarding electoral regulations in that country. He is also a great admirer of Mussolini.

Dr. W. H. and Mrs. Hattie recently returned to Dartmouth after spending the winter in the South. We are glad to know that the Doctor's health has greatly improved.

Both the Halifax City Reporters and the Provincial Press made considerable reference to the Annual Meeting of the Halifax Medical Society as one of the Medical Society of Nova Scotia. As a matter of fact the newly elected President, Dr. J. R. Corston, made the suggestion at our last meeting, our 75th Anniversary, that there was a question as to the paternity or maternity of the Halifax Branch. But we all know the great obligation the medical profession in Nova Scotia owes to the medical men in Halifax, 75 or more years ago, as well as to-day.

Mrs. McLeod, wife of Dr. John Knox McLeod of Sydney, was a visitor in New York in April and May. She was the guest there of her son Ross McLeod.

In the latter part of April the City Hospital of Sydney graduated five native born nurses. Two veteran medical men, health officers, with others, mostly clergymen, gave addresses, Doctors A. S. Kendall and J. K. McLeod.

According to a recent debate in New Waterford in the Calvin church hall, Dr. F. T. McLeod belives the expulsion of the Acadians was justifiable. He may be right.

Sister Frances Teresa, who has for some years been the very efficient head of St. Joseph's Hospital, Glace Bay, has been transferred to Lethbridge, Alberta, to take over a new hospital recently constructed and will be under the administration of the Order of the Sisters of St. Martha. The Reverend Sister, previous to her departure was presented with several gifts and addresses. All members of the medical profession who have visited St. Joseph's Hospital in recent years will regret to learn of her transfer to this new field.

"May I call on you?"
"I'm sorry, but I'm married."
"Well, I'm married too and just as sorry."

Psychotherapy and the General Practitioner

"We must not lose sight of the fact that people have faith in local treatment, that it appeals to their imagination and that—just to this extent—it carries with it *psychotherapeutic potency.* From all these considerations may be coined the therapeutic maxim: *'Use appropriate topical treatment in all conditions in which it is justifiable'.*"
B. Fantus, M. D. ("The Technic of Medication", A. M. A. Press, 1926).

From time immemorial psychotherapy has played a large, though often unrecognized, part in all successful treatment. The application of the general principles of psychotherapy includes all measures, apart from the physical, of influencing the patient and of helping him to overcome disease.

The sensation of pain certainly belongs within the compass of the psychotherapeutist. The pain sensation is exhausting, the fight against the pain decreases the resistance of the individual, and interferes with the normal flow of the mental life. The psychotherapeutic effort, directed toward removing the source of the pathologic disturbance, inhibits the pain by filling the mind with agreeable feelings and pleasant ideas, until the normal equilibrium is again restored.

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