# CONTENTS

# How PABLUM Compares with five principal foodstuffs in essential minerals and vitamins and other nutritional values

| Constituent | PABLUM | ROLLED OATS | FARINA | WHITE BREAD | WHOLE MILK | EGGS | |
|---|---|---|---|---|---|---|---|
| | % | % | % | % | % | % | |
| Calcium | 0.780 | 0.069 | 0.021 | 0.027 | 0.120 | 0.067 | Pablum is rich in minerals and vitamins. It is noteworthy that the calcium-phosphorus ratio of Pablum is 1.2:1, similar to that of average whole milk, which is considered the most favorable ratio for retention. |
| Iron | 0.03 | 0.0038 | 0.0008 | 0.0009 | 0.00024 | 0.003 | |
| Phosphorus | 0.620 | 0.392 | 0.125 | 0.093 | 0.093 | 0.180 | |
| Copper | 0.0013 | 0.0005 | 0.00017 | 0.00034 | 0.000015 | 0.00023 | |
| Vitamin A | + | — to + | — | — to + | + + + | + + + | |
| Vitamin B($B_1$) | + + + | + + | — to + | + | + + | + to + + | |
| Vitamin C | —* | —* | —* | —* | —* | —* | |
| Vitamin D | —** | —** | —** | —** | —** | —** | |
| Vitamin E | + + + | + + | — | — | + | + + | |
| Vitamin G | + + + | + | —to + | + | + + + | + + + | |
| Moisture | 7.0 | 8.0 | 10.9 | 35.3 | 87.0 | 73.7 | |
| Protein | 15.0 | 15.2 | 11.0 | 9.2 | 3.3 | 13.4 | These figures are included to illustrate ordinary nutritional values. Calories, carbohydrates, fats, and proteins constitute a less serious nutritional problem. |
| Fat | 3.0 | 7.3 | 1.4 | 1.3 | 4.0 | 10.5 | |
| Carbohydrate | 70.8 | 66.2 | 76.3 | 53.1 | 5.0 | — | |
| Calories per oz. | 106 | 110 | 103 | 74 | 20 | 42 | |
| Alkaline Reaction | ✔ | | | | ✔ | | |

* **The daily use of specific vehicles for vitamins C and D (e. g., orange juice for C and cod liver oil or viosterol for D) together with the use of Pablum makes it possible for the physician to supply the growing child with all of the essential vitamins in substantial quantities.


*Pablum consists of wheat-meal, oatmeal, cornmeal, wheat embryo, brewers' yeast, alfalfa leaf, beef bone, iron salt, and sodium chloride. Supplies vitamins A, B, E, and G and calcium, phosphorus, iron, copper, and other minerals. 1 lb. packages at drug stores. Samples are available to physicians.*

PABLUM (Mead's Cereal thoroughly pre-cooked by a patented process) is richer than ordinary foodstuffs in calcium, phosphorus, iron, and copper and also contains vitamins A, B, E, and G. In addition, Pablum supplies an abundance of protein, carbohydrate, and calories. It is unique in that it is the only base-forming cereal. Having a fiber content of only 0.9%, Pablum can be fed even to very young infants and hence, because of its high iron content (8½ mgms. per oz.), becomes a valuable prophylactic against the nutritional anemia so frequent in early life. Cooked by a patented steam-pressure process,—

PABLUM REQUIRES NO FURTHER COOKING

# Placenta Previa

By G. F. DEWAR, M.D.

OBSTETRICS, one of the fundamental divisions of medicine in its strictest sense, has reference to the care of women in childbirth, but it is now much broader than that and includes the care of women from the beginning of pregnancy, watching the different ailments and disturbances which may arise, the treating of them intelligently; and in addition the care of women in the puerperal state. Consider for a moment the responsibilities of the obstetrician—two lives at stake; perhaps suitable precautions have not been taken by the pregnant woman regarding her diet, regarding the elimination of waste products with the result that emergencies may arise which may be unexpected, but which nevertheless require prompt action or a fatal result may occur. And sometimes when every precaution is taken, dangerous symptoms arise during the course of pregnancy and the man who hesitates is lost.

We all know how apt friends and neighbours are to cast blame upon the obstetrician in fatal cases because a great majority of people regard pregnancy, labor and the puerperal state simple and natural conditions.

In medical and surgical practice there is usually time to obtain advice and assistance so that responsibilities may be shared and the friends and public feel that every thing has been done to prevent a fatal result: but the doctor in the middle of the night, miles from help, with useless assistants and the lives of two persons in his hands, should an emergency arise, has a very grave responsibility.

In the management of pregnancy there are many disorders which are very serious, and some are positively dangerous, but most of them give sufficient warning so that measures can be employed to correct them. Even in that grave condition known as eclampsia, some warning is given such as headache, nausea, vomiting, giddiness, epigastric pain, etc., and there is time to undertake active treatment and the same with regard to other grave conditions.

It is my intention in this paper to talk about a very grave emergency, one that gives very little warning, and one that demands skillful and intelligent treatment at the hands of the practitioner. I refer to that condition of unavoidable hemorrhage where the placenta is situated at the os uteri. I shall endeavour to present the treatment practiced years ago, as well as that employed at the present time.

Many of us have had several cases in our practice, and all of us are bound ro meet these cases, consequently I consider it a very important subject. In this condition of unavoidable hemorrhage there is a partial separation of the placenta which is abnormally placed; usually, perhaps always, the child is viable.

Accidental hemorrhage may occur, where there is a normal implantation of the placenta due to some diseased condition, but a careful vaginal examination may clear up the diagnosis.

*Read before the annual meeting of the Nova Scotia Medical Society, at Sydney, July 1935.

Placenta Previa is divided into 3 degrees, complete, partial and marginal.

1. Complete attachment, or central in which the centre of the placenta corresponds in situation with the internal os.
2. Partial. Covers the os but the margins of the placenta are not equidistant from it.
3. Marginal. The os is not covered, but the placental edge projects to it and may partially cover it.

A lateral is sometimes spoken of which is low down, quite near the internal os. This condition may not be detected. The patient may go to full term and the fact that there is a considerable amount of bleeding during labor and post partum may cause the suspicion that there has been a low implantation of the placenta.

Dr. Robert Barnes delivered a lecture at the International Congress of Diseases of Women and Obstetrics in Brussels in 1892, showing the division of the uterus into three zones:

1. Superior or fundal zone.
2. A middle or equatorial zone.
3. Inferior zone or lower part below Bandl's ring. This is where the attachment occurs in placenta previa.

1. This is separated from the equatorial zone by an imaginary line which may be called the superior polar circle. It marks the distinction between the characters of the superior and equatorial zones in their relations to the placenta attachment and to hemorrhage. In this zone is the seat of the normal placenta.

2. The equatorial zone is the seat of lateral or equatorial placenta. The lateral attachment of the placenta extends upward into this zone.

3. The inferior zone is separated from the superior by what is known as the ring of Bandl. This is the danger zone for an attachment of the placenta. Any placenta which encroaches upon the inferior zone is liable to premature separation.

*Frequency.*

There is quite a difference of opinion regarding the frequency of placenta previa.

Older writers, such as Johnson, Sinclair, Parvin and Schwartz, make the range from one in five hundred and seventy-three, to one in fifteen hundred. Six hundred thousand cases, compiled from several European hospitals make it one in twelve hundred cases. Pazzi makes it one in seven hundred and forty-eight.

Townsend in 1895, compiled 6,700 cases from the Boston Lying-In Hospital and gave 28 cases, or one in 239—other writers say this report does not seem correct. More modern writers, such as Shears, say one in two hundred cases, but he admits that reliable hospitals give one in one thousand.

One maternity hospital reports 223 cases in 25,000 deliveries, or one in one hundred and twelve cases. Of course, many cases of lateral attachment may pass unnoticed.

As regards the attachment, it is estimated that central occurs in about 25% of cases.

Multipara are more prone than primipara by six to one, some writers say three to one.

*Cause.*

It is perhaps a matter of speculation. We know that it usually occurs in multipara, that it may be due to a diseased mucous membrane caused by abortion, sepsis, etc. Malformation, tumours, subinvolutions, displacements may be causes. It is also claimed that many cases of abortion may be caused by abnormal implantation of the ovum. There are cases of abortion when we feel satisfied that nothing has been done to cause it, and we are unable to satisfy either ourselves or the patient; probably some of these may be due to an abnormal implantation of the ovum, due to a diseased mucous membrane.

In these cases if an abortion did not take place, they might be cases later of placenta previa.

The attachment of the placenta in the lower uterine segment necessitates its separation in part before the child can pass through the cervix. This separation may be before labour or coincident with it.

As the lower uterine segment expands the placenta slips and a bleeding takes place.

The effects of a low implantation of the placenta are:

1. Bleeding comes on before labour is due and pregnancy is brought to a close prematurely by placenta previa, particularly when the attachment is central.
2. There is apt to be uterine inertia from loss of blood, rigidity of the cervix, etc
3. There may be an abnormal presentation.
4. Post partum hemorrhage may follow delivery, due to uterine inertia.
5. Sepsis may occur.

*Symptoms.*

Painless hemorrhage. This may occur before term, particularly if there is a complete attachment, or at term, or near term. The blood is bright, the bleeding is usually profuse, there may be blanching of the face, the pulse is fast, there may be giddiness and faintness. The woman is in a highly nervous state. External examination shows the child to be high up in the uterus. In many cases the head is not engaged if it is a vertex presentation.

A vaginal examination shows an abnormal absence of the presenting part and the cervix feels soft and thick. The os usually admits one or two fingers and a soft mass is presenting and if this covers the os it is either a complete or partial attachment of the placenta.

If a mass is not felt after the hemorrhage, but the presenting part of the foetus is felt it is likely accidental hemorrhage from a normally situated placenta which became separated from the uterus.

*Diagnosis.*

When a pregnant woman at seven or eight months bleeds apparently without cause, she likely has a partial or complete placenta previa. If at full term or near term, it is likely marginal or lateral. If the os is penetrable the finger can touch only placenta tissue in the central variety: in the partial by carrying the finger far in placental tissue is felt on one side and membrane on the other. In the marginal variety the border of the placenta and the membranes are each felt provided dilatation of the os with effacement of the cervix has not occurred, but if it has occurred the placenta has been carried up

with the internal os and only membranes are felt. In lateral attachments it cannot be felt unless the hand enters the uterus.

To diagnose it from an accidental revealed hemorrhage may sometimes be difficult. Roentgen Rays are now employed for this purpose.

*Roentgen Rays in Diagnosis of Placenta Praevia.*

"At the Edinburgh Obstetrical Society a new use was described for the roentgen rays—their assistance in the diagnois of placenta praevia—by Prof. Munro Kerr and Dr. W. G. Mackay. Introducing the subject, Kerr referred to the high percentage of maternal deaths in placenta praevia and the importance of adopting the method suitable to the individual case if this mortality was to be reduced. There was difficulty not only in diagnosing the variety of placenta praevia present but also in differentiating between placenta praevia and accidental hemorrhage. Therefore any method that would not only differentiate placenta praevia from accidental hemorrhage, but also show which variety was present was valuable. He then called on Dr. Mackay to demonstrate a method which they had investigated together.

Mackay first discussed previous investigations that had been made in order to locate the position of the placenta in the uterus. The only one at all satisfactory was that of Manees, Miller and Holly, who injected strontium iodide into the amniotic sac. The placenta, which projected into the cavity, produced a defect at the edge of the shadow when the uterus was pictured from the correct angle. Kerr and Mackay tried this method in ten cases but gave it up, as the fetus died in three cases. They substituted a derivative of iopax, which is montoxic and nonirritant, for strontium iodide. They found that 20 cc. produced a suitable shadow. In ten cases in which this procedure was followed, no untoward effects occurred to either the fetus or the mother, though the injection had a great tendency to terminate the pregnancy. It was necessary to take at least two roentgenograms, one antero-posterior and the other lateral, so as to be sure of getting a full view of the indentation made by the placenta. A number of roentgenograms were thrown on the screen demonstrating the position of the placenta not only in normal cases but also in cases of placenta praevia. In the latter they showed exactly how much of the placenta was in the lower segment and covered the os. Various errors that had to be avoided, such as those due to gas in the bowel and to the presence of two sacs, were described. It was also shown how roentgen rays could in certain cases enable the sex of the child to be diagnosed and show whether any coils of cord were round the child's neck."—*Foreign Letters.*

*Prognosis.*

Forty or fifty years ago the maternal mortality was 20 to 30% and the fetal mortality 50 to 65%. Erdley Holland in 1921 reported 78 cases of complete placenta previa with a maternal mortality of 14%, and 43 cases of incomplete variety with a maternal mortality of 9%. Other writers report a lower death rate. At the same time the foetal mortality would be 50 to 60%. The fatal results are chiefly due to loss of blood, shock from rapid delivery and sepsis.

There is also the danger from post partum hemorrhage in a patient who has already lost a quantity of blood.

In addition to this there may be severe laceration of the cervix which is very soft and will tear like wet blotting paper if there is too rapid a dilatation of the os uteri.

The variety of the attachment of the placenta and the condition of the patient when treated are very important factors in prognosis.

The prognosis is much more favourable with the newer method of treatment.

*Treatment.*

It depends largely on circumstances, therefore there is no fixed treatment for all cases.

I wish to report four cases which occurred in my practice from November 1st, 1934, to March 27th, 1935, (or) a period of five months.

*Case No.* 1—Nov. 1st, 1934—Mrs. McE, age 36, multipara. Was called in consultation to the country about twelve miles away. She was in her ninth month. She had a painless hemorrhage some hours previously and the local doctor had been with her from the beginning. I found her very weak from loss of blood. On examination the cord and part of the placenta were felt protruding from the os uteri—the head was not engaging although the os was partially dilated.

I did a version, giving her very little anaesthetic. The placenta came away at the same time as the child which was evidently dead for some hours.

The usual attention was given to the mother who gradually improved. She became septic but eventually made a good recovery.

*Case No.* 2—Mrs. V., Multipara, age 34. Was called 8 miles away on January 9th, 1935. She had a sharp painless hemorrhage a few hours previously. Examination showed a marginal attachment of the placenta. I packed the vagina and had her removed by sleigh to the Prince Edward Island Hospital where I did a Caesarean operation. Both mother and child made an uneventful recovery.

*Case No.* 3—Feb. 28, 1935. Mrs. C., Primipara, age 36. Lived in Charlottetown. Was pregnant eight months; while at work had a sharp painless hemorrhage. Examination showed a condition of placenta previa. I had her removed to the Prince Edward Island Hospital and a few hours afterwards did a Caesarean operation. Both mother and child made a good recovery.

*Case No.* 4, March 26, 1935. Mrs. L. C., Primipara, age 27. Seven and a half months pregnant. Had an attack of influenza from which she was slow in recovering. There was also a death in the family from the same cause. One week after her recovery from influenza she had a sharp painless hemorrhage. She lived four miles from the city. I saw her two hours after the attack. She had no pain, the child was very high in the uterus, I was able to feel the head. As she was still bleeding I packed the vagina and had her removed to the hospital. The following morning after consultation it was decided to do a Caesarean operation. There was a small fibroid on the fundus. When the uterus was opened it was found to be a case of separation of a normally situated placenta. The child was dead likely for a few days. She made a good recovery.

I do not wish it to be understood that I am in the habit of having three or four cases of placenta previa in as many months. Such is not the case. Like any other practitioner I see a case occasionally, but this out-break was so unusual I decided to report it.

The first case demonstrated the fact that treatment depends largely upon circumstances. She was not in a suitable condition to be removed to the hospital. It is also likely that the local doctor had been attempting to deliver which accounted for the loss of so much blood. The other cases were able to be removed to the hospital and the treatment of choice was undertaken with very favourable results.

Having made the diagnosis it is necessary to take measures to empty the uterus. I think all authorities are agreed on this because a fatal hemorrhage may occur at any moment.

Erdley Holland as reported by Rendle Short in Prognosis and Treatment says that there is one circumstance only where active treatment may be delayed, where the patient is almost collapsed from loss of blood and the hemorrhage has temporally ceased. Blood transfusion and other suitable measures should then be taken to restore her.

Berkely and Bowney Shears and other modern writers say the same thing. Even older writers such as Parvin, writing forty-five years ago and Byford and Playfair, writing sixty years ago advocate active measures to empty the uterus if bleeding is severe.

Writers up to about 1910 all advocate the tampon, the hydrostatic bag, version if the os is not too well dilated, and forceps if the condition of the cervix is suitable. After 1912 Caesarean operation was added to the method of treatment. It was in the Lankenau Hospital in Philadelphia that the first Caesarean operation was performed for placenta previa, about 1910. Dr. John Deaver of Philadelphia was one of the first to treat placenta previa in this way: he recommended it in every case, as it gave the best chance to the mother and child at once, and overcame the danger of sepsis and post partum hemorrhage. Hirst is also a believer in this treatment but he does not employ it in all cases even in the hospital. He says, if the os is dilating to admit two fingers and if the patient is a multipara, version should be performed. Eardley Holland of London says that in a multipara if the os shows signs of dilating and if the membranes can be ruptured, version may be done, but in a primipara with a rigid os, if there is a central or partial attachment, Caesarean operation should be performed; but he says there should be good surroundings, asepsis, efficient help, no previous attempt to deliver, and the patient not too weak from loss of blood.

These authorities of a few years ago admit that if conservative methods are used there is the danger to the mother of fatal hemorrhage, or if she recovers, there is the danger of sepsis, of a laceration of the cerix due to a too rapid delivery with the result that she may be an invalid for some time. There is also the danger to the child, the fetal mortality under the most favourable circumstances being not less than 40%.

E. F. Daily of Chicago Lying In Hospital says—in a patient with a living viable fetus, os partially dilated, with marginal attachment, the membranes may be ruptured, allowing the head to come down and act as a compressor. If that is not sufficient a bag will control the bleeding, or if the baby is dead the scalp can be grasped by a forceps to which a weight may be attached. This would appear to be no better than version, bringing down the half breech.

Daily recommends Caesarean section in certain cases.

L. A. Phaneuf reports 57 personal cases—some were treated by the conservative method with a maternal mortality of 8.6% and a fetal mortality of 66.6%—for the surgical treatment the maternal mortality was 2.9%, and the

fetal 17.1%; of course some of the fetal deaths were due to prematurity. Other present day writers while claiming to use conservative methods in certain cases admit that by operative treatment the maternal mortality is reduced to .99% If there are mechanical difficulties, such as a contracted pelvis and other abnormalities, Caesarean section is advocated.

Joseph B. DeLee rejects the tampon and the bag; he says version seems necessary when delivery takes place at home, or if the child is dead. He does not adopt Caesarean operation in all cases but he says it is the treatment of choice.

*Placenta Praevia.* Wilson, R. A.

"During a period of eight years and eight months ending September 1, 1933, 102 cases of placenta praevia were treated in the Methodist Episcopal Hospital, Brooklyn. In this number 68 were partial and 34 complete, marginal cases not being included. There were 2 maternal deaths, giving a percentage of 1.96. Conservative methods were used in 70 cases, with 2 maternal deaths and 28 viable stillbirths. The 32 cases treated by classical Caesarean section, however, resulted in no maternal deaths or stillbirths. Transfusion was performed once or more in 15 patients, or in 14.7 per cent of the case.

In view of recently published statistics and his own results, Wilson recommends Caesarean section in most cases of partial and complete placenta praevia. The patient should be in a good hospital and in the hands of a competent operator; poor results may be expected if these two requirements are not fulfilled. It is imperative that blood be quickly available for transfusion before, during, and after operation. If the patient must be treated at home, conservative methods are followed. This would apply also if the patient were infected, or the cervix fully dilated and delivery imminent. Excessive haemorrhage at the time of operation may be controlled by packing the uterus with gauze soaked in mercurochrome. Caesarean section not only gives maternal results as good as, or better than, the conservative methods, but in addition we need no longer completely disregard the baby, thereby saving many which would otherwise be lost."—*Am. J. Obst. & Gyn.*, 1934, 27:713.

Fifty years ago Parvin said that the practitioner will act wisely who adapts his treatment to the conditions of the case. It may be necessary to use the tampon, in one case, to use dilators in another, to perform version in a third, to apply forceps in a fourth, simply to rupture the membrane in a fifth, or to combine two or more of the various methods. All these when so used being but means to an end, delivery. At that time these were the only means at their disposal. They felt that delivery must take place to save the mother and one or more of the above mentioned methods must be adopted.

To-day, a half a century later, we have the same object in view, i.e. to deliver the woman as her condition is serious. Recognized authorities to-day condemn the tampon, the bag, and admit of version under certain conditions but they have a strong lever in Caesarean operation.

Under the methods of long ago, the fetal mortality was terrible, as the mother was the chief concern, to-day, in addition to saving the mother, a strong effort is made to save the baby as well.

# "Pulmonary Complications Following Surgical Operations"*

GERALD ROSS BURNS, M.D.

DURING a recent review of American and English literature on the subject of pulmonary complications following surgical operations, I was struck by the high percentage of operative cases which developed pathological conditions in the lungs after the operation. In my limited experience of five years as attending physician to the Victoria General Hospital, I have had the opportunity of investigating some of these complications. Unfortunately we have not collected any accurate figures, but I do believe that the frequency of these cases warrants us to discuss the subject as there are certainly ways and means to prevent these conditions from developing—and also to recognize and to treat them effectively.

Statistical figures are usually tedious to read or to listen to, nevertheless they are facts and I am going to read a few figures which will help to emphasize the statement that pulmonary complications are a too frequent sequalla of surgical operation. Lemon estimates that one in every fifty patients operated on may be expected to develop some type of post operative pulmonary complications, and that one out of every one hundred and eighty-five will die of such a complication. Cutler and Hunt, in a collected series of 18,075 cases, found that two percent of patients operated on for any reason, four percent of patients in laporotomy cases, and eight percent of upper abdominal operations develop such complications. McKesson found 3.03 percent of lung complications in 39,438 cases. Gray, of the Mayo Clinic, reports 422 operations on the stomach and duodenum,—in 10% post operative pulmonary conditions developed. Aikenhead of the University of Manitoba reports 33.066 operations with fifty-five respiratory complications. From these figures it is apparent that pulmonary complications following surgical operations are by no means uncommon—and the fact is also brought out that the complications may follow local or spinal anaesthesia, as well as general. Certainly there is a higher percentage of lung complications following operations on the upper abdominal cavity than the lower.

The complications that may follow surgical proceedures include: Pneumonia, Bronchitis, Abscess, Gangrene, Infarction, Pleursy and Atlelectasis.

In order to explain the mechanism of these complications various theories have been brought forward which may be grouped.

1. Aspiration theory.
2. Embolic theory.
3. Lymphatic theory.

Certainly, there is no one of these theories which can be accepted fully to explain the mechanism, perhaps there may be a combination of several factors. It does seem most likely that, in the case of Pulmonary Atlectasis there are

* Read before the annual meeting of the Eastern County Medical Society, at Antigonish, November, 1934.

several factors. The Embolic theory loses ground on anatomical consideration, for it is difficult to understand how emboli which are set free from some abdominal focus can travel through the portal and hepatic circulation without being held up in the liver before reaching the Lungs, and certain it is that liver abscess is most infrequent, and practically never seen, following surgical operations. The Lymphatic theory is dismissed without discussion in Pulmonary complications following operations on the upper respiratory tract because the Lymphatic drainage of the neck and mouth is quite independent of the thorax. But this theory has its supporters, especially Higgins and Graham who claim it does play an important part in upper abdominal operations. These workers prove that one of the main routes of lymphatic drainage from the upper abdomen is by way of "efferent lymphatic canals passing through the diaphragm—and that normal muscular contraction of the diaphragm contributed much to the passage of particular matter through the diaphragm". Operations on the upper abdominal cavity are attended by what might be called a splinting of the diaphragm, which is either mechanical or reflex; mechanical, due to adhesive strapping and bandage, reflex, due to pain and infection. As a result of this splinting, there is brought about a decreased vital capacity of the lungs and stasis of the lymph flow through the diaphragm. So that there follows a primary involvement of the diaphragmatic pleura and extension to the parenchyma of the lung. The Aspiration theory is the most widely accepted one. In upper abdominal operations on the stomach and duodenum, there is a necessary handling of the parts, which causes a reflux of the gastric contents. With full inhibition of the cough reflex due to the general anaesthesia, the refluxed material escapes down the trachea into the lungs. Even under a local or spinal anaesthesia this reflux may take place as nausea and vomiting are frequent with these anaesthetics—and the least traction on the stomach may produce these symptoms. The Aspiration theory, as may now be understood, does not then actually mean the aspiration of anaesthetic vapors but rather the aspiration of foreign material, blood, pus, stomach content and mucous.

The various complications that are likely to develop in the lungs seem to differ from the ordinary infectious conditions in the lungs.

1. There is no initial chill.
2. Pleural pain is rare.
3. Herpes on the lips are usually absent.
4. The pulse and temperature rise rapidly and assume a maximum in a few hours.
5. Effusions in the pleural cavity are rare.

There are two pulmonary complications which I should like to mention especially, namely Pneumonia and Atelectasis, because these are the two commonest complications which I have seen and which are sometimes most difficult to differentiate between—and because the treatment of the two conditions is different.

Pneumonia may be early, developing within twelve or within forty-eight to seventy-two hours or longer of the operation. It occurs in patients who have taken the anaesthetic poorly, who have had noisy, wheezy, sterterous breathing, who have been poorly relaxed, who have had a recent cold, who have vomited and who have been chilled going to, or in, or leaving the operating room. In the early pneumonias the temperature rises rapidly to 102-105°,

there is no chill, rarely pleural pain, cough is at first unproductive, and later is accompanied by purulent sputum, the physical signs are those of a widespread Bronchitis or Pneumonitis with scattered Rales over the chest, sometimes scattered patches of Broncho Pneumonia may be defined. The temperature falls by lysis in nine to twelve days. The so-called late pneumonia develops after forty-eight hours. It is usually ushered in with pain in the chest, rarely chill, cough and expectoration; which may be blood tinged, moderate fever 101°-104° an runs a septic type. The physical signs are those of pneumonia. The prognosis is bad in the aged and in those who are debilitated from previous disease.

The treatment of these pneumonias is along the following lines:—

(1) Early recognition and careful nursing.

(2) Abundant oxygen. In surgical wards where the air must be kept at a standard temperature and where other patients must be protected from draughts, it is not possible to give the fresh air treatment, so that the patient is fed oxygen. The method we have been using is by way of the nasal catheter. It is found best to bubble the oxygen through the water bath at 120 bubbles per minute—patients do not seem to object to this method and the loss of oxygen is slight.

(3) Symptomatic treatment of the cough. We have found particularly in the early pneumonias that the inhalation of medicated steam is especially soothing to the patient. It frequently aids in the expulsion of thick, tenacious sputum from the trachea and bronchial tubes, and in this way lessens the distressing cough and respiratory embarassement.

Pulmonary Atelectasis is by no means an uncommon complication and in our observations have noted its occurence as frequently as pneumonia. There are some clinical workers who are of the opinion that pneumonia and Atelectasis are really different stages in the same process. Atelectasis or collapse of the lung tissue has been recognizeed for nearly eighty years though only since 1925 have frequent clinical reports appeared in the journals about this condition. Quite apart from surgical operations it appears as a complication following injuries to the chest wall, and penetrating wounds of the thorax. It is not to be confused with Pneumothorax, in which condition we have a collapse of the lung resulting from an equalization of the intra pleura. and intra pulmonary pressures; whereas in Atelectasis, the lung tissue loses its air and contracts. The term, itself, is to be criticized because it means "failure of expansion"—a condition which is seen in the new born, a more descriptive term has been suggested "Apneumatosis", which means an airless condition of the lungs. I have come across no less than eight theories which have been advanced to explain Pulmonary Atelectasis following operations, some of them very fanciful and most of them inadequate to explain the process. It would seem then more fitting that the pedagogues go on with their research in explaining this phenomemon, and let us as clinicians accept its occurence and attempt to treat it.

Chevalier Jackson attributes post-operative Atelectasis as being due to a blocking of the bronchi or bronchioles with thick tenacious secretion. Certainly there are sufficient clinical examples to support his theory.

The symptoms and signs depend on the amount of lung tissue involved. In severe cases the attack comes on within 24 hours to 48 hours following the operation. The patient is seized with pain in his chest, dyspnoea, rapid

pulse, cough and expectoration—the latter is scanty at first and generally becomes abundant, purulent and blood streaked, cyanosis is common. The temperature becomes elevated shortly after the attack and rises to 101°-103°—the leucocyte count increases and may be 20,000. The patient lies on the affected side, with the spine bent, and head towards the affected side—as though to relieve the clutching sensation in his chest—If the area of lung tissue involved be extensive the affected side of the chest appears smaller—and there will be a shift of the heart and mediastinum towards the affected side. The physical signs over the affected side are:—dullness and even flatness on percussion, diminished fremitus and resonance, absence of breath sounds and no rales are heard. It has been called a "dead lung." In three or four days the physical signs gradually return, the lung becomes aerated again and coarse rales are heard over the affected area. In the more severe cases a broncho-pneumonia of septic type may develop, lung abscess or gangrene—these cases usually have fatal termination. On the other hand, with small areas of lung involvement, there may be no pain, dyspnoea or cyanosis, only slight temperature, cough and leucocytosis—the condition being recognized only by careful routine chest examination and X-ray investigation of the lung.

The treatment that we have been following is Posture. The patient is postured on the unaffected side and the foot of the bed is elevated, in an attempt to dislodge the plug which is obstructing the Bronchi. Medicated steam inhalations are also used. Sedatives, like Morphine and Codeine, should be used with caution because they banish the cough reflex and render the respirations shallow, and so prevent the re-inflation of the affected lung. Atrophine in doses of 1/100-1/150 gr. does seem to check abundant secretions. One other point of practical application here is the removal of all restraining bandages and clothing from the patient's chest and allow him as much free inspiration room as possible.

We need say only a few words about Pulmonary Infarction—under which term are included Thrombotic Embolism and Fat Embolism. Just how both these conditions are brought about is not understood the actual treatment is of no avail because they are usually fatal terminations. There are some observers who say that Thrombotic Emolism of the Pulmonary Artery follows a Thrombo phlebitis of the Femoral or Pelvic veins. Yet post-mortem findings do not always show this condition to be present. The attack comes on suddenly with a feeling of faintness, about one or two weeks after the operation. Frequently the patient has just left her bed for the first time, or has taken a tub bath, or has been strainging at stool. There is a feeling of constriction, frequently pain in the chest, intense dyspnoea, cyanosis and collapse—death may be instantaneous or may follow in five to twenty minutes. Head has reported a series of 104 cases of Thrombotic Embolism of the Pulmonary artery following operation—five cases survived the attack.

There is considerable controversy concerning the question of Fat Embolism. There are those who claim it is a frequent complication following operations, especially operations on the Long Bones and in areas where there is considerable deposition of Fat. These observers contend that many of the sudden deaths subscribed to shock, acute Heart Failure, Thrombtoic Embolism and Cerebral Haemorrhage following surgical operations are actually due to Fat Emboli which have passed through the right Auricle into the Pulmonary Artery. The attack comes on within the first or second day following the

operation—and especially extensive operations where there has been considerable manipulation of the long bones, the symptoms may be cardio-respiratory or cerebral. There is one point here that may be of practical application, in the choice of anaesthetics. In prolonged operations on the long bones, it is best to limit as far as possible the duration and depth of the fat dissolving anaesthetics, like Ether and Chloroform.

The most important point in the treatment of these pulmonary complications following surgical operations is the prevention, and avoidance of certain things which may predispose a patient towards having any of these distressing conditions developing.

Perhaps the most important step in the prevention is the selection of the patient—of course, this is applicable only in chronic surgical conditions. Recognizing the important role of upper respiratory infections, like the ordinary "cold," Rhinitis, Tonsillitis and dental sepsis, in the production of pulmonary infections, it should be the surgeons' rule never to operate on a chronic surgical condition in the presence of these upper respiratory infections. At least one week should pass by after the subsidence of any symptoms referable to these infections. In surgical emergencies, however, the anaesthetic, if it must be general should be carefully and skillfully given, and where possible, the preference is given to local anaestesia.

Far be it from any one just practicing the art of medicine to dictate rules and principles to the surgeon in the Operating Room. Nevertheless there are certain points which should be stressed. The Operating Room must be warm. Bearing in mind that the patient under general anaesthesia has a diffuse vasodilitation of his peripheral vessels, he must be protected by all possible means from any cooling to the surface of the body. The temperature of the operating room should not fall below 78°—it may be uncomfortable to the attendants, but it is safe for the patient.

There is one fact which studies of post-operative Pulmonary complications brings out—and it is that pelvic operations are relatively free of these complications as compared with upper abdominal sections. From this observation the posture of the patient is important. A moderate degree of the Trendelenburg position during the operation, allows better drainage from the Bronchial Tree and lessens the influence of the Aspiration Mechanism. This same position should be used when the patient is returned to his bed and until he recovers from the anaesthetic, at this stage he may be placed in a slight Fowler's position.

As regards upper abdominal operations there are several noteworthy principles. In view of the importance of maintaining as free movements of the bases of the lungs as possible, there should be nothing that would impede such movements. Horizontal strapping with wide adhesive straps across the lower costal margins does hamper respiratory movements and should be substituted for diagonally placed straps. And the time honored tight post-operative binder which stretches from pubes to above the costal margins should be condemned for the same reason. Hyper ventilation of the lungs immediately following the operation by means of $CO_2$ and $O_2$ is an excellent proceedure, and should be a routine practice. The mixture used is 10% $CO_2$ and 90% $O_2$ for two or three minutes. In upper abdominal sections undue handling of the stomach and duodenum is dangerous because of the reflux of gastric secretions. In some clinics a small tube is intro-

duced into the stomach during the operation and left in position there. This prevents reflux of material and may aid in the prevention of dilatation of the stomach.

These few suggestions are put forward and they certainly do deserve consideration—they are by no means original. Certainly any procedure or method of routine that would tend to minimize those distressing and frequently fatal pulmonary conditions that too frequently follow surgical operations deserves careful study and adherence to by our surgical confreres.

(1) Pulmonary Complications Following Operations on the stomach or Duodenum, H. K. Gray. Proceedings of the Staff Meetings of the Mayo Clinic, Vol. 8, Feb. 1, 1933. Page 70.

(2) Post Operative Pulmonary Complications, American Journal of Surgery, Vol. 13, July, 1931. Page 165.

(3) Bronchoscopical Observations on Post Pulmonary Complications. Chevalier Jackson. Annals of Surgery, Vol. 97, April, 1933. Page 516.

(4) Five Year Review, Can. Med. As. Journal 26, 55, Jan., 1932.

## PERSONAL NOTES.

Dr. J. A. Sponagle who underwent a serious operation at the Deaconess Hospital, Boston, (cholecystectomy) has returned to Middleton greatly improved in health.

Dr. S. N. Miller, of Middleton, recently celebrated his eighty-fifth birthday. Dr. Miller was a student at the old Halifax Medical College, but completed his course at New York University in 1875. He still attends to office practice.

Dr. Lorne Crowe, of North Bay, Ontario, who formerly practiced in Bridgetown spent his vacation recently in Bridgetown.

## Motor Vehicle Revenue in Nova Scotia.

Twenty-one years ago, Nova Scotia collected $14,839 from registration fees on motor vehicles. Last year, the amount had increased to $1,014,075, but the peak of collections was reached in 1931, when $1,134,956 was colledted from this source alone.

In addition to registration fees, gasoline taxation came into effect in 1926, in which year, with a tax of three cents per gallon, $206,496 was collected. The gax was raised to five cents per gallon in 1927 when this one tax brought in $258,503. A further increase to six cents a gallon in 1932 gave the province $938,047 from the sale of gasoline in that year.

Last year, with a tax of eight cents per gallon, $1.303,045 was poured into the provincial treasury by motorists on their purchases of gasoline, and in the space of nine years, $6,647,242 has been collected from this source alone. Aggregate collections for registration fees ($11,235,448) and gas tax ($6,647,242) have amounted to $17,882,690 since 1914 and 1926 respectively. —*Kentville Advertiser*, July 25.

# The Nervous Child

GORDON WISWELL, M.D.

THE question of the nervous child can very easily involve a discussion of a great many factors, and take us quite far afield to properly cover the ground; but, remembering a great many of my own difficulties in dealing with this type of child and its parents, I feel that it might be worth while to only remind you of some of the most common disorders associated with nervous unrest in childhood. This type of child is becoming increasingly common, and we are all finding that our daily work is more and more concerned with the problems arising out of the unstable nervous systems of our patients. This is not difficult to explain when we look back over the past twenty years and around us to-day, and recall some of the stresses and strains to which we all have been subjected. A great many of the parents of to-day began their lives or grew up during the Great War—a period of intense excitement and fear. They continued on through the post-war years, years of nervous unrest—leading up to the days of apparent prosperity—followed by the crash—and five years of depression with loss of income, loss of home, days of anxiety and fear of what more could happen to-morrow. These are only the obvious examples of the sinister influences at work—to say nothing of the blasts of the loud speakers, the speed of traffic and the constant urge to be going somewhere. Is it any wonder that we have so frequently in our offices the restless, crying, irritable infant; or the pale, toneless, tired, older child?

In a broader sense, the nervous child includes those suffering from definite pathological states, headache, disturbances of sleep, anorexia, bad habits, mental retardation, and moral insanity. In a narrower sense, we have the group without any distinct nervous disease, and classed simply as nervous. Usually in these there is the inherited tendency, which as an underlying basis is merely waiting to be brought into activity by an exciting cause. These exciting causes include the *normal physiological traits* of early life—the incomplete development of the cortical centres with lack of control of the reflexes—the rapid growth of intellect without the balance of experience and judgment—the tendency to irritation and the constant strain undergone by these children from infancy on to the school years—as a result of the desire of parents to make their children learn too quickly and to outdo other children. The competition of the modern class room, the urge to be head of the class, or at least on the honour roll, leaves many of these nervous children wrecked by the wayside, or at any rate marked for life. There should be no school system that forces all children to keep the same pace in the same studies. Other exciting causes commonly operating are *fears* of various types—fear of punishment, fears produced by unsuitable stories, gruesome tales, and frequent attendance at moving pictures. In the long journey from helpless infancy to reason and controlled maturity progress is never steady and continuous in the predisposed nervous child. In addition to the exciting causes mentioned there are a variety of other stresses and strains operating. Among these

we may include faults of management beginning in the nursery, faults of hygiene, infective disorders of different types, errors of diet, and disturbances of metabolism. In the nervously predisposed child illness and excessive fatigue produce such symptoms as habit spasms, stammering, postural defects with toneless muscles, vaso-motor instability with attacks of pallor and faintness. Again, we have the loss of power to control behaviour and conduct as evidence of the neuropathic tendency—with such symptoms as insomnia, night-terrors, thumb sucking, nail-biting, masturbation, fits of crying and rebellion against all authority. The nervous unrest of these children appears as a determined tendency to always do the opposite. This negativism betrays itself more commonly in the refusal of food, refusal to sleep and refusal to go to stool. In other children it is displayed by unreasonable fears and anxieties, faintness and nervous diarrhoea. Management plays a most important role in the conduct of this type of child. Suggestions are often unconsciously conveyed from the grown up persons in control. The child becomes what is said of it, thought of it, or feared for it. Parental fear and anxiety may produce a condition of unrest in the child that normally would scarcely have been noticed. Loss of appetite, bed-wetting and sleeplessness are conditions often directly produced by parental fear and concern—excessive discussion of these disturbances in the child's presence, over-coaxing and threats of punishment. Again we must realize the importance of disturbances of metabolism in the causation of nervous disorder and unrest in these children. Quick, eager, excitable children put a tremendous amount of energy into the business of living and their small little bodies soon become exhausted. Their carbohydrate reserves are quickly used up by fatigue and infection and excitement and emotional stress, and as a result the fats are incompletely burned. Fats are burned in the flame of carbohydrates, lacking which we get a smoky fire and incomplete burning of the fats, and irritability, restlessness, yawning, pallor and prostration, and finally vomiting and acetonaemia. While all children tend to develop ketonaemia just because they are children, the nervous child appears to have this tendency to a special degree. Other metabolic disturbances include urticaria, asthma and eczema, and no matter what the particular nervous disturbance is to which the child is prone, it is bound to be aggravated by the appearance of a metabolic upset. With this in mind, we often treat the enuresis or night terror by attacking the metabolic error, and allowing a definite increase in the amount of glucose consumed.

In a general way, these are some of the causes of nervous unrest in childhood. What then are the symptoms by which we can recognize this condition as the underlying cause of the disturbance? And what method of treatment should we advise for the relief of these unhappy little people?

We may conveniently divide our discussion into a consideration of two age periods—one dealing with the nervous disturbances during infancy, and the other covering the period of the pre-school years.

One of the characteristic features of infancy is the instability of the nervous system. If we add to this, the relatively *huge amount of food requirement*, and the low *v*esistance to infection of all kinds, we can readily see why the digestion of all infants is so easily upset. The most important function of the infant is the *absorption of food*, and when this is interferred with, we have various reactions affecting the body as a whole. Lack of nervous control, and emotional upsets are perhaps the commonest cause of these digestive disturbances—and failure to recognize this fact has led a great many of us

astray in attempting to correct the dyspepsia of infants. We are encountering an increasing number of infants whose digestion is disturbed as a result of nervous unrest, as compared with those upset as a result of infection and faults in the diet. It is true also that we have infants disturbed by a combination of all three factors, but it is important to remember that the emotional condition can alone cause indigestion, and aggravate a primary dietary or infectious origin. Infants at the breast give us a purer type of nervous dyspepsia, as they are not so likely to be suffering from the effects of improper food. Here we have always a mother who is over anxious or inexperienced, or suffering from the nervous sequelae of pregnancy and confinement. The communication of the nervous tension from mother to child is inevitable. No baby will lie quietly in the arms of a restless, excited nurse or mother, and the infant who in his own home is sleepless and crying, will be quiet and calm and cease to fight and struggle when under the cold unemotional routine of a hospital.

In observing these nervous infants we notice several definite characteristics in their behaviour. They are unusually bright—disturbed by the slightest sound or movement, awakening with a sudden start. All their muscles are tense, and their movements are strong and violent. They hold their heads up earlier than the normal baby. Their reflexes are active, and their facial expression is one of anxiety and fear. Hunger is always a prominent symptom and they suck violently and ineffectively with a great deal of air swallowing, and hence a large amount of belching of wind, and sometimes vomiting of a projectile type, and practically always constant regurgitation of food. The crying may be kept up for hours, leaving the baby pale and exhausted. Weight increases are small, or there may be even a loss of weight, which eventually results in inanition and other complications. In contrast to this picture, the dyspepsia of infectious or improper feeding produces a soft, flabby baby. The abdomen is more likely to be distended, and the infant is inactive and quiet. Violent, emotional crying is uncommon, the cry being rather weak and wailing, and as the immunity falls, the skin shows evidence of furunculosis, dermatitis or urticaria of a papular type.

As hunger is a prominent symptom in these infants, it is interesting to note the effect of the increased demand for food on their behaviour. The energy expended for muscular activity in movements and crying is enormously increased by nervous unrest, so much so that the baby crying continuously between feedings may use up more food in energy than it has taken in at the previous feeding. The metabolism may be increased by 20-30%. This greater output of energy increases the demand foor food, and this shows itself in hunger, which again adds to the unrest and nervousness. Under these circumstances, it is not unreasonable to have the mother feel that all that is the matter with the baby is a want of sufficient food, and if the baby is being breast fed, supplementary food is begun. For this reason, nervous unrest is one of the commonest causes of weaning. It interferes with the ability to suck, and when suction is faulty, the breast is insufficiently stimulated and the amount secreted rapidly diminishes. Suction is a reflex act rather than a voluntary one and may be inhibited in two ways. First, it is inhibited by extreme sleepiness, such as we find in weak, premature babies, or lazy, drowsy, somnolent ones. This may be corrected by constant stimu-

lation and efforts to keep the baby awake. Secondly, and more commonly, it is inhibited by emotional disturbances and unrest. These infants cry so hard and so long that they do not seem to be aware of the proximity of the nipple. They refuse to shut their lips over the nipple, but if they do grasp it, they are so hungry and eager for food, that their movements are irregular, and uncontrolled, and the nipple is dropped or lost again in a few moments; or the milk is swallowed in such gulps and so hurriedly, that considerable air is swallowed as well, and the stomach soon becomes excessively distended. If this air is not allowed an exit by holding the baby upright, the stomach contracts so violently that the whole of the milk swallowed is vomited, sometimes forcibly with the air. The distension of the stomach causes marked discomfort, and the baby refuses to nurse until relieved. The bowels also may be excited by the taking of food, and loose, green stools are passed during the nursing.

As the taking and absorption of food is the most important function of the young infant, for this reason the nervous infant presents to us symptoms of dyspepsia as the cause of the most of his difficulties. The treatment then of these babies must bed quite different from those upset as a result of an excess of food, or an unsuitable food. It is useless to attempt to improve matters by changing the food. Limitation of food and purgatives, such as the time honoured castor oil only make matters worse. If we increase the amount of food to meet the excessive demand, we run the risk of getting beyond the digestive capacity of the infant. We must therefore reduce the demand for food by making the baby sleep. In realizing this important fact, and recognizing it as the sole cause of the baby's upset, treatment becomes comparatively simple. In the first place, the mother or nurse must be impressed with the fact that nervousness, overanxiety, and fussing with the baby are important causes of its troubles. The baby will often settle down with removal of the overanxious parent alone. Handling must be reduced to only what is actually necesary. Here contact of the body with that of a nervous mother is enough to upset these babies, so that a pillow may be used on which to carry the baby and to act as an insulator. These babies also require a higher temperature of their environment and cold air must not be allowed in contact with them. More artificial heat than usual at their feet and in their cribs makes a difference; and warmer clothing must be used to protect limbs exposed as a result of their movements. Air swallowing may be prevented by the proper position of the baby during nursing. Both mother and baby must be so placed that both are in a relaxed position, and do not have to be held by taut muscles. It is just as important for the baby to be in a position of perfect relaxation during feeding, so that sucking is the only effort necessary. To relieve the tension of the babies and secure the quiet necessary for proper feeding, chloral is a favourite drug. It may be given in 1 grain to 2 grain doses, 10 minutes, before each feeding, to very young infants, and the dose may be increased if necessary. Bromide may be added to the chloral and atropin 1/1000 will help the hypertonic infant and stop colic and vomiting. The important thing is to make the baby sleep. As soon as he sleeps, naturally or otherwise, the demand for food decreases, dyspepsia and colic disappear, reflex suction becomes possible, and there is a rapid gain in weight. In the bottle fed baby, all these factors are operating in the same manner. It is useless to meet the demand for food

by increasing the amount. The demand must be lessened, and this can only be done by making the baby sleep.

### Symptoms and Treatment of the Older Group of Nervous Children.

There are certain very definite symptoms that almost at once make it easy to recognize children belonging to this group. In the first place, their general expression is one of fatigue and exhaustion. They seem to have an unlimited amount of energy, determined to keep on the move; with an intense interest in living. They have a fragile appearance, which is a source of anxiety to their parents, and they are subject to attacks of irritability and outbursts of temper which are brought on by some trifling disturbance. The more severely affected show a loss of tone, which gives them a characteristic posture. The body is balanced rather than kept erect by muscular tone. The curves of the spine are exaggerated, the shoulders fall down, the chest flattens, and the abdomen protrudes. The joints may be hyperextended and, the arches of the feet go down. They are usually pale and thin, bad sleepers poor eaters, and constipated. They may have many neurotic habits, such as enuresis, stammering, squitning, or habit spasms or tics. They are very often what is called precocious, advanced for their age, quick, eager, active, intellectually gifted, or they may be shy and sensitive to their surroundings at home or at school. They inherit in a great many cases an instability of their metabolism, which expresses itself in different ways, bouts of vomiting, and loss of weight, or attacks of hay fever, migraine, eczema or asthma. The metabolism of fat is particularly at fault in these nervous children. They live for a while in a state of good health, then without warning they fall suddenly into a state of indefinite illness, characterized by gastro-intestinal upsets, severe vomiting, great fatigue, irritability of temper, considerable loss of weight, and possibly a moderate degree of fever. In the severe types, they arrive eventually in the state of ketonaemia, and acidosis, a disturbance of the acid base balance. Some slight emotional disturbance, undue exertion, starvation, even the ordinary starvation of night, or some trivial infection, is enough to bring on one of these storms. Unfortunately, they are often fed large amounts of milk, cream, butter, ice-cream and eggs, with the idea of producing an increase of weight, but with the result that their troubles are magnified, particularly if the available carbohydrate is correspondingly low. When one of these metabolic upsets occurs, the nervous symptoms from which the child previously suffered are always aggravated, and we have an increase in the state of anxiety and fear, night terrors and enuresis. The matter is further complicated by the fact that these children are an easy prey to infection. Immunity tends to fall. Some of them show definite evidence of chronic infection of the naso-pharynx—large tonsils and adenoids. Others in whom the naso-pharyngeal infection may be slight, respond to any trifling infection by a marked metabolic disturbance. It is difficult often to say which is primary, or which is secondary, the metabolic factor or the infective factor.

Treatment of these children requires a great deal of time and patience. The parents must be treated first, and if these can be dealt with successfully, the care of the child is very much simplified. Most parents will co-operate if the situation is carefully explained to them, and if it can be proved to them that the treatment laid down is the road to success. There are a few, of

course, who expect everything from a tonic, and are too weak-willed to exert themselves sufficiently in the interests of the child. Very often the child affected is an only child, and the parents are frightened by the least sign of disturbance. They cannot hide from him the dismay and fear that his behaviour excites in them. The child, of course, has discovered this long ago, and takes full advantage of their willingness to pamper it, and as a means of dominating them, refuses to eat, refuses to sleep, refuses to go in the direction, in other words, which they are overanxious that he should travel. This contact saps the vitality of the child and leaves him exhausted and irritable.

From a more medical point of view, our first concern is the correction of any definite physical defect and the removal of infection. Infection is most commonly present in the naso-pharynx, sinuses and teeth. Tonsils and adenoids are better removed along with any carious teeth. Dental infection alone is responsible for a great deal of ill-health. The digestive functions must be investigated, and the diet arranged along suitable lines. We must control the associated or causative metabolic disturbance. These children cannot digest fats well, and we cannot help them by feeding them quantities of milk, eggs, cream, butter, and ice cream and cod liver oil. Parents so often make this mistake, particularly after an attack of periodic vomiting, and thereby prolong the disturbance. The nervous child does far better on a minimum of fat, and a definite increase in the allowance of carbohydrates. Plain glucose may be prescribed as a medicine, or the house hold corn syrup given in definite amounts at each meal. It is often advisable to give additional carbohydrates between meals to prevent the relative starvation occurring as a result of the tremendous consumption of energy. Sometimes the ordinary period from supper to breakfast is too long for them to go without food, and it is well to waken them at 11 p.m. for a drink of sweetened orange juice. It is often surprising what a routine of this sort will do for the sufferers from night terrors, bed wetting and masturbation. It is also a good plan to allow these children to have a small daily dose of alkali, such as bicarbonate of soda. Excessive fatigue must also be guarded against. These little people wear themselves out with their unusual expenditure of energy. If we add to this, long walks, long hours of play, omission of mid-day rests, and delayed time for bed at night, we are certain to have a child using all his reserves, and not consuming enough food to supply his daily requirement, to say nothing of sufficient to permit normal growth and increase in weight.

Speaking more in detail, the three common symptoms we have to treat are refusal of food, refusal to sleep, and constipation, and the one that disturbs the parent most is the refusal of food. Most parents are very unhappy when their child will not eat the food offered. Incidentally, most parents expect their children to eat far more than they really need. Between the parent on the one hand presenting one food after another, coaxing, bribing, forcing and the child on the other purposely refusing, not because he dislikes the food, but simply because he enjoys the antics of his parents, the result is always the same—very little food is eaten. If physical defects and ill health are not factors, refusal of food is not the fault of the child, but is due to the improper attitude of the parents, and previous faulty training, and it is usually the parents who require advice and treatment. Over anxiety, and a nervous environment do not encourage a child to try to take various foods. Parents must also agree as to what must be eaten; as friction between them is always noticed by the child, and one is played against the other. Parents should

not suggest dislikes by not eating certain foods, or by stating in the child's presence that they cannot eat them. Fear of punishment is also a cause of refusal, when the child is told he will suffer if he does not eat. The desire to dominate is nearly always a cause, and the child soon discovers that meal time affords a wonderful and frequent opportunity to show his power. When the refusal is due to a desire of self assertion, it must be overcome by the mother assuming successfully an air of complete indifference, which is not easy. Until the ground of his conceit is knocked completely from under him, he will continue his tyranny. By faulty suggestions, the appetite of the child may be affected. When he is told day in and day out that he is a poor eater, that he will not eat this or that, he naturally runs true to this reputation. He can be easily made to eat well, by suggesting to him what a good eater he is, and how much better he eats now than formerly, and when the neighbours also hear of his reputation, he is ready to announce that he can eat anything. Negativism is always a symptom of nervous unrest, and refusal of food can often be an act of negativism. In treating this refusal, we only have to adopt an attitude of refusal, or fear of giving too much, and it is not long before the child is eager for food. The parents who control these children best are the ones who get along without commands, threats, do's and don'ts. They assume always that the child will be good, and throw out no dare to them to do otherwise. We have another type of refusal, more frequent in the younger children. It occurs as a result of lack of confidence in the handling of food or a sudden forcing of solid food, which cannot be swallowed. The child must simply be left alone, allowed time to find out what solid foods are like, and time to acquire dexterity in getting food into his mouth and swallowed. He must be allowed to make a mess for a time. Mother with her spoon is better at the other end of the room. Treatment by changing the diet has little effect on any of these children, and the mother should not be led to believe that the food is at fault, or that the ordinary common foods do not agree. Nor do tonics and medicines help these children. They are only useful as a placebo for the mother while an effort is made to correct the mismanagement.

Refusal to sleep as a symptom of nervous unrest presents the same characteristic features as refusal of food. Some children resist going to bed, but once there go off to sleep without further trouble. Others go to bed quietly, but lie awake for a long time talking or playing, and eventually dropping off if left alone. Others demand attention, and keep the mother returning again and again to answer trivial demands, such as a drink of water, a kiss good-night, food, or finally a desire to urinate. This latter request always secures mother's immediate attention. There are others who wake in the middle of the night and lie quietly with eyes wide open for an hour or two. Still others who wake early in the morning, remain quiet or demand immediate attention. This quiet insomnia is always a symptom of nervous unrest. When other causes of insomnia have been eliminated, the treatment becomes a question of proper management. Concentration on the difficulty, discussion of it in the child's presence, usually aggravates matters. Listening at the foot of the stairs, returning to the room every few minutes to see if the child is asleep, answering the many calls for attention only prolongs the difficulty. The earlier the child is taught that bed is a place for sleep, the easier it is later on to secure good sleeping habits. Nowadays, daylight saving is used as an excuse by the parents for allowing their children to stay up later. This is an unreasonable attitude when one realizes that there is just as much

daylight in the evenings in June on standard time as there is in August or May on daylight time. Children properly managed will go to bed and asleep at bedtime, whether is it daylight or dark. In order to get the child started, it is permissible to give chloral at bedtime. Chloral has the advantage of acting almost immediately. It must always be given without the knowledge of the child as to what it is for. Additional carbohydrate is always useful in these cases. Suggestion helps also. A great many of these children hypnotize themselves by clinging to an old blanket, toy or doll. Children afraid of the dark are reassured by a night light or allowed to have a flashlight with them in bed.

Refusal to permit the bowels to move is another common difficulty and constipation may be a symptom in many children of nervous unrest. Parents emphasize the failure to move far too much, and the child soon discovers that by not doing so he will receive extra attention, cause a great deal of excitement. Laxatives have no effect on these children, unless given in sufficient dosage to produce a diarrhoea. The condition is best treated by completely ignoring failure, a change of nurse, or a change of environment. Interest is shown only in increasing improvement. Enemas, suppositories, and local treatment of any kind are not employed. Medicine is given for a time without the child knowing what it is for, and the child is taught to think of other things.

Other symptoms of nervous instability include masturbation, nail biting, thumb sucking, air swallowing, tics and habit spasms. They all require time and patience in their management, treatment of the parent first and then the child. Results may be dramatic and always gratifying, and well repay ouf efforts in solving the different problems.

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**Highway Census Shows Larger Number of Tourists Are Visiting Nova Scotia.**

Motor tourist traffic during the month of June registered a sixteen per cent increase over the corresponding month of last year, a census taken by the provincial highways department at the Amherst gateway shows.

A statement released by Hon. A. S. MacMillan, acting premier and minister of highways, shows that during June, 1935, a total of 6,653 motor cars from the United States and from other provinces in Canada entered Nova Scotia by way of Amherst.

This is an increase of 16.8 per cent over June of last year. The census of these cars was taken between the hours of 7 a.m. and 12 midnight.

The number of cars entering from the United States was 1,293, an increase of 24.1 per cent over the month of June, 1934. There was an increase of 15.1 per cent in the numbre of Canadian cars entering.

During the last day of June, 158 American cars entered via the Amherst gateway, and 122 of these stopped for information at the government information booth at the New Brunswick border. All in all more than 200 American and Canadian cars stopped during the day and more than 600 persons entered the bureau for information. 97 of these cars were from Massachusetts.

During the month of June 300 Canadian cars (exclusive of Nova Scotia vehicles) and 230 American cars crossed into Cape Breton island via the department of highways ferry across the Strait of Canso.

Indications, Mr. MacMillan said, point to a substantial increase of tourist traffic to Nova Scotia during the present season.

# Renal Tuberculosis*

FRANK G. MACK

THIS subject has been discussed before this Society on other occasions, but it is of such importance, perhaps especially so in our province where the incidence of tuberculosis of the genitourinary tract appears to be high, that I am glad that it has been requested by some of the members from Cape Breton that it be dealt with again. It is, rather fitting that this subject should be discussed at this meeting because an unduly large percentage of the cases I see come from this part of the province, from which I judge that it is more prevalent here.

Tuberculosis is never primary in the urinary tract but is always secondary to some focus, active or arrested, elsewhere. The primary source of infection is usually in the lungs or mediastinal lymph nodes, sometimes in the tonsils and cervical lymph nodes and sometimes in the bones. In the lungs there may be active lesions, often quite advanced, or by the time the urinary tract lesions become manifest the primary foci may have been so effectively dealt with by the defensive processes that only firm scars and calcified areas can be found even on careful postmortem search.

It is generally agreed that tubercle bacilli are carried to the kidneys by the blood stream and a tubercle bacillemia is believed to be responsible for the infection of the kidney, although it is quite conceivable that minute emboli containing the bacilli may be carried from the primary focus. The latter hypothesis would at first thought appear to account for unilateral infection more readily than that of a bacillemia. However, it has been pointed out (Hinman) that "there is no more reason to assume the infection of both kidneys because the infection is bloodborne, than to assume both knees must be infected because one is or both femurs or any two other similar parts of the body. Furthermore staphylococcal infections, which are always haematogenous, are usually unilateral even when acute and fulminating."

Within the past fifteen years much has been written on the subject of *tuberculous bacilluria* and many authors have claimed that tubercle bacilli could pass through healthy kidneys and be excreted in the urine. This, if true, would seriously impair the diagnostic value of the finding of tubercle bacilli in the urine. More recently several important papers have appeared which have helped to clarify the situation with respect to bacilluria but, in addition, served to becloud the problem of treatment of renal tuberculosis. In order to attempt to remove some misleading impressions as to the possibility of the cure of renal tuberculosis by medical measures rather than surgical it is necessary to consider these findings in some detail.

One of the most important and widely quoted series of papers was that of Medlar (1926-1930) based on the examination of 100,000 serial microscopic sections of kidneys from about thirty persons *dying of pulmonary tuberculosis* who had not shown symptoms of genito-urinary tuberculosis, and on animal experimentation. He concluded that the kidneys are commonly infected

* Read at the Annual Meeting of the Medical Society of Nova Scotia, at Sydney, July 4th 1935.

with tuberculosis in patients dying of pulmonary tuberculosis, that the renal lesions are haematogenous and that commonly both kidneys are involved but one may be more affected than the other. He found that the majority of the tuberculous lesions arise in the glomeruli or in the tissues between the tubules in the cortex. An occasional lesion was found limited to the papilla and an occasional one apparently arising in the arcuate zone and involving both cortex and pyramid was observed. Scars were demonstrated in a considerable proportion of these kidneys where definite tuberculous lesions were also present. He believed these, in the absence of atherosclerosis, represent healed lesions although there was nothing pathognomonic of their being tuberculous in nature. Lesions in various stages of development were taken to indicate that there had been several "showers" of bacilli which infected the kidneys at different dates. Medlar concludes that (1) "*non-destructive* lesions of tuberculosisis may heal and (2) that tubercle bacilli do not pass through a kidney that does not contain a lesion of tuberculosis."

The work of other investigators such as G. J. Thomas (1929) and Harris (1930) tends to confirm the work of Medlar. They conclude that there is a preclinical or silent stage, perhaps lasting for years, of renal tuberculosis in which diagnosis is impossible. This stage probably explains those cases in which a so-called tubercle bacilluria has been claimed to exist in healthy kidneys. It must be remembered that Medlar's cases were those of patients *dying of far advanced pulmonary tuberculosis* in whom minute lesions are often found in other organs and that the conditions present in these kidneys are not those found in renal tuberculosis *as it is met with in practice.* It may be granted that healing of *microscopic lesions* does occur but the healing of definite *destructive renal tuberculosis* does not appear to have yet been observed by the pathologist. Undoubtedly lesions do become temporarily closed or inactive, because of a process of fibrosis, with misleading findings only to become "open" again. The dangerous feature of this work is that it has given rise to the impression that surgical or destructive renal tuberculosis may heal as a result of medical measures. The most satisfactory statement on the subject seems to be that of Band (1935) who states that "the earliest tuberculous lesions of the kidney are epitheloid and mononuclear tubercles which are found in relation to the glomeruli of the renal cortex. These primary or minor tuberculous lesions of the kidney are bilateral and many of them heal. The presence of tubercle bacilli in the urine withdrawn from the renal pelvis means a tuberculous focus in the kidney. Early tuberculous follicles may become encysted and fail to discharge infected debris to the tubules i.e. remain "closed". As a rule caseating foci ultimately ulcerate to the tubules. The collecting tubules converge at the apex of the pyramid which is thus liable to infection by direct spread from foci in the corticomedullary zone and by tubular extension. A lesion is *open* when it communicates with the renal pelvis either directly or through the tubules. The presence of *open cortical lesions* can be diagnosed clinically when *tubercle bacilli and pus cells* are found in the renal urine and changes in the pyelographic outline of the renal pelvis and calices *are absent.* The later stage of confluence of follicles and ulceration at the papilla leads to the pyelographic changes and the clinical syndrome of tuberculous disease of the kidney."

The incidence of renal tuberculosis in males and females is about the same although some report rather more male cases than female. It is predominantly a disease of early adult life. 71% of 315 cases (Wildbolz) were

between 20 and 40 years. In a total of 1,082 cases reported by various authors only 6 were under 11 years and the disease may occur in persons in the sixties. About 85% when first diagnosed are apparently unilateral. My own experience has, I believe shown a larger proportion of bilateral cases which leads me to urge the great importance of early investigation, for all too often the history shows that symptoms have been present for several years and the conclusion is inevitable that earlier recognition would have made effective treatment possible in a larger number of cases.

*Symptoms.* Tuberculosis of the kidney, of the ureter and of the bladder are all parts of the one process which begins in the kidney and extends downwards. The symptoms are chiefly due to the irritative effect upon and actual tuberculous infection of the ureter, bladder and posterior urethra. Tuberculosis of the ureter leads to the formation usually of strictures, especially in the juxtavesical portion of the ureter and frequently to marked dilatation of the ureter and pelvis above the stricture. In some instances the ureter is so uniformly infiltrated and fibrotic as to form a rigid tube easily palpable on rectal or vaginal examination. Much shortening and retraction results and in one far advanced bilateral case this was so marked that at each expiration the whole trigone was drawn upwards so that one could visualize the cord-like ureters transmitting the movements of the diaphragm to the floor of the bladder. The capacity of the bladder tends to become steadily less as infiltration and fibrosis progress until in advanced cases it may hold only a few cubic centimeters and frequency is consequently so great as to amount almost to incontinence.

There is no typical clinical picture of renal tuberculosis for each case has its own variations depending upon the virulence of the infection and its duration as well as upon the extent of involvement of the ureter and bladder. The most constant symptom is frequency of micturition due to irritation of the bladder. When frequency is nocturnal, especially in young persons it is even more important. Pyuria is almost always present. Haematuria is common and is much more likely to be noticed by the patient. Chills, fever, and sweats have been found in 22.5% of a series of cases reported by H. H. Young. Pain referred to the kidney region and renal colic are the only localizing symptoms but these are frequently entirely absent.

Ordinary physical examination gives little information of value in most cases but should always be carefully made because the finding of an enlarged kidney or a thickened ureter may be very helpful. The diagnosis must be made by the employment of the cystoscope and the X-ray together and the examination of the urine for pus and Tubercle Bacilli especially. Intravenous pyelography is a valuable supplementary aid in certain cases but those who depend upon it for a diagnosis routinely are apt to fall into grave error.

The following case reports of representatives cases were presented with lantern slides of the X-ray films of pyelograms.

Mrs. L. K. 36. Adm. June 28, 1934, Disch. July 24, 1934.

*Complaints.* Pain in right loin.

Frequent and burning micturition.

*P. History.* Tuberculous peritonitis at 17, hysterectomy 7 years ago. 6 or 7 months ago began to have pain in right side following an attack of vomiting. Pain would come on on arising in morning but rest relieved it. It began over the crest of the ilium and radiated up towards the back and

down along the ureter. It was steady and severe but after the first week did not prevent working. 10 or 11 months ago first had frequency which was very marked at first and assciated with burning afterwards. Not so frequent in past 3 or 4 weeks. Last night only up once. No haematuria. Has lost 12 lbs. in last 3 months.

*Abdomen.* Large firm mass in right loin.

*Lungs*—no active disease. She is an old arrested case of pulmonary T.B.

*Cystoscopic*—June 30, 1934. Capacity normal. Some congestion of trigone. R. U. O. retracted and gaping with area of ulceration about it. L. U. O. normal. On right catheter obstructed at 1½ inches. On left No. 6 easily to pelvis. Fair rhythmic flow from each. Indigocarmine deep blue on left in 5 min. none on right. in 20 min.

*Urine*—Common alkaline Sp. Gr. 1.020, trace albumin, 250 pus cells to H. P. Field and a few reds. *Right* 150 pus cells. Left no pus. All 3 negative for T. B. and also 24 hr. specimens.

*Pyelogram*—Left kidney normal. Right ureter injected to level of 2nd sacral segment and moderately dilated with numerous negative opacities in lower portion. Right kidney not injected but lower portion enlarged.

Blood chemistry normal.

*Operation*—July 7, 1934. Right nephrectomy Very large solid kidney.

*Pathological*—Typical caseous tuberculosis.

Good recovery.

---

E. J. 48. Baggage Agent. Adm. April 8, 1934, Disch. May 16, 1934.

*Complaints.* Frequency.

Burning after micturition.

*P. History.* Nothing important in previous history. Several months ago after lifting a side of beef felt frequent desire to micturate. About same time fell on his back which he thinks aggravated frequency. Has some burning after. N-3-4. After treatment for pyelitis improved somewhat. No haematuria. No loss of weight.

*Abdomen.* Patient very stout but some resistance in right flank. Temp. normal.

*Lungs.* Nothing indicative of active disease, clinically or by X-ray.

*Cystoscopic.* Apr. 11, 1934. Capacity Oz. 4, base of bladder irregular with bullous oedema. Right U. O. relaxed and oedematous, left large and oedematous. Right No. 6, easily to pelvis. Left No. 4 with difficulty. Indigocarmine deep blue left in 6 min. and right in 8 min.

*Urine.* Common-acid, Sp. Gr. 1.008, trace albumin, over 100 pus cells, no casts. Right 40-50 pus cells, left no pus. *Tubercle bacilli* present in right and common, absent in left.

*Pyelogram* showed normal pelvis and calices on left. Right pelvis of bifurcated type with dilatation and irregularity of minor calices.

*Blood chemistry* slightly increased.

*Operation* Apr. 25, 1934. Large adherent kidney very difficult to free. Nephrectomy.

*Pathological* Caseous tuberculosis.

Now doing well and is about to resume work.

A. McS.16. Adm. March 11, 1935, Disch. April 27, 1935.

*Complaints.* Frequency.

*P. History.* Pleurisy when quite young. Had a recurrence and spent 10 months in hospital. Appendix removed 2½ years ago. Good appetite. Looks rather pale and thin. Frequency for nearly a year. Urine is sometimes reddish. Frequency varies, sometimes only every 2 to 3 hours.

*Abdomen.* Kidneys not palpable or tender.

*Lungs.* X-ray showed old infection of hilus region. Clinically no evidence of active disease.

*Cystoscopic.* Mar. 12, 1935. Spinal anaesthesia. 50 mg Novocaine. Capacity very much diminished. Mucosa dulled and scarred with apparent ulceration and infiltration of posterior wall. Ureteral orifices not seen. Indigocarmine appeared in 12 min. palely but its source could not be seen.

*Intravenous pyelograms* were made. Showed no evidence of "dye" in left kidney. Right pelvis well defined and calices appear normal. Right kidney normal in size, shape and position.

*Cystoscopic.* Mar. 18, 1935. Capacity 3-4 oz. Mucosa as before. Only one ureteral orifice seen somewhat to left and very much retracted upwards. No. 5 catheter passed for 3-4 inches only. No flow. Indigocarmine appeared as before faintly in 12 to 15 min. but its exact source not seen.

*Pyelogram.* Left kidney shows marked distortion and irregularity with evidence of numerous abscess cavities.

*Blood chemistry* normal.

*Urine* alkaline, Sp. Gr. 1.016, albumin + +, 25 pus cells, over 100 reds to H. P. field, no casts. Tubercle bacilli present in three consecutive specimens.

*Operation* Mar. 23, 1935. Extensive tuberculous pyonephrosis, thickened nodular ureter. Kidney removed under spinal anaesthesia 120 mg. Novocaine.

*Pathological.* Typical caseous tuberculosis.

10 twenty-four hour specimens negative for T. B. following operation.

Frequency much relieved. Patient eating well and obviously much improved.

Incision healed well except for a slight sinus.

Here the normal right intravenous pyelogram made one feel justified in removing the grossly diseased left kidney.

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G. McR. 13. Adm. Feb. 20, 1935, Disch. Mar. 29, 1935.

*Complaints.* Haematuria for 1 month.

Eight weeks ago had measles. In bed 3 days, not very sick. Was up for a week; seemed well. Haematuria then appeared for first time lasting one day. Recurred 4 days later and again 7 days after that. Then developed pain in right subcostal region in anterior axillary line and had frequency, urgency and dribbling. For the next week there was no blood and frequency subsided. The last haematuria seen 2 days before admission. No cough, renal or other pain on admission. Had been on a low protein diet and in bed for past month. He was emaciated, toxic, and dull, with moderate fever.

*Urine* turbid with pus. Tubercle bacilli found in 3 out of 4 specimens.

*Cystoscopic.* Bladder very small, pale and scarred in parts with some patches of granulation and ulceration. The ureteral orifices could not be seen and intravenous pyelography was done. The passage of No. 18 Fr. cystoscope was very difficult because of a stricture in penile urethra presumably tuberculous. Frequent attacks of retention occurred and because of extreme irritability of patient a catheter could only be passed under gas.

*X-ray* of lungs showed evidence of old disease and moderate fibrotic changes in both upper lobes most marked on left. No present evidence of active disease. This agreed with clinical examination.

*Intravenous pyelograms* showed hydronephrosis on right with dilatation of all calices. Ureter shows angulation at pelvioureteral junction. No "dye" on left but very extensive *calcification* extending down ureter.

*Blood chemistry* on admission—T. N. P. N. 130, 9, Urea N. 60. 7, Uric Ac. 3.07 Creatinine 1.99.

As condition was considered active tuberculosis of right kidney with left autonephrectomy and as dilatation of urethral stricture was not considered wise a suprapubic permanent drainage was established.

*Blood chemistry* on discharge was T. N. P. N. 35.7, Urea N. 16.6, Uric Ac. 2.03, Creatinine 1.6.

It was subsequently learned that the patient had been troubled with enuresis and much frequency about three years ago. This probably coincided with the involvement of the left kidney which underwent a process of autonephrectomy.

---

E. MacM. 65. Clerk. Adm Sept. 6, 1934, Disch. Sept. 29, 1934.

*Complaints.* Chills, night sweats and fever for 6 months.

1 brother, 1 sister died of Tuberculosis.

*P. History.* At about 20 had pleurisy with much cough and bronchitis. Had a cough at times for years. Well until about 1 year ago when began to feel "run down" and have pain in bladder every few days, sharp and severe. Some burning on micturition felt at end of penis. Frequency N-4-5. Never pain in loins or back, always in bladder or penis. Saw blood in urine once 6 months ago and at times it looked milky. Bladder lavage for some time with decrease in pain. 7 months ago fever, chills and night sweats began not associated with pain. Sent to V. G. H. for investigation.

*Lungs.* Dulness both apices, no signs of activity. X-ray confirms, with some calcification. *Abdomen* nothing palpated, no tenderness. *Prostate* slightly enlarged, firm not nodular.

*Cystoscopic.* Capacity *normal*, mucosa—some swelling and congestion of base, trigone elevated. Right U. O. oedematous, congested and retracted with *pus oozing* from it. Left normal. Catheter No. 5 to right pelvis with scant greenish flow. Left No. 6 good rhythmic flow. Indigocarmine deep blue left 10 min. right none in 15 min. Prostate slightly enlarged bilaterally with slight median bar.

*Blood Chemistry.* Sept. 7, 1934, T. N. P. N. 42.24, Urea N. 19.7, Uric Ac. 3.24, Creatinine 1.5 mg.

*Urine. Alk.* Sp. Gr. 1.015, albumin +, sugar neg., *pus* 4 *plus*, no reds, no casts. Right much pus. Left an occasional pus cell. Three 24 hr. specimens

negative for T. B. Nephrectomy Sept. 12, 1934. 160 mg. Novocaine. Sacculated, matted to tissues about. Very difficult to remove.

*Path. Report.* Calices distended with thickened pus, forming loculated pockets which have a typical caseous lining. Typical caseous tuberculosis microscopically.

Wound healed well with slight moisture at one point on discharge.

---

V. D. 24. Laborer. Adm. Apr. 8, 1935, Disch. June 3, 1935.

*Complaints.* Frequency.

Haematuria.

*P. History.* No loss of weight. A year ago found he had to pass urine more frequently, as often as every 10 or 15 minutes at times. This lasted for several months but improved somewhat after rest in bed. At present has to micturate every two or three hours day and night. Has noticed reddish color at times. No pain, no burning. At onset there was some delay in starting stream. Was treated as case of pyelitis with ketogenic diet but not improving was sent to V. G. H.

*Abdomen*—negative on palpation.

*Lungs*—X-ray evidence of old disease of right upper lobe with slight fibrosis and calcification. Clinically no evidence of active disease. Temp. normal on admission.

*Cystoscopic*—Apr. 11, 1935. Capacity slightly decreased. Mucosa showed large areas of tuberculous infiltration involving posterior wall. On right base definite ulceration, otherwise only slight injection of rest of bladder. Ureteral orifices slightly congested. No. 6 catheter on right easily to pelvis. On left No. 5 with some difficulty nearly to pelvis. Good flow from both, *very pale on left.* Indigocarmine deep blue on right in 4 min. none on left in 15 min.

*Urine.* Common, alkaline, Sp. Gr. 1.009, ablumin ++, 20 pus cells to H. P. field. Right—no pus. Left-over 200 pus cells to H. P. field.

*Pyelograms.* Normal right pelvis and calices. Left kidney not injected but whole extent of ureter shows marked dilatation. Left and common specimens showed *tubercle bacilli.*

*Blood chemistry.* T. N. P. N. 40.8, Urea N. 19.01, Uric Ac. 3.81, Creatinine 1.5.

*Operation* showed a large sealed pyonephrotic kidney with greatly dilated and thickened ureter. Nephrectomy with removal of ureter well down into pelvis.

*Pathological.* marked caseous tuberculosis with an impermeable stricture of ureter just below pelvis. Ureter studded with tubercles. On discharge was doing well. Incision not quite healed.

---

F. D. 40. Chauffeur.

*Chief Complaint.* Severe pains and stiffness referred to left costovertebral angle.

*Urine* negative repeatedly in 24 hour and cystoscopic specimens for T. B. and only a rare pus and red corpuscle seen.

Cystoscoped twice. Bladder normal. Indigocarmine appeared in good color on both sides but some delay on left. *Right* 4-5 pus to H. P. field. *Left* no pus.

*Pyelograms* showed such marked appearance of ulceration of calyx on left that diagnosis of renal tuberculosis seemed certain.

Patient was sent home for two weeks to return for re-examination. Search for T. B. still proved negative. Pyelogram showed "irregularity of superior calyx on left not so marked as at previous examination but still some irregularity of minor calices of this division.

Because of the negative laboratory reports the diagnosis was not felt to be justified at the time and operation was not advised. With the finding of gonococci in the prostatic fiuid a probable diagnosis of gonorrhoeal fibrositis and arthritis was made. This probably was the cause of the pain.

This case shows the danger of attaching too much importance to a single finding. With intravenous pyelograms alone the danger would have been greater.

# The Nova Scotia Medical Bulletin

Official Organ of The Medical Society of Nova Scotia.

Published on the 5th of each month and mailed to all physicians and hospitals in Nova Scotia Advertising forms close on the 15th of the preceding month. All Mss should be in the hands of the Business Editor on or before the 10th of the month. Subscription Price:—$3.00 per year.



VOL. XIV. AUGUST 1935 No. 8

## FEDERATION WITH THE CANADIAN MEDICAL ASSOCIATION

AMONG the questions relative to medical organization which have come before the Medical Society of Nova Scotia during the past decade, that which at present confronts us, namely, the proposed merger with the Canadian Medical Association, easily ranks as first in importance.

At the present time a definite affiliation exists between the two bodies, the provincial Society regularly appointing representatives on the Council and on the Executive Committee of the C. M. A., and having, or being supposed to have, a voice in the editorial staff of the Canadian Medical Journal. Our medical organization as a whole, however, remains as ten distinct societies, nine provincial and one national in scope.

This degree of affiliation has existed for some fifteen years or thereabout. The advocates of closer federation feel that while it has made for pleasant relations between the various sections of the profession in Canada, it leaves much to be desired in effectiveness when united action by Canadian Medicine is required.

It is pointed out that the occasions for such limited action are inevitably increasing in frequency and importance. We are told that social legislation, already enacted and probably to be enacted by the Dominion Government including a system of national health insurance, constitutes an immediate challenge to our profession to close its ranks, and to be prepared as a unit to influence such legislation and its administration, with the best interests of the public and of the profession itself in view.

The elimination of overlapping in work, with consequent reduction in costs,—more effective contact with other nation-wide organizations such as the Victorian Order of Nurses, the Canadian Red Cross, etc.—the proven value of a similar organization to that now proposed, in the British Medical Association,—its value as a gesture of national unity of purpose, as a contribution by our profession to the age long effort to make Canadians think nationally,—these ideas and many others are advanced in support of the proposal for federation.

Dr. J. S. McEachern, of Calgary, now past-President of the C. M. A., during his term of office, in company with Dr. T. C. Routley, General Secretary, made a tour of Canada presenting the scheme to various medical goups. At

Halifax these gentlemen addressed a large meeting of the local Branch, which included several visitors from other provincial points, and received a sympathetic hearing.

The principle of the scheme was endorsed at this meeting, but apart from that no action was taken, nor was it in order, pending the consideration of the matter by the Society as a whole at the Sydney meeting.

At the recent annual meeting of the Society at Sydney Dr. J. C. Meakins, President of the C. M. A., and Dr. Routley brought the proposal, in as much detail as was then possible, before the profession of the province.

In essence, it consists in the merging of the identity of the Medical Society of Nova Scotia in that of the Canadian Medical Association, the provincial organization to be known thereafter as "The Canadian Medical Association, Nova Scotia Division." Similar merging is proposed for every provincial society in the Dominion. One membership and one fee would then replace the present two of each.

It was explained that every effort would be made, and made with success, to have each provincial Division retain all of its present autonomy, assets, and liabilities (if any), while the provincial organization would accept as a basis of its Constitution and By-Laws, those of the Canadian Medical Association, in order that there might be a certain degree of uniformity in procedure across Canada.

Each Division would nominate a representative to the National Executive Committee, and to all intents and purposes it would be the Canadian Medical Association in its own provincial area.

We were informed also that a revision of the Constitution and By-laws of the C. M. A., in anticipation of the proposed changes in organization, had been made and was about to be published.

After general discussion, which was unfortunately limited by the amount of time available, the Executive Committee, who had previous.y discussed the matter with the C. M. A. representatives, reported that the following resolution had been passed by them:

"That the Executive approve of the principle of merging the Medical Society of Nova Scotia with the Canadian Medical Association, the Society to be known thereafter as "The Canadian Medical Association, Nova Scotia Division;" and that a Committee of five, and the President of each Branch Society be appointed to study the matter and report back at the next general meeting."

This action of the Executive was, by motion, endorsed by the Society' and, later, the necessary notice of motion re. the appropriate changes in our Constitution and By-laws was filed.

It appears, therefore, that our provincial Medical Society is now committed to the principle of this merger. Our present task is to study the plan in detail, to assess the difficulties, and to devise ways and means of overcoming them.

The object of this writing is not to advocate or to oppose the scheme, but our wish is to keep it before the attention of our members, with the hope that free discussion of it by them, in our pages, will help to clarify the ideas of us all.

The Committee which is charged with the study of this matter desires a frank expression of views from the membership of the Society. Such expression cannot be made more conveniently or effectively, we think, than in the form of letters to the BULLETIN, which we now cordially invite.

J. R. C.

# AMENDMENT

## Refresher Course Programme

Halifax, N. S.,
August 16, 1935.

To the Medical Society of Nova Scotia.

Gentlemen:

After our programme had been mailed word was received from Dr. Bloodgood in which he told us of an accident that had befallen him, and that all his engagements had to be cancelled for months to come. It is with regret that we make known to you this unhappy news. We all are indebted to Dr. Bloodgood for the series of articles he prepared for us during the last six months. A letter expressing our sympathy and appreciation has been forwarded.

Needless to say this Committee was somewhat embarrased. Friends have come to the rescue, however, and the periods allotted to Dr. Bloodgood will be cared for as follows:

### MONDAY AUGUST 26th

**12.00-1.00 p.m.** "The Progress and Value of Tissue Culture" (with a practical demonstration)—Dr. Martin Silberberg, Ex-Professor of Pathology, University of Breslau, Germany. Carnegie Research Scholar, Dalhousie University.

**2.30-3.30 p.m.** "Pathogenesis of Some of the Commoner Forms of Cardiac Disease"—Dr. Luther B. MacKenzie, Clinical Professor of Medicine, University of New York Medical College.

### TUESDAY, AUGUST 27TH

**12.00-1.00 p.m.** Clinical Talk: "Haemorrhage from the Intestinal Tract"—Dr. Edward Hodge, Surgeon Presbyterian and Germantown Hospitals, Philadelphia.

**2.30-3.30 p.m.** "Some Common Affections of the Upper Respiratory Tract"—Dr. E. Ross Faulkner, F.R.C.S. (Eng.), Surgeon Director, Manhattan Eye, Ear and Throat Hospital, New York.

Yours sincerely,

H. W. SCHWARTZ,

Chairman, Refresher Course Committee.

# Programme of Dalhousie Refresher Course August 26th to 30th, 1935

**Daylight-Saving Time.**

## Monday, August 26th, 1935.

**9.00-10.10 a.m.** Surgical Clinic, Dr. W. Alan Curry, Dr. E. F. Ross.
Victoria General Hospital.

**10.20-11.20 a.m.** Medical Clinic, Dr. J. R. Corston,
Victoria General Hospital.

**11.30-1.00 p.m.** Surgical Clinic, Dr. Joseph Colt Bloodgood, Prof. of Clinical Surgery, Johns Hopkins University, Baltimore—"Biopsy—Diagnosis and Pre-operative Treatment of Benign and Malignant Tumours of the Female Breast." (with lantern slides).

**2.30-3.30 p.m.** Chairman, Dr. H. K. MacDonald.
"Cancer of the Cervix" (with lantern slides), Dr. J. C. Bloodgood.

**3.30-4.15 p.m.** "The Modern Conception of Benign Uterine Bleeding." Dr. H. B. Atlee.
Discussion to be led by Dr. G. A. Dunn, Pictou.

**5.00 p.m. SPECIAL LECTURES AND DEMONSTRATIONS.**

"Orthopaedic Appliances for Conditions about the Foot and Ankle,"
Drs. T. B. and J. C. Acker.

"Infant Feeding", Dr. N. B. Coward,
Lecture Room, Children's Hospital.

**7.30 p.m.** "Applied Anatomy," Dr. Donald Mainland, Prof. of Anatomy, Assisted by Drs. Graham, Holland and Noble.
Dept. of Anatomy, Forrest Building.

## Tuesday, August 27th, 1935.

**9.00-10.10 a.m.** Surgical Clinic, Dr. N. H. Gosse, Dr. J. A. Noble.
Victoria General Hospital.

**10.20-11.20 a.m.** Medical Clinic, Dr. M. J. Carney, Dr. G. R. Burns.
Victoria General Hospital.

**11.30-1.00 p.m.** Surgical Clinic, "Benign and Malignant Tumour of Bone," (with lantern slides), Dr. J. C. Bloodgood.

**2.30-3.30 p.m.** Chairman, Dr. W. Alan Curry.
"Earliest X-ray and Microscopic Diagnosis of Tumours in the Region of the Tongue and Jaw," (with lantern slides). Dr. J. C. Bloodgood.

**3.30-4.00 p.m.** "Injuries about the Ankle Joint—A Modern Method of Classification and Treatment," Dr. A. L. Murphy.
Discussion to be led by Dr. S. R. Johnston.

**5.00 p.m. SPECIAL LECTURES AND DEMONSTRATIONS.**

"The Examination of the Central Nervous System." Dr. Ian Macdonald,

"The Investigation of the Gastro-Intestinal Case," Dr. J. W. Reid.

**7.30 p.m.** "The Examination of the Heart," Dr. K. A. MacKenzie.

**10.30-11.00 p.m.** "The Control of Cancer," Radio Broadcast. Dr. J. C. Bloodgood.

## Wednesday, August 28th, 1935.

**9.00-10.00 a.m.** Genito-Urinary Clinic, Dr. Frank G. Mack, G. A. Winfield.
Victoria General Hospital.

**10.10-11.20 a.m.** Clinic by the Staff of the Children's Hospital at the Public Health Clinic

**11.30-1.00 p.m.** Clinics by members of the Staff of the Public Health Clinic.

**2.30-3.15 p. m.** Chairman, Dr. A. E. Doull.

"What the Medical Practitioner should know about the Teeth,"Dr. S. G. Ritchie, Professor of Dental Anatomy.
Faculty of Dentistry—Dalhousie University.

**3.15-4.00 p.m.** "Basic Factors—Clinical & X-ray, in the Diagnosis and Treatment of Bronchiectasis," Dr. A. F. Miller, Medical Superintendent, Nova Scotia Sanatorium.
Discussion to be led by Dr. T. M. Sieniewicz.

**5.00 p.m. SPECIAL LECTURES AND DEMONSTRATIONS.**

"Infant Feeding," Dr. N. B. Coward.
Children's Hospital.

"Orthopaedic Appliances, for conditions about the Foot and Ankle,"
Drs. T. B. and J. C. Acker.

**8.30 p.m.** Dinner at the Nova Scotian Hotel. (Strictly Informal).

## Thursday, August 29th, 1935.

**9.00-10.20 a.m.** Surgical Clinic, Dr. H. K. MacDonald, Dr. V. O. Mader,
Victoria General Hospital.

**10.30-11.50 a.m.** Clinic by Members of the Staff of the Grace Maternity Hospital, at the Grace Hospital.

**12.00-1.00 p.m.** Medical Clinic, Dr. E. E. Cleaver, Department of Medicine, University of Toronto.

**2.30-3.30 p.m.** Chairman, Dr. J. R. Corston.

"The Interpretation of Symptoms in Chronic Gastro-Intestinal Disease",
Dr. E. E. Cleaver.

**3.30-4.30 p.m.** "Prophylactic Use of Sera and Vaccines," with demonstration,
Dr. A. L. McLean.
Discussion to be led by Dr. G. R. Burns.

**5.00 p.m. SPECIAL LECTURES AND DEMONSTRATIONS.**

"Examination of the Central Nervous System," Dr. Ian Macdonald,
"Investigation of the Gastro-Intestinal Case," Dr. J. W. Reid.

**7.30 p.m.** "Applied Anatomy," Dr. Donald Mainland, Assisted by Drs. Graham, Holland and Noble,
Dept. of Anatomy, Forrest Building.

## Friday, August 30th, 1935.

**9.00-10.20 a.m.** Surgical Clinic, Dr. C. E. Kinley, Dr. A. L. Murphy,
Victoria General Hospital.

**10.30-11.50 a.m.** Medical Clinic, Dr. C. W. Holland, Victoria General Hospital.

**12.00-1.00 p.m.** Medical Clinic, Dr. E. E. Cleaver.

**2.30-3.30 p.m.** Chairman, Dr. M. J. Carney.
"The Functional Colon" Dr. E. E. Clever.

**3.30-4.00 p.m.** "The Child's Abdomen from a Diagnostic Standpoint," Dr. P. Weatherbe.

**4.00-4.30 p.m.** "Common Neuroses," Dr. K. A. MacKenzie.
Discussion to be led by Dr. L. R. Morse, Lawrencetown.

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NOTICE—Clinics and lectures will take place in the Lecture Room of the Public Health Clinic unless otherwise indicated.

# Executive Meeting

## MEDICAL SOCIETY OF NOVA SCOTIA, 1935

THE meeting of the Executive of the Medical Society of Nova Scotia was held at the Isle Royale Hotel, Sydney, N. S., on Tuesday, July 2nd, 1935, at 8.30 p.m.

Present: W. R. Dunbar, M. J. Wardrope, D. F. McInnis, H. G. Grant, N. H. Gosse, H. W. Schwartz, D. A. McLeod, W. A. Hewat, J. J. Roy, W. L. Muir, J. C. Ballem, F. O'Neill, A. F. McGregor.

In the absence of the President and the Vice-President it was moved by Dr. Schwartz and seconded by Dr. Wardrope that Dr. Dunbar be Chairman.

The first item considered was the question of appointing two members to act in an advisory capacity to the Editorial Board of the Canadian Medical Association. Two years ago the Society discontinued appointing these members. Dr. K. A. MacKenzie, of Halifax, asked to have the question brought up and two members appointed as a friendly gesture.

Here the business was suspended and the meeting was addressed by Dr. J. C. Meakins, President of the Canadian Medical Association, and Dr. T. C. Routley, secretary, who each gave a talk on the question of the merger of our Society with the Canadian Medical Association, at the conclusion of which they were thanked by Dr. Dunbar. After some discussion it was moved by Dr. Gosse "That the Executive approve of the principle of merging the Medical Society of Nova Scotia with the Canadian Medical Association to be known as Canadian Medical Association, Nova Scotia Division, and that a committee of five and the President of each Branch Society be appointed to study the matter and report back at the next general meeting". Seconded by Dr. Schwartz and carried.

Continuing the question re members to the Editorial Board of the Canadian Medical Association it was moved by Dr. McLeod and seconded by Dr. Ballem that the action of the last general meeting be rescinded and two members be appointed. Carried.

The following reports were then read and received:

*The Report of the Cancer Committee* was read by the Chairman, Dr. Gosse. Dr. Dunbar asked that the word "regular" be inserted before "organization having similar aims" to which Dr. Gosse agreed. Carried.

The report of the *Victorian Order of Nurses* was read by Dr. Grant. Dr. Roy said he did not agree with Dr. Morton in that the V. O. N. was not sufficiently appreciated, as it was very much appreciated in Cape Breton. It was moved by Dr. Muir and seconded by Dr. O'Neill that this report be received. Carried.

Dr. Grant next read the letter of Dr. M. G. Burris as Chairman of the *Committee on Public Health.* It was moved by Dr. Roy and seconded that this be received. Carried.

The report on the *Nova Scotia Society for Cripple Children.* It was moved and seconded that this report be received. Carried.

Report of *Committee on Histrical Medicine.* It was moved by Dr. Roy and seconded that this report be accepted and that Dr. Scammell's recommendation of having the Committee appointed this year from Cape Breton be followed. Carried.

*Provincial Medical Board Committee* report was next read by the Secretary. It was moved and seconded that this report be received. Carried.

*Committee on Narcotic Drugs Report.* It was moved by Dr. Roy and seconded that this report be received. Carried.

The report of the *Editorial Board* was read by the Chairman, Dr. Gosse. It was moved and seconded that this report be received. Carried.

The *Treasurer's Report* was read by Dr. W. L. Muir. It was moved by Dr. Gosse and seconded that this very excellent report be received. Carried.

The *Secretary's Report* was read by Dr. Grant. It was moved by Dr. McLeod and seconded by Dr. Hewat that this report, including the recommendation re. the clerical secretary, be received. Carried.

The secretary read the report of the *Committee to investigate nursing conditions in Nova Scotia and in Nova Scotia Hospitals.* It was moved and seconded that this report be received.

The Secretary stated that no reports had been received from the Workmen's Compensation Board, the Cogswell Library Committee, the Legislative Committee, or the Tuberculosis Commission.

A letter from Dr. Lebbetter, Secretary of the Western Counties Medical Association, was next read.

The Secretary read a letter from Mrs. Crockett containing a resolution of the Provincial Council of Women of Nova Scotia.

The resignation of Dr. Atlee from the Editorial Board was next considered.

The Secretary read a resolution from Dr. Atlee re. the appointment of an auditor and it was moved by Dr. Gosse and seconded "that the Executive consider the present arrangement adequate and that Mr. M. L. Bellew of Halifax be appointed auditor at a salary of $25.00."

The Secretary read a letter from Dr. Routley of April 8th, 1935, asking for a report in regard to the Report of their Committee on Economics. Dr. Muir suggested that Dr. K. A. MacKenzie who had attended the meeting at Atlantic City of the Canadian and American Medical Associations could give a good report.

Regarding the place of meeting for the next annual meeting the matter was discussed and the concensus of opinion seemed to be that Halifax was a very good place to have the next meeting, at the same time as the Refresher Course would be held.

There being no further business the meeting adjourned at 1.15 a.m.

# Minutes of the Annual Business Meeting

THE 82nd Annual Meeting of The Medical Society of Nova Scotia was opened at the County Court House, Sydney, N. S. on July 3rd, 1935 at 9.45 a.m. The meeting was called to order by the Secretary, Dr. H. G. Grant, who said that as the President was unable to attend the meeting and the Vice-President, Dr. Dunn, had sent a wire that he would be unable to attend, acording to the Constitution a Chairman would have to be appointed from the floor. It was moved by Dr. Muir and seconded that Dr. D. A. McLeod act as Chairman for the meeting.

Dr. McLeod: "If the meeting will come to order we might as well try to get along with our business, as there is a great deal of detail to be worked on this morning. I am sure I voice your common regret that the illness of our President prevents him from being with us this morning, and we also regret the absence of the Vice-President. The first item on the agenda is the reading of the Minutes."

It was moved by Dr. Dunbar and seconded by Dr. Granville "that the Minutes of the Annual Meeting at Yarmouth, July 4th and 5th, 1934, as published in the BULLETIN, August, September and October, 1934, be taken as read." Carried.

The next matter was "Unfinished Business." It was suggested that we prepare a written communication to be forwarded from the Society to the President at his home in Glace Bay. It was moved by Dr. Gosse and seconded by Dr. H. K. MacDonald that a Committee be appointed from the Chair to carry this out. Carried.

Dr. Grant read the following letter from Mrs. Crockett.

"Dr. Dan McNeil,
President, N. S. Medical Association,
Sydney, N. S.

Dear Sir:—

The following resolution was passed by the Provincial Council of Women of Nova Scotia.

*Resolved*: That this Provincial Council of women urge upon the Nova Scotia Medical Association and the Provincial Department of Health the advisability of legislation controlling the examination and registration of midwives throughout this province.

Yours truly,

(Sgd.) (Mrs. D. W.) ANNIE O'N. CROCKETT,
Prov. Cor. Secretary.

Westville, N. S.
Oct. 1, 1934."

Dr. P. S. Campbell advised that the licensing of mid-wives was in existence in the city of Halifax only, and that as this matter came under the jurisdiction of the Provincial Medical Board, it might well be referred to them. It was moved by Dr. Campbell and seconded by Dr. K. A. MacKenzie that the resolution of the Provincial Council of Women of Nova Scotia be referred to the Provincial Medical Board. Carried.

Dr. McLeod named the following Committee to prepare a letter to be sent to the President: Dr. J. J. MacDonald, Dr. Peter Carter and Dr. A. McD. Morton, the first named to be Chairman.

Dr. Grant stated that formerly it had been customary to appoint two members to the Advisory Board of the Editorial Staff of the C. M. A., more or less to try to stimulate interest in the Canadian Medical Association Journal in Nova Scotia, although these members had nothing to do with the acceptance of articles. Last year it was decided not to appoint any representatives, but Dr. K. A. MacKenzie had asked to have this matter brought before the attention of the meeting and have the two members re-appointed as a friendly gesture.

It was moved by Dr. Beckwith and seconded by Dr. Mack to rescind the action of the last general meeting and re-appoint two members. Carried.

The Reports of Committees were then taken up:

**Report of the Cancer Committee.**

"Mr. president:

Last year this Society decided that some action should be taken looking to the greater dissemination throughout this province of correct information concerning cancer, and your Committee was instructed to approach the Government and ask that the Department of Public Health assume this responsibility.

Before these instructions could be acted upon information had come to hand indicating that the Canadian Medical Association Cancer Committee felt that a National organization for the control of cancer was necessary and should be developed. It then appeared to your Committee that if such an organization as was foreshadowed came into being any Provincial body with similar aim should be so constituted as to admit of its easy dove-tailing into the structure of the greater institution. Your Committee met, and feeling that a Government control organization might not satisfactorily fulfill that requirement, unanimously decided to defer action in the matter. This seems to have found justification in subsequent events which we would next record.

Your Committee has pleasure in recording that early this year a fund was instituted by Her Excellency, the Countess of Bessborough, and was known as King George V. Silver Jubilee Cancer Fund. It was understood that the fund was to be raised for the purpose which has so much concerned us, namely, the dissemination of cancer knowledge. It was hoped that it would reach an amount in the vicinity of a million and a half dollars, and it was to be handed over to a Board of Trustees composed of prominent Canadian laymen and medical men for administration. Your Committee feels that this Society should here record its profound appreciation and gratitude to Lady Bessborough for thus bringing to public notice this great national need.

For completeness of record it should be stated that to this Cancer Fund only $500,000 was subscribed. In this connection we would like to express our feeling that the lack of enthusiasm for the Fund throughout this province is a matter of extreme regret.

It is now apparent to your Committee that the help which was to have come from that source will now be seriously curtailed. Consequently, the need for us to assume the responsibility for the organization of our own province has become all the more urgent.

Your Committee was further instructed to address itself to the matter of cancer quacks. To this end, and acting upon your instructions, we addressed the various Branch Societies for the specific data from their district which would form the basis of our approach to the Government. Only two replies were received. This was wholly inadequate and no further action was taken. It is understood, however, that the abuses complained of last year are as widely practiced as ever. As an example, it is stated, that within a few miles of this place of meeting at least two quacks are operating; that at least one of them has his name side by side with that of our own members in drawing so much a month through the Company check off, and that the other has the most blatant advertising accepted by the daily press of this city of Sydney.

It is now submitted that both these matters referred to us last year and now reviewed indicate a great need for more cancer education. We believe that this should be made the occasion for a re-statement of our position which we would crystalize in the following recommendations:

1. Believing in the urgent need for the undertaking of an educational cancer campaign in this province, we recommend that the Department of Health be approached with a view to having them assume this responsibility.
2. That if they will soon undertake this activity the co-operation of this organized profession in general and its Cancer Committee in particular be tendered to them.
3. That failing that, the Cancer Committee of this Society be charged with the formation of an organization for the purpose named.
4. That in the implementing of this recommendation while much must be left to their discretion insofar as it is possible they shall be guided by the following suggestions:

(a) That looking to financial support and a wider field of usefulness the organizations should include a number of prominent provincial laymen.

(b) That the members of the Cancer Committee of this Society shall be ex officio members of the Board or Council of such an organization, and that affiliation with this Society shall be further maintained by provision for this Society either directly or through its Cancer Committee to appoint or nominate other medical personnel to such Board or Council.

(c) That provision be made for the closest possible working arrangement with any cancer-control body that might arise out of the Canadian Medical Association, or with any other regular organization having similar aims.

3. That the Cancer Committee be instructed to continue its efforts in the matter of cancer quacks looking to the instituting of such legislation as will protect our people from this form of exploitation, and remove an important cause of delay on the part of cancer patients in presenting themselves for proper treatment.

Respectfully submitted,
(Sgd.) N. H. GOSSE,
Chairman, Cancer Committee."

Dr. Gosse—Mr. President, this is subscribed to by Dr. Schwartz, the second member of the Committee, and Dr. Johnson. I beg to move the adoption of this report."

Dr. Schwartz started to give some information regarding the Cancer report but was interrupted by the entrance of Mayor S. E. Muggah of Sydney, who was introduced by the Chairman and extended a very gracious welcome to the Society for which a sincere vote of thanks was extended. Dr. Schwartz then explained in detail some points of the report and seconded the adoption of the report. Carried.

**Victorian Order of Nurses.**

In the absence of Dr. C. S. Morton of Halifax, the report of the Victorian Order of Nurses was read by Dr. Grant.

"To the President and Executive
Of The Medical Society of Nova Scotia.

Gentlemen:—

RE VICTORIAN ORDER OF NURSES.

The work of the V. O. N. carried on in 1934 in Nova Scotia with fourteen branches shows an increase of 800 patients with visits practically as last year. Financially the condition is much the same as with the medical profession—less collections. The work of the Order fluctuates to a considerable extent as hospitalization of indigents increases or decreases. The fact that the service is available for the public generally on a visiting nursing basis for medical and surgical, as well as for maternity cases and for those able to pay as well as for those who cannot, is not sufficiently appreciated, I think, either by the medical profession generally or the public. The Victorian Order is capable of adjustment to local conditions and has throughout the years worked out a system of supervision of the nurses' work which undoubtedly assists the branches in maintaining a high standard of efficiency and service.

All applications for organization are made to the National Office.

Often I commend the Order to the medical profession of this province and assure them that in the V. O. N. we have a thoroughly qualified and most efficient organization, ready, willing and able to respond to and perform all and any demand for nursing at any time. A Canadian Institution in which we may as Canadians feel unbounded pride.

I append a summary of work done by the Order in Nova Scotia for the year ending December 31, 1934.

Respectfully submitted,
(Sgd.) CHARLES S. MORTON."

30 May, 1935.

**VICTORIAN ORDER OF NURSES FOR CANADA.**
**NOVA SCOTIA, 1934.**

| | |
|---|---|
| Number of Centres | 14 |
| Number of Nurses in Nova Scotia | 30 |
| Total Cases Attended | 11,418 |
| Total Visits | 97,646 |
| Medical and Surgical Cases | 3,373 |
| Total Obstetrical Cases | 1,945 |
| Visits to Infants of Obs | 14,032 |
| Obstetrical Visits | 14,444 |
| Child Welfare Visits | 9,818 |
| Communicable Disease Visits | 2,714 |
| Instructive Visits (Others) | 1,894 |
| Total Fees Collected | $18,594.45 |

Dr. D. J. MacKenzie moved the adoption of this report which was seconded by Dr. Hewat. Carried.

**Committee on Public Health.**

In the absence of Dr. M. G. Burris of Dartmouth, Dr. Grant read the following letter.

"Dartmouth, N. S., May 30, 1935.

Dear Dr. Grant:—

In reply to your letter of May 29th notifying me of my duties as Chairman of the Committee on Public Health (Medical Society of Nova Scotia) I may say that I was not previously aware of this appointment and will be unable to act in any capacity on that Committee. I do not plan to attend the meeting at Sydney and would therefore ask you to make such other arrangements regarding the Report of the Committee as may seem best to you.

I remain,

Yours, etc.

(Sgd.) M. G. BURRIS."

It was moved by Dr. K. A. MacKenzie and seconded by Dr. Mack that this communication be filed. Carried.

**Nova Scotia Society for Crippled Children.**

In the absence of Dr. L. R. Morse of Lawrencetown Dr. Grant read the report of the Nova Scotia Society for Crippled Children.

WORK FOR CRIPPLED CHILDREN—NOVA SCOTIA
June 16th, 1934—June 16th, 1935.

During the past year 16 Crippled Children's Clinics were held in Nova Scotia, 13 under Junior Red Cross and 3 under the auspices of the Yarmouth Rotary Club with Junior Red Cross assisting; 472 patients were examined and 54 were treated. This makes a total of 133 Clinics and 1,397 patients examined since the work was started in 1923.

A total of 461 Crippled Children have been treated through Junior Red Cross and many others through the Shrine, Rotary, and other Service Clubs and Organizations.

These figures do not include the weekly Clinic held at Dalhousie Health Centre, Halifax.

Clinics this year were held at Windsor, Kentville, Digby, Yarmouth, Liverpool, New Glasgow, Antigonish, Sydney, Sydney Mines, Glace Bay, (both hospitals), and New Waterford.

With the exception of Kentville and Liverpool, Clinics were held in the hospitals.

Several hospitals have made special bed and X-ray rates for crippled patients. All have co-operated in full towards the success of the Clinics. Some Rotary and Kiwanis Clubs take special interest in this work.

It is gratifying to note that children are being brought in earlier. Last fall three of the patients treated at the Cape Breton Clinic were babies 2 and 3 months old. Another was 10 months old, and another 2½ years.

The Department of Education, School Attendance Branch, sends out Disability Forms to all teachers. In this way it should be possible to list all Crippled Children in the schools and most of those in the homes.

Recently a child, referred in this manner, reported at a Clinic where it was found that she had a marked deformity of the spine. Nine years ago she had Infantile Paralysis affecting the left leg, both arms and hands. She

was treated for this and at that time there was no evidence of a spinal condition. The family noticed it six years ago; but she was not seen at Clinic until last Fall. Treatment was immediately planned for. This girl was 14 years old and had never been to school.

Two little girls aged 8 and 11 years came in this Spring. Both were found to have Congenital Dislocated Hips. The mother of one child reported that they had never had a family doctor. They live in an isolated district.

Amherst and St. Peters have asked for Clinics and information has been asked regarding one for Inverness.

Crippled Children's Clinics under Junior Red Cross may be organized on request from the district, either through a Senior Red Cross Society or some active Service Club. Junior Red Cross Branches must be organized in the schools as many of the Clinic patients requiring hospitalization, braces, etc., are dependent on help from the Crippled Children's Fund—a Fund made up of money earned and saved by the Junior members of the Red Cross.

All child patients helped must be reported through a Junior Red Cross Branch in the district. Through this method boys and girls actively participate in acts of service.

Clinics are held Spring and Autumn in Sydney, Glace Bay, Sydney Mines, New Waterford, Yarmouth, Windsor and Kentville; and once a year in Digby, Liverpool, New Glasgow and Antigonish.

Clinics are open to underprivileged crippled children up to sixteen years of age.

Stops are sometimes made on request of a doctor.

Work for Crippled Children in Nova Scotia has enlisted the interest and support of many organizations and individuals. To make it completely effective, however, the following points should be assured:

1. Listing of every crippled child.
2. Immediate treatment—(more economical and more humane).
3. A convalescent home—to release hospital beds for acute illnesses, teaching of exercises, close supervision, school training, etc., etc.
4. Close follow up in the home.
5. *Special* arrangements for education.
6. Vocational Guidance.
7. Education of public, especially girls and mothers, in proper care of babies and children and in *prevention* of deformity.
8. State provision for clean, healthy, light surroundings, adequate and proper food, and institution of above points as early as possible.

The Junior Red Cross sincerely appreciates the co-operation and assistance of the medical profession throughout the Province, also Hospital Staffs, School Nurses, Public Health Nurses, and Victorian Order Nurses.

It was moved by Dr. J. J. Macdonald and seconded by Dr. Benvie that this report be adopted. Carried.

**Historical Medicine.**

In the absence of Dr. H. L. Scammell of Halifax, Dr. Grant read the following report.

"May 30th, 1935.

Dr. H. G. Grant,
Sec't., The Medical Society of N. S.,
Halifax, N. S.

Dear Dr. Grant:—

As Chairman of the Committee on Historical Medicine, I beg to report that the said Committee has not met, nor so far as I know, functioned during the past year. This I regret deeply, and in my last report if I remember correctly I pointed out that the Society might appoint this Committee yearly from one of the Branch Societies so that it could meet, the members being near together, and accomplish something in the way of local historical research. The recommendation was evidently not accepted as the present Committee is residentially scattered from Dan to Beersheba. If the Society thinks it worth while to maintain this Committee, it should adopt some scheme to permit the members to meet frequently. I thought at that time and still do, that if the Society offered a yearly prize or medal to the member presenting for publication in The BULLETIN the best original historical article each year, much interest would be stimulated. In closing my report for last year, I tendered my resignation as Chairman, feeling that as I was unable to accomplish anything of value, some other person should be tried, who, I felt, under different arrangements, would be more successful. This you did not see fit to accept and while I appreciate the honor greatly, I feel that valuable years are slipping by when local Medical historical material might be preserved which otherwise will be lost in a few years, and your Committee is functioning in name only. Why not appoint your Committee for this year from the Cape Breton Medical Society and ask it to publish during the year at least two papers on local history?

Yours truly,

(Sgd.) H. L. Scammell, M.D."

Dr. Grant: "Last year Dr. Scammell made two suggestions in his report, first, that we offer a prize for the best historical paper, and secondly, that the Committee appointed from one Branch Society, and somehow or other these suggestions were overlooked. I would suggest that the Committee be appointed this year from the Cape Breton Medical Society."

It was moved by Dr. K. A. MacKenzie and seconded by Dr. Beckwith that the report on Historical Medicine be referred to a special committee appointed by the Chairman. Carried.

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**Traffic Laws in Japan are Few—but Funny.**

The following rules of the road, copied literally as they appeared in English at police headquarters in Tokio, have been brought back by an American visitor to Japan:

1. At the rise of the hand of policeman, stop immediately.
2. Do not pass him or otherwise disrespect him.
3. When a passenger of the foot hooves in sight tootle the horn, trumpeting at him melodiously at first, but if he still obstacles your passage, tootle him with vigor and express by word of mouth the warning, "Hi! Hi!"
4. Beware the wandering horse that he shall not take fright as you pass him by. Do not explode an exhaust blow at him. Go soothingly by.
5. Give big space to the festive dogs that shall sport in the roadway.
6. Avoid entanglement of dogs with the wheel-spokes.
7. Go soothingly on the slippery mud and avert the skid demon.
8. Press the brake on the foot as you roll around the corner to save collapse and tie up.—*Nation's Traffic.*

# REGISTRATION

## 82nd Annual Meeting, July, 1935, Sydney, N. S.

Dr. J. G. B. Lynch, Sydney, N. S.
Dr. H. G. Grant, Halifax, N. S.
Dr. G. G. Cormier, Sydney, N. S.
Dr. D. A. McLeod, Sydney, N. S.
Dr. H. R. Corbett, Kentville, N. S.
Dr. M. J. Macaulay, Sydney, N. S.
Dr. J. A. Langille, Pugwash.
Dr. H. A. Ratchford, Inverness, N. S.
Dr. P. McF. Carter, Sydney, N. S.
Dr. Frank G. Mack, Halifax, N. S.
Dr. E. K. Woodroofe, Canning, N. S.
Dr. G. W. Sodero, Guysboro, N. S.
Dr. E. M. McDonald, Sydney, N. S.
Dr. H. W. Schwartz, Halifax, N. S.
Dr. W. L. Muir, Halifax, N. S.
Dr. A. R. Reid, Windsor, N. S.
Dr. N. H. Gosse, Halifax, N. S.
Dr. Hugh R. Peel, Truro, N. S.
Dr. D. Murray, Tatamagouche, N. S.
Dr. John K. McLeod, Sydney, N. S.
Dr. W. R. Dunbar, Truro, N. S.
Dr. D. J. MacKenzie, Halifax, N. S.
Dr. R. M. Benvie, Stellarton, N. S.
Dr. J. R. Corston, Halifax, N. S.
Dr. E. T. Granville, Bedford, N. S.
Dr. Chas. J. W. Beckwith, Kentville, N. S.
Dr. T. R. Johnson, Great Village.
Dr. A. McD. Morton, Halifax, N. S.
Dr. J. J. MacDonald, New Glasgow, N. S.
Dr. H. K. MacDonald, Halifax, N. S.
Dr. F. R. Davis, Halifax, N. S.
Dr. W. B. Moore, Kentville, N. S.
Dr. W. Alan Curry, Halifax, N. S.
Dr. A. F. McGregor, New Glasgow, N. S.
Dr. M. R. Elliott, Wolfville, N. S.
Dr. F. F. Eaton, Truro, N. S.
Dr. M. J. Wardrope, Springhill, N. S.
Dr. J. J. Cameron, Antigonish, N. S.
Dr. W. A. Hewat, Lunenburg, N. S.
Dr. Thos. A. Kirkpatrick, Kentville, N. S.
Dr. P. S. Campbell, Halifax, N. S.
Dr. K. A. MacKenzie, Halifax, N. S.
Dr. H. J. Townsend, Louisbourg, N. S.
Dr. A. L. Sutherland, Sydney, N. S.
Dr. James Bruce, Sydney, N. S.
Dr. J. J. Carroll, Antigonish, N. S.
Dr. T. C. Routley, Toronto, Ont.
Dr. E. C. Menzies, Saint John, N. B.
Dr. J. C. Meakins, Montreal, Quebec.
Dr. G. K. Smith, Hantsport, N. S.
Dr. John J. Roy, Sydney, N. S.
Dr. Gordon B. Wiswell, Halifax, N. S.
Dr. V. D. Schaffner, Kentville, N. S.
Dr. F. O'Neill, Sydney, N. S.
Dr. J. W. Smith, Liverpool, N. S.
Dr. R. Ross, Sydney, N. S.
Dr. J. C. Ballem, New Glasgow, N. S.
Dr. A. T. Bazin, Montreal, Canada.
Dr. Wm. R. McRae, Sydney, N. S.
Dr. Arthur L. Murphy, Halifax, N. S.
Dr. J. J. F. Macaulay, Sydney, N. S.
Dr. J. R. Macneil, Glace Bay, N. S.
Dr. F. T. Densmore, Dominion, N. S.
Dr. G. F. Dewar, Charlottetown, P. E. I.
Dr. D. W. Archibald, Sydney Mines, N. S.
Dr. Eric W. Macdonald, Reserve, N. S.
Dr. D. A. Campbell, Bridgewater, N. S.
Dr. P. J. MacGregor, Laurenceville, Ill.
Dr. F. G. MacAskill, Glace Bay, N. S.
Dr. B. C. Archibald, Glace Bay, N. E.
Dr. J. C. Morrison, New Waterford, N. S.
Dr. J. S. Brean, Mulgrave, N. S.
Dr. J. S. Munro, North Sydney, N. S.
Mr. G. A. Anqhrin, 5328 Snowdon Ave., Montreal, Que.
Dr. L. R. Meech, Morth Sydney, N. S.
Dr. A. K. Roy, North Sydney, N. S.
Dr. A. Calder, Glace Bay, N. S.
Dr. D. W. McDonald, Glace Bay, N. S.
Dr. H. J. Martin, Sydney Mines, N. S.
Dr. B. S. Bishop, Kentville, N. S.
Dr. S. McCurdy, Truro, N. S.
Dr. Arthur Green, Glace Bay, N. S.
Dr. C. E. Stuart, Parrsboro, N. S.
Dr. John Fraser, Montreal, Quebec.
Dr. F. T. MacLeod, New Waterford, N. S.
Dr. W. W. Patton, Port Morien, N. S.
Dr. W. T. McKeough, Sydney Mines, N. S.
Dr. J. L. MacMillan, Westville, N. S.
Dr. D. R. MacRae, Sydney Mines, N. S.
Dr. Harvey Sutherland, Glace Bay, N. S.
Dr. A. S. Kendall, Sydney, N. S.
Dr. J. W. McLean, North Sydney, N. S.
Dr. C. J. Sparrow, Reserve, N. S.
Dr. H. B. Havey, Stewiacke, N. S.
Dr. D. J. Hartigan, New Waterford, N. S.
Dr. J. J. MacRitchie, Halifax, N. S.

# CANCER SECTION

## Preventive Medicine in Relation to Cancer

JOSEPH COLT BLOODGOOD, Baltimore, Md.

I HAVE been studying the best way to present to the public and to the medical and dental professions the little things that may precede cancer or may be the beginning of cancer, the little things, which if recognized in time, mean that cancer can be prevented or cured. In contrast to these little things, think of the neglected cancers which originated in these little things. A person may be perfectly aware of the little things, but absolutely ignorant of the danger of delay. For example, in 1894, one of the patients in Johns Hopkins with a huge fungous tumor occupying the right temple asked me, after I had completed the history, whether it was "ripe enough to be operated on." This patient had observed a little nodule the size of a pea for ten years and had watched it grow, from a scab, ulcerate and produce a fungus. During this time there was no pain, or discomfort of any kind. She was not influenced by its disfigurement. She was an old fashioned mother who gave more thought to her children, her husband and the care of the home than to her own comfort and appearance. And now she wanted to know whether "it was ripe enough to operate on it." Modern surgery, removed this huge fungous growth without difficulty. The large area was then grafted. The cancer never reappeared in the locality of its origin. But the patient died of internal metastases because during this period of delay cancer cells entered the blood vessels or lymphatics, were carried like chips on a stream, were caught in various parts of the body, and those cells that lived grew until new tumors destroyed the life of the patient.

Now, this woman who had carried this skin defect on her temporal fossa was aware of it for ten years; the family knew all about it; her family physician must have seen it when he came to attend her for a cold. Her children and her grandchildren knew of its presence. But all of them were ignorant of the danger of that little skin nodule.

During twenty years I have been rewriting, under various titles, what every doctor should know about cancer and what everybody should know about cancer, and what every child should know about cancer. It can be written and illustrated differently every few years. In the beginning we could only illustrate late cancer and prophesy what we could do for early cancer. Now we know all the little things that precede cancer and of the early stages of cancer. We have accumulated the facts to prove that cancer of the skin, of the mouth and the cervix of mothers, and of the nipple of the breast, are preventable diseases. We are not the first prophets, but *we are the first who have lived to see our prophecies come true.*

The Eighth Challie Memorial Oration abridged for the Refresher Course Committee Faculty of Medicine Dalhousie University and published by courtesy of the Medical Society of Nova Scotia.

Let me contrast here for a moment the difference between the cancer of the old lady, my patient in 1894, with the janitor of an apartment house in Baltimore in 1933. Remember, the old lady waited ten years until the tumor had become a fungoid mass and wanted to know whether "it was ripe enough to be operated on." This janitor may have been just as ignorant, but fortunately the people about him knew the danger of neglecting the little things visible on the skin. A colleague of mine, a paediatrician, in going down the elevator noticed a nodule the size of a pea on the temporal fossa of this janitor. At one point it had begun to ulcerate. He called me up by telephone and, as the janitor left work at four-thirty, he was advised to come to the clinic. Within ten minutes he was in the little operating room and under local anaesthesia the nodule was removed with the proper margin of healthy tissue. A frozen section was made demonstrating that the proper margin had been given the tumor. The tumor was a subepidermal nodule of basal epithelial cells which had ulcerated and become malignant. The janitor was back at work at six o'clock and lost a little time later for one dressing. We may be quite certain that there will be no recurrence and no metastasis.

We now know that no beautiful woman develops cancer of the skin, because she pays attention to the first skin blemish. The wife of a well-known senator reading this statement in the morning paper said to her husband: "If I had that mark on my nose, I would have it looked at by a doctor." The senator was at the clinic the next day, received the same treatment as the janitor and with the same result. Some ten years ago I used to see beautiful women with cancer on one side of the nose due to the neglect of irritation caused by the pressure of the never-slip glasses. Apparently such no longer occur thanks to newspaper publicity

All women should be informed by the medical profession, public health departments, through the press and in the school books on preventive medicine, that any neglected irritation of the nipple when nursing a child is apt to lead to a mastitis or infection of the breast which may produce an abscess. The same neglected irritation of the nipple, while not nursing a child, may lead to cancer. The nipple is no different from the skin, except it is difficult to keep it clean, and still more so when the nipple is retracted. A physician should always see any skin defect, like a wart or a mole, whether pigmented or not, or a nodule, whether in or beneath the skin in order to decide whether it should be removed at once or left alone until it gets larger. All elevated warty pigmented moles and of all pigmented areas beneath the nails, or in areas subjected to trauma, like by a razor, a belt, a suspender, should be removed. Recently I was consulted by a man aged thirty-five. His physician had removed from the skin of his back a wart and an elevated pigmented mole. They were not saved for microscopic study. The patient was subsequently examined for life insurance and passed all the tests, but had been rejected because the mole had not been studied microscopically to determine whether it was benign or malignant. We now must inform the public and the profession that when any kind of a skin defect is removed, especially a mole, it must be subjected to microscopic study and the sections preserved. It is important to mention here that the American College of Surgeons has attempted, from the very beginning of its existence, to establish the rule in all standardized hospitals, that all tissue removed from patients is to be sent to the laboratory for microscopic study and the opinion recorded.

Any irritation of the skin, any little spot that is rough, or looks irritated should be washed with soap and water, using absorbent cotton, washed off with medicated alcohol and then covered with a little vaseline or yellow oxide of mercury (2 per cent). If in a few days the lesion does not disappear, the treatment should continue, but a bit of cotton should be put over the vaseline or yellow oxide of mercury and fixed with collodion. Then if it does not disappear, one should see one's physician. The cotton and a small bottle of medicated alcohol, the tube of vaseline or yellow oxide salve should be part of every toilet set, and the care of the skin should be taught to children and adults just as much as first aid for cuts and bruises. *Fully developed cancer of the skin is a disease of dirt, ignorance, and neglect.* The greater the vanity of personal appearance, the less the danger of cancer of the skin. Since the new fashion of the low-cut back, I have been fortunate to observe, on the backs of some of my colleagues' wives very dangerous looking black moles and have succeeded in getting them removed.

As the number of women reached through the press and other channels of publicity increases, the number of women who consult doctors within the first month after their first symptoms calling attention to the breast, the most common disease that will be diagnosed will be chronic cystic mastitis. When one hundred women are examined within the first month of the first symptom and repeated transillumination is employed in addition to palpation and inspection, eighty-five per cent of the women will not need to be subjected to operation, and will run no risk.

Every general practitioner, every interne, everyone who makes a general examination must be familiar with the new interpretation of breat lesions by inspection, palpation and transillumination. The transillumination light for the diagnosis of breast tumors must be as universally accepted and employed as the stethoscope. Surgical pathologists in the operating room of the hospitals of this country must familiarize themselves with the varying microscopic appearances of chronic cystic mastitis. This disease is one that the entire medical profession needs to know more about.

**Cancer of the Cervix in Mothers.** The contrast between cancer of the cervix in mothers and cancer of the skin and nipple, and cancer of the mouth is dramatic. To-day, in enlightened communities, the majority of the lesions of the skin and mouth are benign; in cancer of the cervix in mothers the reverse is true.

The educational effort is influencing mothers with cancer of the cervix who have definite symptoms, but *is not yet reaching the mothers who have no symptoms.* Cancer of the cervix can and should be discovered by semi-annual pelvic examination in mothers in which there are absolutely no symptoms—pain or discharge. We now know that cancer never begins as cancer, but that there is first a local growth of cells which differ from normal cells. These cells may be embryonic residues, or cells changed by chronic irritation or injury. For this group of cells which are abnormal but not yet cancerous, the term percancerous is employed. In this stage there is usually neither pain nor discharge. In the change from the abnormal cell to the cancer cell there may be no pain or discharge of any kind. We can easily observe this in the skin, in the nipple and in the mucous membrance of the mouth. When any local lesion here changes from abnormal to cancer, as a rule the patient is unaware of it, and sometimes the trained eye of an expert cannot detect that the malignant change has taken place. The detection rests upon the biopsy and

a frozen section. That is, early cancer is a microscopic disease. *The old and vast knowledge of the clinical picture is becoming less and less valuable,* and even the gross appearance in which so many surgeons have become so proficient, is no longer to be depended upon. These facts are best proved in cancer of the cervix. Protection of mothers from cancer of the cervix rests upon the modern conception of periodic examinations and biopsy, and the cure of cancer of the cervix in this stage may be either by surgery or irradiation. At the present moment, the majority of authorities favor radium, with the addition of X-ray treatment in certain cases. In spite of this definite proof of the possibility of prevention and cure, our educational efforts have either not reached the mothers, or, if they have, very few have acted upon it. It is my hope that ignorance rather than fear, is the basis of the lack of progress in the prevention and cure of cancer of the cervix in mothers.

**The Oral Cavity.** Inspection of the mouth should be part of every physical examination, and, no matter what the patient consults you for, there should be at least a brief look at the mouth, fauces and nasopharynx with a light, just as there should be an inspection of the cervix in a mother, and a glance at the skin for defects that should be removed or treated. The first changes in the mucous membrane due to the irritation from teeth or dental plates and *aggravated by tobacco in any form,* may be painless and not visible to the individual. The normal mucous membrane of the mouth, fauces and nasopharynx is so typical that one recognizes in a moment a change. The moment anything abnormal is seen, the source of irritation should be searached for and removed. There are many—ragged, dirty teeth; ill-fitting plates; tobacco in any form are the chief offenders. Vincent's angina ranks next.

The great mistake that many physicians and dentists make to-day is that they do not make a thorough inspection of the oral cavity, They do not understand or accept that the irritations of ragged dirty teeth, ill-fitting plates and tobacco is cause of cancer of the mouth. The removal of these causes should be the first procedure in ay preventive or curative treatment.

**Bone.** Briefly, some of the rules are: Always take and X-ray film of the opposite bone for comparison. It is a good plan never to omit X-rays of the pelvis, chest, lateral view of the skull, and films of the teeth. In this way it will be possible to determine at once whether the single bone lesion is part of a general condition of the skeleton, benign or malignant. The next procedure is a Wassremann test. If there is no pain and no suspicion of maligancy in the X-rays, wait for the Wassermann test and if it is positive, begin the intravenous treatment. If there is pain and a suspicion of malignancy exists, start the deep X-ray treatment at once, and when the Wassermann report comes in and is positive, start the intravenous therapy and discontinue the X-ray treatment temporarily. Perhaps the most neglected examination is the blood chemistry, chiefly for calcium and phosphorus, and the palpation of the neck for parathyroid tumors. When the X-ray films rouses suspicion of a lesion suggesting osteitis fibrosa and there are changes in the blood chemistry, it is wise to give X-ray treatment over the patathyroid even when there is no enlargement or no definite tumor.

The point I wish to emphasize is this: That every bone malignancy, primary or metastiatic, should be given the benefit of a course of irradiation. We must remember that syphilis, osteomyelitis, multiple myloma, metastatic tumors, have to be considered, even when only one bone is involved. Theoretically, every bone lesion should have a complete examination. This is

more difficult in private cases because of the expense. When surgery is indicated, after trial of irradiation has failed, the decision as to the nature of the lesion may rest upon a biopsy. What is the danger, if your pathologist is unwilling to take the responsibility of advising an amputation or resection? Apparently, if there has been irradiation first, one may do a biopsy with as little traumatism as possible, cauterize the wound, close it, continue irradiation and send the sections or tissue to a number of pathological experts on bone diseases. In my first reported case of sarcoma of bone cured by amputation, there was an interval of two weeks between the biopsy and the amputation, and there was no irradiation.

To increase the number of cures of sarcoma of bone, the public needs continuous education, especially the teachers in public schools and parents must know that the first thing to do for a pain or swelling near a bone or joint is to have an X-ray picture. None should be treated for rheumatism, bruise, charliehorse, growing pains, bursitis, arthritis, without an X-ray study first.

**The Stomach.** One should be able to detect an organic lesion of the esophagus and stomach including the duodenum by one complete fluoroscopic examinination and one or more films.

I know of only two proved carcinomas of the stomach that were overlooked after careful fluoroscope and X-ray film examination on first admission, but detected at a second examination a few months later, and confirmed by operation. The great trouble is that the so-called indigestion is so common that the majority of cancers of the stomach are not studied with the X-rays until they have become inoperable.

It is difficult to give proper care to your own family and friends and to colleagues in the medical profession when they mention their ailments casually without coming to consult you in the usual way. Apparently this is a fundamental fault in explaining the little progress in curing cancer of the stomach.

The problem is how best to influence the general public and the profession to realize that a gastrointesinal study, if there are any symptoms in the upper abdomen, is as essential as the stethoscope and electrocardiogram for the heart, and the transillumination of a mass in the breast.

**The Colon.** The problem is identical with that in cancer of the stomach. We cured cancer of the colon ten or fifteen years before we cured cancer of the stomach by resection, and we first cured cancer of the left colon, especially the sigmoid, because patients came under observation with obstruction.

There is no difficulty in examining the colon properly. We can take an X-ray picture after an enema of barium, and examine the colon by fluoroscope and the X-ray film. We can use the proctoscope. The difficulty is to get the examination in time. I think the majority of patients consult doctors in time, just as they do for gastric symptoms, but the majority of doctors, even to-day, do not use these methods of examination in time.

**The Rectum.** With finger and the proctoscope, the rectum is just as visible to the physician as the skin of the mouth or the cervix of the uterus. Every clinic now is getting earlier cases of cancer with many benign polypoid tumors.

To protect from and to increase the number of cures of cancer of the rectum depend upon the rectal examination with the finger and the proctoscope as a part of every routine examination.

# Department of the Public Health

## PROVINCE OF NOVA SCOTIA

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

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

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

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

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Braine, L. B. W., Annapolis Royal.
Kelley, H. E., Middleton (County & Town).

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McNeil, J. R., Glace Bay.
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O'Neil, F., Sydney (County), South Side.
Murray, R. L., North Sydney.
Townsend, H. J., Louisburg.
Gouthro, A. C., Little Bras d'Or Bridge, (Co. North Side.)

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Drury, D., Amherst (County).
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Withrow, R. R., Springhill.

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Rice, F. E., Sandy Cove (Mcpy.).
Belliveau. P. E., Meteghan.Clare Mcpy.

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Moore, E. F., Canso.
Monaghan, T. T., Sherbrooke (St. Mary's Mcpy).

### HALIFAX COUNTY

Almon, W. B., Halifax.
Forrest, W. D., Halifax (County).
Glenister, E. I., Dartmouth.

### HANTS COUNTY

Bissett, E. E., Windsor.
MacLellan, R. A., Rawdon Gold Mines (East Hants Mcpy).
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Chisholm, D. M., Port Hood.
Chisholm, M., Margaree Harbour (County).
Ratchford, H. A., Inverness.

### KINGS COUNTY

Bishop, B. S., Kentville.
Bethune, R. O., Berwick (Co. and Town).
deWitt, C. E. A., Wolfville.

### LUNENBURG COUNTY

Marcus, S., Bridgewater (Mcpy.).
Rehfuss, W. N., Bridgewater.
McKinnon, C. G., Mahone Bay
Zinck, R. C., Lunenburg.
Zwicker, D. W. N., Chester (Chester Mcpy).

### PICTOU COUNTY

Crummy, C. B., Trenton.
Blackett, A. E., New Glasgow.
Chisholm, H. D., Springville, (County).
MacMillan, J. L. Westville.
Stramberg, C. W., Trenton.
Sutherland, R. H., Pictou.
Benvie, R. M., Stellarton.

### QUEENS COUNTY

Ford, T. R., Liverpool (County).
Hebb, F. J., Liverpool.

### RICHMOND COUNTY

Deveau, G. R., Arichat (County).

### SHELBURNE COUNTY

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

### VICTORIA COUNTY

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

### YARMOUTH COUNTY

Blackadar, R. L., Port Maitland (Mcpy).
Burton, G. V., Yarmouth.
O'Brien, W. C., Wedgeport.
Siddall, A. M., Pubnico (Argyle Mcpy.).

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

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

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

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**Report on Tissues sectioned and examined at the Provincial Pathological Laboratory from July 1st., to August 1st., 1935.**

The number of tissues sectioned is 212. In addition to this, 26 tissues were sectioned from 7 autopsies, making 238 in all.

| | |
|---|---|
| Tumours, malignant | 37 |
| Tumours, simple | 22 |
| Tumours, suspicious | .. |
| Other conditions | 153 |
| Tissues from 7 autopsies | 126 |
| | —238 |

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

| County | Chicken Pox | Diphtheria | Influenza | Measles | Mumps | Pneumonia | Scarlet Fever | Paratyphoid | Tbc. Pulmonary | Tbc. other Forms | V. D. G. | V. D: S. | Whooping Cough | German Measles | Undulant Fever | Erysipelas | Septic Meningitis | Chancroid | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Annapolis | .. | 1 | 2 | 1 | 26 | .. | .. | .. | .. | .. | 2 | .. | 34 | 2 | .. | .. | .. | .. | 68 |
| Antigonish | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Cape Breton | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Colchester | .. | .. | 8 | .. | .. | 2 | .. | .. | 1 | .. | 2 | .. | .. | .. | .. | .. | .. | .. | 13 |
| Cumberland | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Digby | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Guysboro | .. | .. | .. | .. | .. | 1 | .. | .. | 2 | .. | 1 | .. | .. | 1 | .. | .. | .. | .. | 5 |
| Halifax City | .. | 13 | .. | .. | .. | .. | 36 | .. | 3 | .. | .. | .. | 1 | 3 | .. | 2 | .. | .. | 58 |
| Halifax | .. | .. | .. | 5 | .. | .. | 4 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 9 |
| Hants | .. | .. | .. | 11 | .. | .. | 5 | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | 17 |
| Inverness | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Kings | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 | 1 | 1 | .. | .. | .. | 4 |
| Lunenburg | .. | .. | .. | .. | .. | .. | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 1 |
| Pictou | .. | .. | .. | .. | .. | .. | .. | 1 | 1 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 2 |
| Queens | .. | .. | .. | .. | .. | .. | 5 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | 5 |
| Richmond | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Shelburne | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Victoria | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | ... |
| Yarmouth | .. | .. | 3 | 2 | .. | 1 | .. | .. | 3 | .. | .. | .. | .. | .. | .. | .. | .. | .. | 9 |
| TOTAL | .. | 14 | 13 | 19 | 26 | 4 | 53 | 1 | 10 | .. | 5 | 1 | 37 | 7 | 1 | 2 | .. | .. | 193 |

Positive cases Tbc. reported by Dr. M. H. O's. 62.

**RETURNS VITAL STATISTICS FOR JUNE, 1935.**

| County | Births | | Marriages | Deaths | | Stillbirths |
|---|---|---|---|---|---|---|
| | M | F | | M | F | |
| Annapolis | 18 | 13 | 13 | 14 | 4 | 0 |
| Antigonish | 19 | 9 | 3 | 8 | 6 | 0 |
| Cape Breton | 123 | 117 | 66 | 45 | 33 | 8 |
| Colchester | 23 | 21 | 25 | 9 | 10 | 3 |
| Cumberland | 39 | 41 | 37 | 19 | 11 | 3 |
| Digby | 11 | 14 | 22 | 6 | 8 | 3 |
| Guysboro | 22 | 18 | 4 | 11 | 4 | 2 |
| Halifax | 107 | 106 | 93 | 54 | 46 | 5 |
| Hants | 12 | 14 | 17 | 7 | 6 | 0 |
| Inverness | 20 | 18 | 4 | 11 | 17 | 2 |
| Kings | 25 | 21 | 26 | 13 | 17 | 1 |
| Lunenburg | 25 | 22 | 24 | 20 | 9 | 1 |
| Pictou | 31 | 28 | 28 | 18 | 11 | 0 |
| Queens | 20 | 10 | 13 | 3 | 2 | 1 |
| Richmond | 10 | 12 | 1 | 5 | 5 | 1 |
| Shelburne | 9 | 9 | 8 | 9 | 5 | 2 |
| Victoria | 6 | 6 | 3 | 3 | 2 | 0 |
| Yarmouth | 13 | 8 | 17 | 9 | 11 | 0 |
| | 533 | 487 | 404 | 264 | 207 | 32 |

# Personal Interest Notes

DR. and Mrs. W. G. Colwell of Halifax have left for a motor trip to Ottawa, where they will be the guests of Mrs. Colwell's parents, Mr. and and Mrs. E. H. Mathewman.

Congratulations to Dr. S. N. Miller of Middleton who celebrated his 85th birthday on Sunday, July 21st. Dr. Miller is probably our oldest active member, having been engaged in practice for sixty years. May he continue the good work for many years to come.

Dr. and Mrs. Carl Eaton and their young son, of Vancouver, are visiting at Truro, guests of the former's parents, Dr. and Mrs. F. F. Eaton.

A recent wedding of interest, not only in Halifax but in general throughout the maritimes, took place at St. Johns United Church, Halifax, on Saturday. July 20th, when Ida Isabella, daughter of Mrs. and the late Wm. H. Mitchell was united in marriage to Dr. Henry Walter Moyse, of Bedeque, P. E. I. Following the ceremony Dr. and Mrs. Moyse left for a motor trip to New Brunswick and Quebec. Dr. Moyse is a graduate of the Dalhousie Medical School, 1933.

Dr. J. K. MacLeod, of Sydney, and son, Hugh MacLeod are visiting St. John's, Newfoundland.

Dr. Bernard F. Miller of New Waterford has spent two weeks in July at the Militia Camp in Prince Edward Island.

**"New Biologic for Control of Cancer, announced by Canadian physician."**

The press carries the announcement of a new biologic for the treatment of cancer, by Dr. Hendry C. Connell of Queens University, Kingston, Ont. The product, which Dr. Connell calls "Ensol" has been tried out clinically (says the report) and in certain cases has brought about a decided improvement in cases of advanced carcinoma. So far as we know there has been no publication of this work in any Medical Journal. Every few months the press announces something new in the way of a cancer cure. Let us hope that perhaps there may be an element of truth in this one.

Dr. J. M. Barry of Saint John was elected president of the New Brunswick Medical Society at the recent annual meeting at Fredericton.

Dr. John Stewart, who has been in practice at Upper Stewiacke for several years has taken a position on the medical staff of Camp Hill Military Hospital, Halifax.

Patient at Dalhousie Chest Clinic, "I was in the Tuberculosis Hospital and Dr. Sieniewicz and a lot of students held a panic over me."

Congratulations to Dr. and Mrs. H. L. Scammell of Halifax on the birth of a daughter.

Dr. W. H. Robbins of New Glasgow spent a week-end recently at Digby.

We are pleased to hear that Dr. Day of Thorburn has recovered from his recent illness and was able to return from the Aberdeen Hospital to his home.

Dr. and Mrs. Beckwith of Kentville spent a pleasant week at Herman's Island, Lunenburg County.

Dr. Gordon McCurdy and wife of Halifax spent "Old Home Week" at Sydney, guests of Dr. McCurdy's parents.

Dr. G. W. T. Farish of Yarmouth visited Boston during the latter part of July.

**Politics:** Dr. D. M. Cochrane of River Hebert was nominated representative of the Conservative Party for Cumberland County at the convention held in Amherst July 22nd.

Dr. Joseph Brody of New York City spent a few days with his parents, Mr. and Mrs. Brody of Sydney.

Dr. and Mrs. Bruce of Brooklyn, N. Y., were visitors during the month at Weymouth.

The wedding took place at St. Mary's Cathedral, Halifax, on July 16th, of Miss Helen Mary Boudreau, daughter of Mr. and Mrs. H. C. Boudreau of that city, and Dr. Gabriel Boudreau of Cheticamp. Following a reception breakfast given at the home of the bride's aunt, Mrs. Arthur Chaisson, Dr. and Mrs. Boudreau left for Port Hood.

### Medicine Men Bang Drums, Try to Rouse Their Dead

Regina, Sask.—Modes of the white men creep into lives of western Indians, but one old traditional figure—the medicine man—still haunts the reserves.

They practise their weird herbal rites, bury deceased brethren and then rattle drums in the hopes they will return to life.

Their influence is dying, says W. Murison, inspector of Indian affairs for Saskatchewan, but it will be another generation before they are extinct.

Medicine men are always old men, and their charms appeal to the old Indian with the ancient aboriginal beliefs.

"The old timers still cling to the medicine man's claim of healing," Mr. Murison said, "but the younger men are increasingly anxious to go to a hospital when ill.

"I can't think of a reserve where there isn't a medicine man," Mr. Murison said. "Sometimes we have difficulty in persuading the older Indians to take medicines prescribed by the medical officers, but influence of the medicine man never causes serious trouble."

One ancient custom of the medicine man in conducting a funeral was to shake a medicine drum containing a rattle. The medicine man believed it would bring the deceased back from the Indian's happy hunting ground to ground where hunting was perhaps not so happy but maybe more productive.

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### Bones were Plentiful.

The inspector had come to examine the class in physiology. He tried a little girl with this teaser:

"How many bones have you in your body, little lady?"

"Something like nine hundred," was the prompt reply.

"Oh, indeed," said the inspector. "Well, that's a great many more than I have."

"Very likely," said the child, "but I guess you ain't had herring for breakfast."

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"Here lies our wife, Samantha Proctor;
She ketched a cold and wouldn't doctor;
She couldn't stay; she had to go—
Praise God from whom all blessings flow."

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There was a hold-up at a busy London crossing, and the traffic was slowly getting into more and more of a tangle. On the front of one of the waiting lines of cars and buses was a luxurious limousine. Suddenly its occupant, a very elegant-looking lady, could restrain her impatience no longer.

Leaning out of the window, she cried in imperious tones:—

"Officer, I demand that you let me proceed. I am the wife of a Cabinet Minister."

The dour Scots policeman turned to her with a tolerant smile.

"Lady," he said, "I coluldna let ye do that even if ye was the wife of a Presbyterian meenister."