Recent Advances in the Study of Artificial Hypertension

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WITHIN the last four years our knowledge of the factors involved in the production of arterial hypertension has advanced with such rapidity that a brief summary of some of the more important conceptions regarding this disease would appear to be acceptable to the busy medical practitioners, who so frequently meet with it in their clinical practice.

Since the days of Richard Bright it has been realised that cardio-vascular-renal disease is of prime importance in the production of hypertension, yet it has not been clear how this mechanism works in the majority of cases. Following Bright's classical description of chronic glomerulonephritis, it was shown that an arteriolosclerosis was present in the kidneys and certain other organs in these cases, it was therefore assumed that the hypertension and cardiac hypertrophy were compensatory mechanisms whereby the blood flow through the damaged kidneys might be enhanced. Volhard and Fahr soon afterwards differentiated the hypertension of chronic glomerulonephritis (secondary granular contracted kidney) from that associated with primary renal arteriolosclerosis (primary granular contracted kidney) and thus essential hypertension became recognised as an entity. With this division it was generally conceded that the inflammatory damage to the renal glomeruli and arterioles in chronic nephritis was sufficient to explain the rise of blood pressure in such cases, while in essential hypertension the rise was said to be due to an increased peripheral resistance, the result of arteriolar sclerosis. Further histological study however proved that the organic disease of the arterioles, even in the severest cases, was not sufficiently widespread to explain the persistent hypertension. Allbutt[1] then suggested that generalised vaso-constriction was the initial cause of the raised pressure and that the arteriolo and arterio-sclerosis were due to the prolonged "wear and tear" of the sustained tension within the vessel walls. The cause of the generalised vasoconstriction was never satisfactorily explained, but sympathetic nervous disturbances and adrenal gland dyscrasias were variously accused.

Thus the conception of hypertension generally held in the present day text-books is that it may be:

1. Secondary to renal disease; chronic glomerulonephritis; polycystic kidney; severe renal amyloid disease; chronic pyelonephritis; arterio-sclerosis due to lead poisoning, etc.
2. Primary in nature, i.e., Essential hypertension. This group includes by far the majority of cases and has been defined by Fishberg[2] as, "Those cases of chronic hypertension which neither clinically nor anatomically can be demonstrated to have evolved from antecedent inflammatory disease of the kidney or urinary obstruction."
3. Paradoxical hypertension; associated with various disorders, e.g., chromaffin tumours of the adrenal gland, basophil adenoma of the pituitary (Cushing's syndrome), toxaemias of pregnancy, arterio-venous aneurysm, etc.

The entire problem confronting the clinician and pathologist was the etiology of essential hypertension, namely: "Was the hypertension actually caused by generalised vasoconstriction as outlined above or was the arteriolosclerosis the primary factor and not secondary to the raised pressure as suggested?" These questions now appear to be satisfactorily explained from the experimental work done, and certain factors have evolved which give hopes of even more efficacious methods in the future for the treatment of hypertensive cases.

Goldblatt's Experimental Hypertension

Goldblatt,[3, 4, 5] by a series of ingenious experiments, has been able to produce a persistent hypertension in dogs identical with essential hypertension in humans. He uses a special silver clamp by which the renal arteries can be constricted. When one artery is clamped the blood pressure rises but returns to normal after a period varying from a few weeks to six months; when both arteries are moderately constricted the rise in pressure is persistent but not accompanied by changes in the renal excretory function, i.e., it simulates the benign phase of essential hypertension. When both arteries are severely constricted, however, there is a rise in blood pressure associated with reduction in renal excretion, the animal finally developing uraemia with convulsions, the picture thus being typical of the malignant type of hypertension.

The main factor involved in this rise in pressure is an ischaemia of the kidneys; the actual hypertension being produced either by a nervous reflex set up in the ischaemic kidney or by some humoral mechanism. Further experiments involving denervation of the kidneys, section of the splanchic nerves and even pithing of the animal failed to prevent or reduce the hypertension of renal ischaemia, thus ruling out the nervous reflex. In another series of experiments Goldblatt was able to obtain hypertension by producing ischaemia in a kidney transplanted to the neck of the animal; furthermore if the renal vein of the ischaemic kidney were tied, or if a nephrectomy was performed, the hypertension promptly fell. Goldblatt thus concluded that some "pressor substance" was formed in the ischaemic kidney which, on being absorbed in the blood stream, produced the hypertension.

It should be noted that in his experiments he was never able to produce a generalized arteriolosclerosis such as is seen in benign essential hypertension, but in those animals in which he produced uraemia and hypertension, there was an arteriolonecrosis identical with that seen in humans who have died of malignant hypertension, and he states that "the recent conclusion that widespread sclerosis is produced by hypertension alone is not justified," but that hypertension associated with renal failure is probably the cause of the typical arterial changes seen in the malignant form of hypertension.

The Pressor Substance

Page[6], Munoz[7], and others have done a great deal of work on the pressor substance apparently liberated from the ischaemic kidney. Their conclusions, briefly summarized, would indicate that the ischaemic kidney secrets an enzyme called renin which acts on a blood globulin variously termed "Renin-activator," or "Hypertensin precursor." This interaction results in the formation of a substance "Hypertensin" which has a direct vasoconstrictor action

on the blood vessels, thus resulting in an increased peripheral resistence as the result of which hypertension is produced.

Another enzyme "Hypertensinase" has been demonstrated in blood and normal tissues which destroys the action of hypertensin. Although this work is still in the experimental stage, it can be appreciated that if this "Hypertensinase" could be suitably extracted then a new method for treatment of hypertension might be evolved.

Application of Experimental Hypertension to Clinical Cases

It is perhaps too early to attempt an application of this experimental work to all cases of clinical hypertension, but it appears quite clear that at least the pathogenesis of so-called renal hypertension can be explained on Goldblatt's conclusions. As the result of inflammation in chronic nephritis, a fibrosis occurs in the glomerular capillaries and afferent arterioles leading to the production of ischaemia with the release of renin and consequent generalised vasoconstriction and hypertension. In the same way the blood pressure rises in cases of chronic pyelonephritis. It is of great interest to note that several cases of hypertension resulting from unilateral chronic pyelonephritis have been completely cured by the removal of the affected kidney, thus completely substantiating in clinical cases the finding of Goldblatt in his experimental dogs.

As regards essential hypertension the proof is not as yet so complete. Moritz and Oldt[8], after a very careful study of 100 cases of hypertension, controlled with 100 non-hypertensives, conclude that renal arteriolosclerosis is the most common cause of chronic hypertension. This conclusion is not in agreement with many other authorities, who, while admitting that renal arteriolosclerosis is almost invariably associated with hypertension, claim that it is due to the hypertension and not its cause. However, as noted above, Goldblatt disagrees with this latter theory on the basis of his histological examination in his experimental cases; it thus appears reasonable to suggest that the arteriolosclerosis is primary and causes a renal ischaemia with the release of renin and the production of hypertension. The latter intensifies the "wear and tear" effect on the arterioles as the result of which further narrowing occurs and thus a vicious cycle is set in motion. If this theory be accepted, it confirms the truism propounded by Fishberg: "As so often in science, the advance has followed a closed orbit leading back to where Bright started."

Regarding treatment of hypertension, Page et al[9] have published some very interesting data on the use of normal kidney extracts. The fact that when Goldblatt's clamp is used unilaterally the hypertension is not persistent, suggested the possibility of the normal kidney secreting some type of depressor substance which would cause a fall in blood pressure. With this in mind these workers have used normal kidney extracts in 60 dogs with hypertension and in all the blood pressure was reduced; in six humans with benign hypertension all showed clinical improvement after injection of the extract, while in five with malignant hypertension, three showed good results. In all these cases improvement was only noted while the extract injections were kept up, the blood pressure rising about one week after the last treatment.

One cannot comment on this phase of the work as yet, but surely one can hope that the day is not too far distant when we shall have some potent type of extract with which to alleviate the numerous patients suffering from hypertension.

SUMMARY

1. A discussion of the recent work on experimental hypertension and its clinical application is given.
2. Hypertension appears to be due to the release of a vaso-pressor substance secreted by an ischaemic kidney.
3. The ischaemia may be produced as the result of inflammation, e.g.—chronic glomerulonephritis, or due to primary renal arteriolosclerosis, e.g. essential hypertension.
4. An extract from normal kidney has been produced that causes a fall in raised blood pressure.

REFERENCES

1. Allbutt, C.: Diseases of Arteries, MacMillan & Co., London, 1915, Vol. 1.
2. Fishberg, A. M.: Hypertension and Nephritis, Lea and Febiger, Philadelphia, 1940; p. 555.
3. Goldblatt, H.: Annals Int. Med. 1937; 11, 69.
4. Goldblatt, H.: The Harvey Lectures, 1937-38; Williams and Wilkins, Baltimore, p. 237.
5. Goldblatt, H.: Am. J. Clin. Path. 1940; 10, 40.
6. Page, I. H.: J. Exper. Med. 1939; 70, 521.
7. Munoz, J. K.: et al: Am. J. Med. Sc. 1940; 200, 608.
8. Moritz, A. R. and Oldt, M. R.: Am. J. Path. 1937; 13, 679.
9. Page, I. H.: J. Exp. Med. 1941; 73, 7.

A certain lady we shall call Mrs. White once invited a wealthy uncle to stay at her summer place hoping she and her family would make such a good impression that the uncle would . . . well, she wasn't in a hurry but when the time came she could do with a little extra money.

Before the uncle's arrival she spoke sternly to her husband and children: "Uncle Will has the most frightful nose. It's long and red and seems to fill up his whole face. People in the subway have been known to break out laughing. He's very sensitive about it so the way to spoil everything is to talk about long noses—anyone's nose. As a matter of fact, while he's here, we won't mention noses at all. Don't even mention a bird's beak.

"Now please try to remember what I have told you!"

The uncle arrived and Mrs. White silently observed that the great nose should have been taken into the movies where such things have a commercial value. The children appeared not to notice. As for Mrs. White, she feared it would slip out, that fatal word that seemed to dance on the tip of her tongue. Noses became her obsession. But still nothing happened. The day of departure came and the farewell pieces were spoken. The uncle had enjoyed a perfect, noseless holiday. Mrs. White spoke up at last, "We've all enjoyed it so much and you must come up and nose us again sometime soon."

The uncle looked straight into her eyes and smiled sourly. The truth took only fifty seconds to filter in.—Loren Carroll in *Coronet*, Chicago.

On Vaginal Discharges

H. B. Atlee

It is probably no exaggeration to state that most of us, when confronted with a vaginal discharge, order a douche or a medicated pessary and let it go at that. Some will go so far as to take smears of the cervix and urethra in the hope of trapping an elusive gonoccocus. But beyond that, diagnosis and treatment merge into the mists of empiricism. This—like our economic system in which men starve in the midst of plenty—is an extraordinary phenomenon, since in both cases diagnosis and cure are relatively simple. Anyone with a microscope, a slide, a coverslip and a drop of tap water can very easily put salt on the tail of most of the diagnoses involved; with the necessity of calling in the Public Health Laboratory only to pith love's little diplococcus. It really is as simple as that.

These vaginal discharges deserve discriminating treatment. God knows women have enough to suffer because of the quaint and ironic arrangement of their physiological processes. Anything that can be done to make the patient more comfortable is very much an aid to the better female life.

Bloodless vaginal discharges divide themselves for the most part into the following groups:

1. The acute gonococcal.
2. Chronic cervicitis, usually accompanied by more or less simple erosion, due either to the gonococcus or infection by other organisms grafted on a parturient birth injury, and occasionally complicated by the presence of simple adenomatous polypi.
3. Trichomonas infestation.
4. Thrush, or moniliasis.
5. Senile vaginitis.
6. Simple leucorrhea, or the whites.
7. Leucorrhea cerebri.

Since one bacteria's poison may be another bacteria's meat, complete success in treatment rests on diagnosis. What will knock the gonococcus cold may only give the trichomonad a headache. And diagnosis is, as I have stated, comparatively easy. Here you are, looking at the woman's perineum. Is there any sign of irritation as shown by redness of the perineal skin? If there is such redness, can we exclude diabetes? It's astonishing how often you get a surprise and find that the red perineum is due to sugar in the urine. In the absence of diabetes, two and possibly three of the above-mentioned discharges will cause perineal irritation; the acute gonococcal, the trichomonad, and sometimes thrush. With these discharges the woman will complain of the irritation—perhaps it is the irritation rather than the discharge that has brought her to you. The other discharges do not, as a rule, cause irritation.

Now separate the labia. If there are little white spots on the inner sides of the minora, you are almost certainly dealing with thrush, and a direct smear will show this—but we will deal with smears later. Are the labia acutely inflamed? If they are the condition is probably acute gonorrhea. What is the character of the discharge? If it is stringy mucus—whether purulent or not—it is coming from the cervix and is either gonorrheal, or that mixed infection that goes with most simple cervical erosions. Sometimes it is clear

mucus without apparent purulent content. At other times, and this is characteristic of acute gonorrhea, the mucus is as yellow as daffodils. But whether clear or yellow, if it is mucoid, it is coming from the cervix and nowhere else. If it has the pale insipid color of the lowest two inches of a bottle of Halifax milk, it is a simple leucorrhea. The trichomonas discharge varies greatly in color and consistency, as there is really no characteristic trichomonas discharge, textbooks to the contrary notwithstanding. I have found this piquant little organism in a discharge that was a thick, buttery cream; in a discharge that was thin, yellow and full of bubbles; in a discharge that was almost as pale as simple leucorrhea. But one thing it never is: it is never stringy and mucoid. If you touch it with a wooden applicator it adheres, whereas the mucoid discharge that comes from a sick cervix is as hard to pick up as a pea from a plate. The discharge of senile vaginitis also varies in character; usually it is thin and purulent, sometimes it is blood-stained, occasionally it is thick and purulent. Having noted all this, one now milks the urethra for the golden bead of gonococcal pus. If it is not golden, it is unlikely to be gonococcal. And finally one looks for the tell-tale redness around the mouths of Bartholin's ducts, and palpates for possible enlargement of the glands—either of which puts the gonococcus behind the eight ball.

Of course I have oversimplified these observations with my dogmatism. What one sees with the naked eye can only be like newspaper headlines in war-time, an approximation to the truth. Here, as elsewhere in life, one must probe deeper to grasp the ultimate realities. But I would to God it were as simple to pierce the realities behind this world sickness that has engulfed us in a savage war as it is to discover the truth behind the appearances of most vaginal discharges. If only the flux from the mad lips of Herr Adolph Schicklegruber could be placed on a glass slide, and its virulent causative organism made as visible as those of these vaginal fluxes, what a hope for civilization!

Perhaps such a discovery, and the resultant treatment, is beyond the capacity of our science. Perhaps there is a limit beyond which science cannot extend in the diagnosis and healing of such soul ills as Herr Schicklegruber's fluxes symptomatize. But I do not entirely despair of science in this regard. I ask myself if perhaps the scientific *method* may not hold the key to ultimate morality. For is it not inherent in that method that we accept as truth only that which can stand the scrutiny of unfettered experimentation; that we reject all opinion that cannot stand so rigid a test? Is it not inherent in the scientific method that there is no ultimate truth, that truth is, in the Bergsonian sense, constantly in a state of becoming? Day before yesterday the molecule, yesterday the atom, to-day the electron—tomorrow something more infinitesimal, and more truthful—but never completely truthful? Is it not a fact that if we had applied the scientific method to our social and economic problems, Hitlerism would not have survived the first experiment?

But let us return from the empyrean to the vagina. Here is our discharge whose naked-eye characteristics have already given us some faint insight into its nature. We now place a drop of tap water or saline on a slide. We mix thoroughly with an applicator some of the discharge with the tap water. We place a coverslip over it. We put it under the *high* power of the microscope. I emphasize the word "high" purposely and for this reason: Despite my most urgent pleadings, my internes and students insist upon turning the low power on these fluxes—as though they were afraid that if they magnified these organisms too greatly, they would bite. They assure me that they can

see everything with the low power that I can with the high. (Thus hath youth always attempted to ridicule age!) But let me confess to you, my peers, that for years I sought and failed to find the secrets of vaginal pathology with the low power. It is out of humiliating experience that I abjure you to use the high. Or, to paraphrase the well-loved song: "Ye'll tak' the low power, and I'll tak' the high power, and I'll trichomonas before ye!"

But as there is more to a flower than its perfume, so is there more to these vaginal discharges than their organismal content. Here, as elsewhere, it is so easy to miss the forest for the trees. Forget organisms for a moment and have a regard for cells. If, gazing down the microscope, you see only epithelial cells of normal-size and shape, you can be certain you will find no *pathogenic* organism, though you search with the eyes of angels. If there are only normal epithelial cells, you are dealing with a simple leucorrhea or leucorrhea cerebri. On the other hand if you find practically nothing but pus cells you can be sure that you are not dealing with trichomonas and thrush. With these two there is usually a fairly even admixture of both types of cells —in some cases more epithelial than pus, in others more pus than epithelial. If the woman is at or past the menopause, or has been castrated by operation, one should note more carefully the character of the epithelial cells. If these cells, instead of being large and rectangular with a comparatively small nucleus, are small and round with a comparatively large nucleus, and if along with such epithelial cells there are many pus cells, you can safely make a diagnosis of senile vaginitis.

And now to organisms. Since staining by the Grams method and the recognition of the gonococcus are a specialist's job, smears of the cervix and urethra should be sent to the Provincial Laboratory when gonorrhea is suspected. But as truly as one swallow does not make a summer, so truly does one negative slide not exclude gonorrhea. Not long since I found the little rascals after five negatives. Even in acute gonorrhea one may take two or three smears without getting a positive.

But here we are gazing down at this drop of water mixed with flux. We have noted the cellular content and character. We now look for the trichomonas and monilia. The trichomonas is quite easy to spot. In many cases you see the actual organism, larger than a pus cell, smaller than an epithelial, oval in outline, with a little whip sticking out from his behind (or before). He moves. He whips himself across the field with the jerky gait of a Ford on a frosty morning. In other smears you may not be able to spot him as an individual. He will be mixed up with a group of pus cells, which he seems to be trying to tear to pieces as a cat tears a mouse. You will see, in effect, jerky movement in a clump of cells. But don't let eagerness betray you. Very often you will see in these fluxes cells that are being pushed by motil, bacteria. In this case, however, the movements are gentle and wormiane and have not the wide, angry excursions of the trichomonad savagery.

Thrush, or monilia, shows no movements. Instead one sees a thread-like network of fine strands, with cells caught between, or adherent to them. In my experience thrush is not common—but it can be very distressing. It is practically always associated with the small white characteristic patches on the side of the labia minora and on the vaginal walls.

A word about leucorrhea cerebri. This is the most intractible of all vaginal discharges to cure, since it is not really a discharge, but a state of mind. Here is the picture. A woman, or girl, who approaches the confessional

furtively and with much side-stepping, as though she harboured a profound sense of guilt. Or a woman who walks right up to the point with the dogmatic "Doctor, I have the most *awful* discharge. Nobody seems to be able to do anything for me. It's making my life *so* miserable—and such a *terrible* odor."

On examination, such a case presents as a rule a perfectly normal vagina and cervix with very little secretion lying about. In fact the passage is usually as clean as Saturday night's children. A direct smear shows nothing but normal epithelial cells with the occasional pus cell. I had a girl not long ago who was so hipped on her discharge and its odor that she had given up practically all social activity and yet her vaginal secretion was normal. The point I would like to stress is that the first step to rational treatment in such cases is the direct smear. The most vital step towards treatment is to convince *yourself* that there is nothing in this patient's vagina but a normal secretion. When you have done that you can leave her nether parts alone and come to grips with her mind, for it is only through mental therapy that this type of discharge can be cured.

And so to treatment. I will not waste your time with yet another dissertation on the handling of acute gonorrhea. What with sulphanilamide and local applications to the cervix and urethra, this is fairly well standardized to-day. My own practice is to put these cases on sulphanilamide for about three weeks —sometimes with a nightly picric acid cone and morning weak permanganate douche—and then go a-smearing. If the smears are consistently negative up to six, I call it a day and rejoice. If they are still positive, I bow to the inevitable of the long-drawn-out weariness of local applications to the cervical canal and the urethra.

In chronic cervicitis, with or without erosion, the quickest and most satisfactory treatment is the cautery. Usually linear cauterizations of the entire length of the canal—one or two sittings done in the office—are enough to clear up both the cervical pathology and the discharge. But in those cases where the gonococcus is known to be present I believe it is better to cone out the whole cervical canal epithelium with the diathermy cautery under an anesthetic. Occasionally—but only occasionally—one encounters a great, thick, brutal-looking, grossly-eroded cervix that would be the better of a Sturmdorf amputation. If adenomatous polypi are present, the cauterization takes care of them, but it should be through in the region of the polypus-base.

The trichomonas infestation is sometimes easy, sometimes difficult to cure. There is a great tendency to relapse. The patient gets relief from the irritation and stops treatment before all the organisms are destroyed. The simplest form of treatment is to have the woman insert a devegan tablet high up the vagina every night, and take two douches a day of vinegar, six tablespoons to the quart of water. She should hold her vulva around the douche nozzle so that the vagina will be ballooned out and the fluid reach the troughs of all the vaginal folds. This treatment should be continued until two menstrual periods have ensued, and for a week after the second. During the menstrual periods she should discontinue the douches but continue to insert the devegan tablets each night. A great many failures in treatment have resulted from a neglect of treatment during the menstrual periods. A week after treatment is stopped, the patient should return for another smear examination.

While the above treatment will cure the majority of cases, it fails in a fair proportion. For that reason I carry out the following treatment immediately when possible. Every second or third day for three sittings the vulva and

vagina are thoroughly scrubbed with a gauze sponge soaked in dilute green soap. The parts are then dried, and the cervical canal painted with Tr. iodine. Dry silver picrate, or aldarsone, is blown into the vagina, and the urethra washed out with 1.1000 acriflavine solution (aqueous) applied with a medicine dropper. Thereafter the patient is told to use the devegan tablets and vinegar douches herself until a week after her next period. A week later she is re-examined. I find that trichomonas infestation is a relatively common condition. It should be searched for in all cases where the discharge is accompanied by perineal irritation and itching. Oddly enough, one finds it quite frequently in cases where no discharge is complained of. I run into it surprisingly often in my routine post-natal examinations.

Thrush is best treated by cleaning off the little white patches with 5 per cent soda bicarb solution, and then painting vulva, vagina and cervical canal with gentian violet 1 per cent (aqueous) and acriflavine 1 per cent (aqueous) in equal parts. This type of discharge is also associated with perineal irritation and itching.

Senile vaginitis yields pre-eminently to the estrogenic hormone. While the simpler cases will respond to weak vinegar douches, there are others that no douche—not even Il Duce—can cure. To these the hormone should be given. While pessaries are advised by some, I have found this method of treatment not so effective as intramuscular injections, and it is better to start with not less than 2 mg. twice a week. After the condition improves, the hormone can be given by mouth. Cure should be checked by examining direct smears. When the small round epithelial cells return to the normal large rectangular shape, and the pus cells become few in number, the long day is ended.

Simple leucorrhea, or the whites, is unlikely to be benefitted by local treatment; may indeed be made worse due to the added chemical irritation of douche. The condition should be looked upon as an excess of a normal secretion, and not as something actually pathological. If the patient can be thus reassured, if she can be convinced that the discharge is normal rather than pathological, this is sometimes all the treatment required. On the other hand, leucorrhea, while not in itself pathological, is usually evidence of a run-down physical, or overstrung nervous condition. In such cases building up the patient's general health and ameliorating her psychic strains will cause the discharge to disappear.

What I have called leucorrhea cerebri is the most difficult of these discharges to cure. What douche can minister to a mind diseased? And it is entirely to the mind that treatment in these cases should be directed. To prescribe local therapy of any kind is the worst possible course to pursue, since it tends to reinforce what is, in effect, a delusion. Having made certain of the diagnosis by the direct smear, one should most dogmatically assure the patient that her vagina is normal and its discharge free of any pathological, or venereal taint. Particularly should one stress that it has no venereal taint. But that is not enough. Behind the delusion is a very real and tragic state of the mind that deserves our most careful attention.

Here, alas, we fall down sadly. Obsessed by the reality of physical disease, we have not yet as a profession come to grips with the mental ill-health that is all too prevalent. Because we have not studied psychology in the sense that we have studied physiology, we do not understand mental ill-health and tend to show anger and impatience in the face of it. We diagnose the neuroses negatively, by a process of exclusion, and not by positively recognizing their

dynamic manifestations, and because we feel hopeless over our incapacity to treat them, our reaction is one of annoyance—"just another bloody neurotic!"

But if we are ever to understand the phenomena of our Hitlers and Mussolinis—phenomena in themselves essentially neurotic—we must face this matter of mental ill-health with the same scientific detachment and lack of passion with which we have faced, and to such a magnificent degree conquered, so many of the manifestations of physical ill-health. In fact, I go so far as to make this prophecy: the next great field of medical endeavour, and the one in which ultimately we will cover ourselves with our greatest glory, will be that of the mind diseased. Three hundred years ago Shakespeare put the challenge to us. Soon, surely, we must take it up.

But let us once again, and for the last time, return to the unhappy vagina. These discharges deserve more than the thoughtless douche. Their diagnosis is so simple, their treatment once diagnosed so straightforward and satisfactory, that the reward is worth the trouble. Is it too much then to plead for such diagnosis and treatment:

> "Before decay's effacing fingers
> Have swept the lines where beauty lingers?"

The Story of First Aid in Nova Scotia*

LIEUT.-COLONEL EDGAR W. MINGO, V.D.

UNCHARTED oceans, cannibal islands, spanking sails and the patter of children's feet on well honed decks, Victorian ladies complete in bonnet, bustle and pantalettes swinging aloft in a bosun's chair to view, in the rising sun, the palms on Tahiti.

These things were, I am sure, far from the mind of the Director of Ambulance when he suggested a short article on the work of the Order of St. John in Nova Scotia. So inured have we become to a world of power, machinery, materialism and make believe that the human realities of fifty years ago, when they cross our path, have all the shock of a phantom in a ruined mill.

The name, S. S. *Sunbeam* may mean nothing at all to the present generation. To older men and women it is a phantom of pleasing memory. A memory of happy hours of escape from the mundane stuffiness of our youthful sitting rooms to a few hours of play in the South Sea Islands. In delightful English the Log speaks, walks, breathes and fires our imagination with living pictures until we sing the songs of Polynesians, clothed only in flowers and smiles, and growing weary, refresh ourselves from the juice of imaginary green coconut. The *Sunbeam* was owned by the Brassey family and was first used by them for a sort of extended and belated honeymoon in the Pacific Ocean. In all, she made four voyages of which we have a record. On one of these Lady Brassey came ashore at Halifax and made a serious effort to establish the St. John Ambulance Association on Canadian soil.

The Brasseys were a family of railroad builders. In the eighties and nineties of last century, the fatal accidents in that industry in Britain alone ran to over one thousand per year. It is only natural to suppose that the lethal properties of the family occupation were a matter of great interest to the Brassey family. They were among the earliest apostles of "First Aid" and their work on behalf of the Association was widespread.

Halifax did not, at first, take Lady Brassey very seriously. The "Warden of the Honour of the North" was then a garrison city, starched in precedence and brilliant in gold braid. It was not until 1892 that definite action was taken. In that year Capt. Lees-Hall, who commanded Cogswell Street Station Hospital, returned from furlough in England, full of enthusiasm for the cause of First Aid. In those days the Army Medical Service did not extend much beyond the Bearer Sections of units while the increase in both the lethal power of weapons and the knowledge of surgery made some additional provision necessary. As is customary in long periods of peace, authority was slow to act and army medical men were glad to recruit and train voluntary bodies, without being too particular about the excuse.

On St. John's day, 24th June, 1892, a meeting was held at Government House. Sir Malachi Daly, the Lieut. Governor, extended his patronage. The Commander-in-Chief of North America, General Sir John Ross, presided. Among those who supported him were the Admiral in Command of the North Atlantic Squadron, the Bishop and Archbishop, the Premier, the Attorney-General, the Chief Justice and a number of judges, the Mayor and the City

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Clerk, the Grand Master of Masonry and a concourse of Naval and Military officers. These gentlemen brought their wives. The record names them with the appendix, "*And also a number of other ladies were present as well.*"

A carefully prepared address by Capt. Lees-Hall was followed by speeches from others present who apparently took the floor in order of precedence. In the end a resolution was passed establishing a Centre with the following officers:

President—General Sir John Ross.

Vice-Presidents—Admiral Hopkins, Lieut-Governor Sir Malachi Daly.

Hon. Secretary—Rev. F. B. N. Norman-Lee.

Hon. Secretary—Mrs. James Morrow.

Forty members signed the roll and apparently a number of them planned to attend lectures. The others were unanimous in the hope that the Volunteer Fire Brigades would take up the work.

In that year classes were held in the Church of England Institute and a Junior group was trained in St. Paul's Hall. Dr. Tobin instructed the latter and Surgeon Colonel Oliver was the examiner. Some effort was also made to extend the work to Stellarton, Springhill, Sydney and other mining centres. Contact was made with the Intercolonial Railway at Moncton, where their head office and repair shops were located.

On the night of the 14th of February, 1895, a meeting was called in the old Drill Hall on Spring Garden Road for the purpose of forming a Division of the Brigade. Colonel Oliver, Dr. Tobin and a young medical practitioner Dr. Guy Carleton Jones (now Major-General Guy Carleton Jones) attended. The recruits were drawn largely from the Boys' Brigade class at St Luke's Hall. This Division became a sort of elite Corps. They trained weekly in the drill hall and attended the militia at gun practice in the forts. Later to some extent the recruits were drawn from the then Dalhousie Medical College. There was a waiting list longer than the membership roll. Discipline was strict and a favourite punishment for absenteeism was to transfer the delinquent to the waiting list.

The first public service of this Division was during Queen Victoria's Jubilee celebration in Halifax. In 1897 they went to Aldershot Camp and gave voluntary service during the training of the militia. The following year they went again and were inspected by Sir Frederick Borden. He was quite pleased with the service rendered and Dr. Jones took advantage of the occasion to ask for the loan of uniforms from the Militia Stores. The Minister promised to take the matter under consideration. He could find no legal or other precedent but the difficulty was overcome by making them a Militia unit with the title of 1st Bearer Coy., Canadian Militia.

When the Boer War broke out they volunteered for active service and with the C.O., Major Guy Carleton Jones, they served in the Campaign in Africa as a part of the Detachment sent from Canada under Colonel Worthington of Sherbrooke, Quebec.

After their return they were reorganized and became the 1st Field Ambulance, Canadian Militia. During the Great War from 1914 to 1919 this unit took over and ran Cogswell St. Station Hospital at Halifax as well as supplying many detachments and personnel for overseas and other services.

When the Canadian Militia was again reorganized in 1920 they lost their old number and became the 22nd Field Ambulance, R.C.A.M.C. This unit is again on service as part of the C.A.S.F.

The work of the Association in the province was somewhat intermittent during the early days of the century. General contact was kept with coal

mines and the railway with an occasional class in Halifax. About 1910 a new start was made at a meeting at Government House. Sir Joseph Chisholm, then Mayor Chisholm of Halifax, was elected President of the Nova Scotia Council. In 1911 a class was organized among the Halifax City Police.

Major J. A. Rudland, who was then Chief of Police, has this First Aid story to tell about that police class. The course was not too popular but eleven men were persuaded to attend outside of their hours of duty. One of these was Constable Lovett. Four or five years after, Lovett and Major Rudland's brother were buddies in the Canadian Railway Corps in France. One night during an air raid a bit of German bomb came through their tent and severed Rudland's leg. Lovett, because of his knowledge of First Aid, was able to stop the haemorrhage and treat him for shock. It was two hours before medical attention could be obtained, but Rudland lived.

During the following year, 1911, interest in the work began to grow in the capital city. W. H. Studd was then Hon. Secretary of the Provincial Council and a Centre was organized in Halifax under the Chairmanship of R. V. Harris, K.C., then a Controller of the City.

When war broke out in 1914 this Centre sponsored in all three Nursing Divisions of the Brigade. These did noble work all through the war and in particular during the strenuous days of the explosion. At this time some two thousand people were killed and upwards of five thousand injured. The facilities available could not begin to cope with the situation. The members of the Brigade, who were able to be about, worked day and night for weeks among the debris of what once had been happy homes, innocent of danger.

Throughout the war the Provincial Council looked after the province, the Halifax Local Centre and the Nursing Divisions, the city. A large number of women took courses and many enlisted in the V.A.D. Council and served in England and France. When peace came the interest lagged. Gradually the Brigade, one Division after another, ceased to hold meetings, ceased to elect officers, ceased to exist. About 1924 the Provincial Executive was again reorganized. The most notable recruit to the Council at this time was J. J. Kinley, M.P., of Lunenburg, who has from those dull days been unwavering in his support and who for the past fourteen years has filled the chair.

The late W. H. Studd continued to be the Hon. Secretary until his death in 1937. He built anew on a foundation of solid public service that has again stood the Association in good stead in these present troubled years.

Perhaps the most notable achievement rendered by the Order was the parentage of the 1st Bearer Corps, Canadian Militia, in the latter days of the last century. Perhaps the most notable name is that of Major General Guy Carleton Jones. Perhaps the most outstanding public service was the help rendered during the Halifax Explosion in 1917.

At the same time we must remember the miners who daily assist each other in this most dangerous of occupations. We must remember the people who have served on public occasions such as the Royal Visit when eighty-two post were fitted out complete with material and personnel. We must remember the Medical Profession. Since the first of January, 1939 (twenty-one months) over one hundred doctors have without charge taught or examined three hundred classes. We must remember the unrecorded contribution of hundreds of men and women who, in their homes and about their work and their play have used their knowledge of first aid to allay pain and to save life among their families and their neighbours.

We have gone a long way since S.S. *Sunbeam* dropped anchor in Halifax Harbour a half a century or more ago. Like the *Sunbeam* not all of our course has been the smooth and scented waters of the Southern Seas. But unlike the *Sunbeam* we have not reached our final haven. Before us lies the eternal struggle of good against evil. The Order in Nova Scotia looks forward to continuous effort wherever and whenever human suffering may arise.

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1. The Order of St. John, or to give its full name, the "Grand Priory in the British Realm of the Venerable Order of the Hospital of St. John of Jerusalem," the English branch of the ancient Order of Chivalry and Knighthood was founded about 1048 to render aid to pilgrims to the Holy City of Jerusalem. This Order established hospitals and ministered to the wants of sick and distressed pilgrims. The knights and soldiers of the Knights Hospitallers, as they were called, played a leading part along with the Knights Templar, throughout the Crusades in the defence of Europe from the Turks. Driven from Palestine in 1272, the Order established itself in later years at Cyprus and Rhodes, and in Malta in 1535. From Malta they were driven by Napoleon in 1798. The badge of this great Order of chivalry is an eight-pointed white cross on a black ground. The King is Sovereign Head of the British branch of the Order; the Duke of Gloucester is the Grand Prior. A Commandery of the Order was established in Canada in 1934. The Earl of Athlone, Governor-General, is Knight Commander. The Commandery controls the work of the St. John Ambulance Association and the St. John Ambulance Brigade in Canada.

2. The St. John Ambulance Association was established in 1877 by the English Branch of the Order, for the purpose of giving instruction in the treatment of accident cases, sanitation, home nursing and other subjects.

3. The Association is organized as a world-wide organization, with headquarters in London, England. The St. John Ambulance Association in Canada has its headquarters in Ottawa, with branches in each Province. The organization in all cities and towns is known as a local centre. A centre was first organized in Halifax in 1892 and reorganized from time to time. The Provincial organization was formed in 1910. The secretary of the Provincial Association is Colonel E. W. Mingo, Halifax.

4. Instruction is given in First Aid to the Injured, 6 to 12 lectures; Home Nursing, 6 to 14 lectures; Hygiene, 24 lectures. Junior courses in First Aid or Home Nursing for children under 16.

5. Of what use is the First Aid Course? Accidents and injuries, fractures, dislocations, sprains, burns, bites, drownings, poisonings occur every day. Policemen, firemen, sailors, soldiers, athletes, factory and industrial employees, trainmen, school teachers, scoutmasters, housekeepers, in short, everyone, may need such knowledge any day. Candidates for Master's or Mate's certificates in the British mercantile marine are required to hold First Aid certificates.

6. The First Aid Course consists of a brief description of the human skeleton and the muscular system; fractures and treatment; bandaging; dislocations; strains; sprains; the circulation of the blood; haemorrhage; wounds; bruises; burns; scalds; bites; stings; frost bite; sunstroke; foreign bodies in eye, ear and nose; the nervous system; respiration; restoration of apparently drowned; insensibility; poisoning; carrying and lifting the sick and injured. Instruction is limited to what best to do between the time of the accident or sudden illness and the arrival of the Doctor. Diagnosis treatment and after-care are forbidden.

7. The Home Nursing Course gives elementary instruction under the following headings: Selection and preparation of sick room; bed and bedding; infectious and non-infectious diseases; quarantine; fever; disinfectants; the nurse; visitors; lifting patients; diet; food; medicines; stimulants; observation; sleep; appetite; temperature; baths; treatment; symptoms; bandaging; personal and family hygiene; convalescence. Like First Aid, all instruction that might conflict with those professionally trained is avoided.

8. The Home Hygiene Course aims to teach the first principles of sanitary science and the laws of health; heredity; the functions of the human body; nutrition; personal habits; exercise; rest; cleanliness; bathing; effects of surroundings on human body; air and ventilation; water; sources, purity and filtration; foods, diets; cooking; adulteration; clothing; the dwelling; lighting and heating; sanitation.

9. Any number up to thirty of one sex form a class for instruction on completion of which an examination is held and if passed, entitles the candidate to a certificate issued by the Canadian Association, registered in London, England, and recognized throughout the world. Vouchers, medallions, labels and pendants may be obtained on re-examination.

10. The fees for instruction are fixed by the class and are sufficient to cover instructions, books, bandages, examination and certificate. The Association makes no profit and its officers are not paid.

11. The St. John Ambulance Brigade is an organization distinct from the St. John Ambulance Association and composed of those who hold certain certificates granted to them by the St. John Ambulance Association or are possessed of certain other qualifications.

12. Men who hold certificates in First Aid from the Association are eligible to join an Ambulance Division. Women holding both First Aid and Home Nursing Certificates or who are trained or graduate nurses may join a Nursing Division of the Brigade.

13. Members obligate themselves to attend at least 12 drills or practices a year; to keep up their knowledge of First Aid (and Home Nursing); to be ready to act whenever an emergency arises.

14. All Divisions operate under a Doctor licensed in the Province in which they are located.

OSLER—"*Evolution of Modern Medicine.* (p. 13)—One department of Egyptian medicine reached a high stage of development, viz., hygiene. Cleanliness of the dwellings, of the cities and of the person were regulated by law, and the priests set a splendid example in the frequent ablutions, shaving of the entire body, and the spotless cleanliness of their clothing. As Diodorus remarks, so evenly orderly was their whole manner of life that it was as if arranged by a learned physician rather than by a law-giver.

On a shopping expedition with a life-wise lady I know, I saw her buy several men's neckties, have them wrapped separately, and write on each package, "Soft Soap." . . . To my puzzled inquiry she explained: "With a husband and two grown sons in the house, I have found that a gift-surprise necktie, produced at the right moment, will often work wonders when I'm getting ready to talk one of my menfolk into doing something that he may not want to do."—Princess Alexandra Kropotkin in *Liberty*, New York.

Editor's Column

THE NOVA SCOTIA PHARMACY ACT 1940 AMENDMENT

At the annual meeting of the Medical Society of Nova Scotia in Digby in July, 1939, a discussion arose over the sale of dangerous drugs to the public. It was pointed out that codeine, suplhanilamide, sulphapyridine, nembutol and other potent drugs were being sold over the counter without a doctor's prescription and this state of affairs was regarded as a menace to public safety. A committee composed of Doctors K. A. MacKenzie, C. M. Bethune and H. W. Schwartz was appointed to consult with the Nova Scotia Pharmaceutical Society and discuss ways and means of coping with this problem. This committee met with Dean G. A. Burbidge, Mr. A. A. Thompson and Mr. J. D. Walsh on November 7th and discussed various aspects of the problem. It was suggested that the Nova Scotia Pharmaceutical Society proceed to ask the Government for an amendment to the Pharmacy Act.

The Federal Department of Health has, under the Opium and Narcotic Drug Act, for some years prohibited the sale of opium and its preparations, such as laudanum, paregoric, and any opium alkaloid such as morphine, heroin, or any preparation containing these substances, cocaine and related substances such as eucaine and Cannabis Sativa and its preparations. This year—1940—codeine was added to the list. The control of the sale of other dangerous drugs was a Provincial matter. The Pharmacy Act of Nova Scotia as it stood had two schedules of drugs: one list included drugs which could be sold only if labelled "poison" and had to be entered in the Poison Book; the second list included drugs which could only be sold by a registered pharmacist. The revised schedule added two other groups, one of which, Part III, is of special interest to physicians and is herewith given:

> The following substances may be dispensed or sold only by a registered pharmaceutical chemist, or a certified clerk in his employ and by them only on prescription of a duly qualified medical practitioner, dentist or veterinary surgeon:
>
> All substances included in Part I of the Schedule of the Opium and Narcotic Drug Act of Canada.
>
> Pentobarbitone and its compounds and preparations whether sold under their chemical names or under any other names or trade marks or designations.
>
> Cinchophen and chemically related compounds.
>
> Codeine and its compounds and preparations.
>
> Dinitrophenol and chemically related compounds.
>
> Ergot and its preparations.
>
> Sulphanilamide, Sulphapyridine and their chemically related compounds, and preparations thereof, whether sold under their chemical names or any other names or trade marks or designations.

In explanation of the above list it should be noted that pentobarbitone is another name for nembutol; cinchophen for atophan; and dinitrophenol is an ingredient of obesity remedies. It is now illegal to sell any of the above

drugs except on the prescription of a physician. This change required an amendment to the Act. It is now possible to add other drugs to the list by securing the approval of the Governor-in-Council. The procedure is to communicate with the Narcotic Drug Committee of the Medical Society of Nova Scotia, who will take the matter up with the Nova Scotia Pharmaceutical Society and if the suggestion meets with the approval of each committee then such drugs will be put on the proscribed list designated Part III of the Act. A forward step has been taken and a beginning made to remedy a very obvious danger to the public.

It is requested that physicians co-operate with the druggists in carrying out our own recommendations as well as those of the Federal Department of Health. It is very difficult for the druggist to refuse his customer's request, especially when supported by the authority of the doctors. If he refuses, he injuries his business; if he consents he exposes himself to the penalties laid down in the Act. When the druggist asks that your prescriptions be written in ink and your name in full he is only carrying out the requirements of the Narcotic Drug Act, and incidentally protecting himself against severe penalties.

The Committee appointed at the last annual meeting at Halifax is as follows: Dr. F. V. Woodbury and Dr. C. W. Holland of Halifax and Dr. M. G. Burris of Dartmouth.

Status of the Mead Johnson Vitamin A Award*

Meeting in New York June 4, 1937, the Judges** stated that the presentation of the Award "at this time is not warranted since no clinical investigation on vitamin A has yet been published which completely answers any of the objectives of the original proposal. The Judges, therefore, agreed to defer further consideration of the granting of this award until December 31, 1939. This action was taken because of the existence of pronounced differences of opinion among investigators as to the reliability of any method yet proposed for determining the actual vitamin A requirements."

On November 19, 1940, the Judges met at Memphis and stated that "considerable progress in research with vitamin A has been made, principally along two main lines of endeavor. The fields showing most promise are those involving dark adaptation and blood serum studies. The Judges feel that there is still too much uncertainty about the relative merits of several investigations to warrant making the award at this time. It was, therefore, agreed that the giving of the award be postponed until clear resolution of various factors is achieved."

The sum of $15,000, called for by the Main Award, remains as a cash deposit in escrow with the Continental Illinois National Bank and Trust Company of Chicago, and will be paid immediately upon official notification of the Judges' decision.

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*$15,000 Award for Clinical Investigation. There was also a $5,000 Award for laboratory investigation, which was awarded by the Judges April 10, 1935, one-half to Dr. Karl E. Mason, Vanderbilt University, and one-half to Dr. S. B. Wolbach, Harvard University. Full information will be found in the J.A.M.A., Jan. 30, 1932; May 12, 1934; April 27, 1935; October 23, 1937.

**The Judges are: Isaac A. Abt, Northwestern University Medical School, Chicago; K. D. Blackfan, Harvard University Medical School, Boston; Alan Brown, University of Toronto, Toronto, Canada; Horton R. Casparis, Vanderbilt University, Nashville; S. W. Clausen, University of Rochester, Rochester, N. Y.; H. F. Helmholz, Mayo Clinic, Rochester, Minn.; E. V. McCollum, Johns Hopkins University, Baltimore; L. T. Royster, University of Virginia, University, Virginia; Robert A. Strong, Tulane University, New Orleans, La.

The War

THE following items arising in recent meetings of the Canadian Medical Advisory Committee are published for the information of the members of the Association:

Foreign Exchange Control Board

By invitation, the Committee conferred with the Foreign Exchange Control Board, at which conference the Committee stated that the medical profession of Canada is qualified to provide adequate medical care for its people, thus making it unnecessary for Canadians to proceed outside of Canada for treatment. Your Committee was asked to provide a letter to be sent to every medical practitioner in Canada, setting forth the position which has been taken. This has been done.

The attention of the Committee was directed to a form of medical certificate issued by the Foreign Exchange Control Board, applicable to Canadian citizens who desire to go to the United States either for medical treatment or for reasons of health. In studying the form, the Committee felt that many of the questions requiring answers by the examining Doctor might be deleted or separated to a second form, and so recommended. The form is being restudied by the Board.

Cooperation With the Air Force

The Committee interviewed the Hon. Mr. Power, Minister of Defence for Air, who accepted our offer of cooperation, and subsequently Group Captain Ryan, Senior Medical Officer in the Service, advised the respective P.M.O.'s in Canada to cooperate fully with the Advisory Committee of the C.M.A. in respect to the selection of medical personnel for the Air Force.

Cooperation With the Navy

The Committee interviewed the Hon. Angus MacDonald, Minister of National Defence for Navy, offering the full cooperation of the Association in the selection of medical officers as required. Mr. MacDonald assured the committee that in the further selection of medical officers for the Navy this Association will be consulted in matters which would properly come under our review.

It may be regarded as a matter of gratification that the Association has now formally and officially been recognized by the three Departments of National Defence to act in an advisory capacity coming within our scope and functions.

Enlisting of Interns

It is the Committee's understanding that the various services look favourably upon a recent medical graduate completing a year of junior internship before enlistment. Accordingly, enlistment of junior interns in the services will not be encouraged. There always remains, however, the matter of choice on the part of the individual, and the Committee is not in a position to guarantee that enlistment by junior interns will not take place.

Recruiting of Interns and Medical Students for Military Training

The Committee was assured by Major General LaFleche, Associate Deputy Minister of the Department of National War Services, that every consideration would be given interns and medical students in the selection of a time for their military training which would interfere as little as possible with their hospital and university obligations. As far as possible, the period of one year's internship will not be disturbed so long as the prospective trainee can take the training within twelve months of the date of proclamation calling out his age group. Notification to this effect has been sent to hospitals and medical schools throughout Canada.

The following additional information was given to the Committee by Major General LaFleche:

(1) Categorization of prospective trainees by original medical examiners was reasonably satisfactory but could be improved. The attention of the profession is redirected to the instructions sent to them. In this connection, Major General LaFleche provided the Committee with a letter to be published in our Journal and in Provincial Bulletins, the publication of which was approved by the Committee.

(2) Statistics re Rejections due to physical unfitness are not yet ready for release but it may be stated that the percentage is lower than might have been anticipated. When the break-down of statistics is available for publication, full particulars will be supplied the Committee.

(3) Medical Advisers have been selected and appointed by the Department of National War Services in the various Military Districts, part of whose duties will be to examine all medical certificates of trainees, with particular reference to rejections. An agreement was entered into between your Committee and Major General LaFleche by which the C.M.A., cooperating through its Divisions and the respective Colleges of Physicians and Surgeons, would undertake to nominate Medical Boards (three members to a Board—a physician, a surgeon and an Eye, Ear, Nose and Throat specialist) for the purpose of re-examining recruits who were rejected at the first medical examination. On the nomination of the C.M.A., the Boards will be appointed by the Minister, in the areas and to the number required, as set forth by the Minister. Each member of a Board will be paid $10 a day or $5 for part of a day, together with travelling expenses where such are necessary when the Board is asked to proceed from its base. It is suggested that these Boards might be recruited from senior members of the profession who are less likely to be called upon for active military service due to age or some physical disability.

Journals to First Canadian Division Medical Society in England

The members of the first Canadian Division Medical Society in England will be glad to receive current Medical Journals and Year Books. If any of our members can spare copies of these publications they will be performing a real piece of service by mailing them to the First Canadian Division Medical Society, Canadian Army Overseas.

Military and Civil Medical Needs

It is recommended to all the Divisions that in the matter of enlistment of medical personnel for war services a careful watch be kept to provide a balance between military and civilian needs as related to medical practitioners.

Journals to Military Hospitals in Canada

It has been decided that the Canadian Medical Association Journal will be sent, with the compliments of the Association, to the Military Hospitals in Canada of 250 beds and over, the list of such to be provided by the D.G.M.S.

It has been suggested that Medical Societies and members of the Association who are in possession of Journals which they do not require for permanent keep, might forward them to hospital units and medical personnel in military service, where they will be very much appreciated.

Industrial Medicine

Some time ago the Committee had under consideration a proposal for the establishment of a Committee on Industrial Medicine, and the General Secretary was instructed to secure more detailed information on the proposal. The following suggestions were submitted:

1. That the attention of the Dominion Government, perhaps through the Minister of Munitions and Supply, be drawn to the contribution to the war effort which can be made by the medical profession through the practice of preventive medicine in war industry. This involved the employment by industry of physicians mainly on a retainer basis for work within the factory.
2. That an alternative might take the form of representation to Provincial Governments to pass regulations requiring employment by employers in war industry, of physicians and nurses necessary for the maintenance of health. Such a measure is in effect in Great Britain. Expand the post-graduate training facilities of the Association to include industrial medicine, using short intensive courses in industrial centres to prepare physicians to meet the demand.
3. That a Committee on Industrial Medicine be appointed to consider and eventually to define the objectives and scope of industrial medicine; to consider the qualifications and training for industrial physicians and industrial nurses; and to make a survey of present personnel and training facilities.

It was the feeling of the committee that this matter was of sufficient importance to be studied by a Committee set up for the purpose; and it was agreed that Dr. J. G. Cunningham of Toronto and Dr. Vance Ward of Montreal be appointed a Committee, with power to add, to study the question of Industrial Medicine and report back to the Executive Committee.

Central Medical War Committee of the B.M.A.

The Committee had before it a letter from the Central Medical War Committee of Great Britain requesting that 100 medical officers be recruited in Canada by the C.M.A. for the R.A.M.C. The military authorities at Ottawa were conversant with the request.

In order that the committee might consider this request thoroughly, it had available a list (in the various age groups) of unmarried men who had already signified their willingness to proceed overseas; a list of those who had already joined one of the services; and an indication from the three military services as to the number of medical men who might be required during the course of the next twelve months. It was the unanimous opinion of the committee that every endeavour should be made to secure for the R.A.M.C. at least 100 men as had been requested. The following procedure was agreed upon:

That the Divisions be acquainted with the request from the Central Medical War Committee of Great Britain by sending them a copy of the letter together with information re pay and allowances.

That there be sent to each Division information already available as to enlistments within the Division of unmarried men thirty years of age and under; that the Divisions be asked to check the enlistments against their records, noting the men not over thirty years of age, unmarried, who have volunteered to serve in any capacity overseas; and that inquiry be made of these men to ascertain if they would be willing to serve in the R.A.M.C.

If it is ascertained in such inquiry that a man has married since completing his registration card, this information should be noted in the Divisional Records and communicated to the General Secretary.

It is hoped that it will not be necessary to disturb interns serving their first year in hospital, nor that local medical services will be disrupted unduly.

That the Divisions be asked to take immediate action to ascertain the number of men not over 30 years of age and unmarried, who are licensed to practise and who, in the opinion of the Division, are eligible to be recommended to the Canadian Medical Association for appointment in the R.A.M.C. according to the requirements herein specified.

All nominations from a Division are to be submitted to the General Secretary of the M.A. who will arrange through the D.G.M.S. to have the candidates medically examined and documented to ascertain their fitness for service.

To secure at least 100 officers for the R.A.M.C. it seems wise to the Committee to ask for upwards of 125 nominations.

The General Secretary was authorized to carry out the arrangements discussed and agreed upon, as outlined herein.

Would it not be appropriate to apply to Hitler (inquiries a correspondent) the terms which I once heard Tim Healy, speaking from a platform, not on the floor of the House, apply to an opponent whose word he chose to doubt? "The man is such a liar," he said, "that I should hesitate to believe that the exact opposite of what he said was the truth."—*Manchester Guardian Weekly*, Manchester.

A man was called upon to address the members of a lunatic asylum and during his address one man had been removed from the room for having exclaimed "What rot!" The attendant had told him afterwards that he might have thought he was wasting his time addressing them, but actually he must be doing them good, as it was the first sensible remark the man in question had made for months!—Roy Glenday in *International Affairs*, London

The flat-fish, such as the plaice, the sole, the turbot and the halibut, do not acquire their flattened shape and one-sided coloring until they sink. Up to that time they are tiny symmetrical fish like the young cod. But when they sink down they lie upon their sides and flatten out. The plaice, the sole and the halibut lie on their left sides. The turbot lies upon his right side Then the lower eye, since it would be of no use buried in the sand, travels round to the upper side of the head, taking its blood vessels and nerves with it, and there from a position on the side of the head alongside its fellow, it directs its proud unwinking stare upwards. Both eyes, elevated upon knobs so that the fish can bury itself almost entirely save for its eyes, stand together on the same side of the head and the fish swims always on one side—F. D Ommanney in "*North Cape*," (Longmans).

Special Meeting of the Medical Society of Nova Scotia

A MEETING, called by the President, Dr. A. B. Campbell, of the members of the Executive of the Medical Society of Nova Scotia resident in Halifax, and a few other interested members, was held at the Lord Nelson Hotel, Halifax, on Monday evening, February 10, 1941, at 9.15.

There were present Dr. A. B. Campbell, the President; Major C. E. A. deWitt, Lt. Col. G. R. Burns, Doctors D. J. MacKenzie, J. V. Graham, K. M. Grant, H. A. Payzant, J. W. Reid, D. M. MacRae, K. A. MacKenzie, H. W. Schwartz, J. R. Corston, H. L. Scammell, G. H. Murphy, H. K. MacDonald, W. L. Muir and H. G. Grant.

The first item of business was the consideration of a letter received from Dr. T. C. Routley, the General Secretary of the Canadian Medical Association, dated November 12, 1940, concerning 1941 membership in the Canadian Medical Association for doctors in the armed forces. The letter is given below

184 College Street
Toronto 2, November 12
1940.

Doctor H. G. Grant
Dalhousie Public Health Clinic
Halifax, N. S.

Dear Doctor:

Re 1941 *Membership in C.M.A. for Doctors in the Armed Forces*

Hereunder we quote a resolution and a Minute dealing with the above-noted subject from the minutes of the last meeting of the Executive Committee:

"That members engaged in full-time service in the C.A.S.F., who are not engaged in any private practice, be exempted from the payment of the C.M.A. Membership fee for the year 1941, on the recommendation of the Division to which they belong, each Division to take steps to satisfy itself as to the individuals who come within this ruling; and that Doctors so exempted shall not receive the *Journal.*

"The General Secretary was instructed to inform each Division of the provisions which the Executive Committee has made with respect to medical officers in the armed forces. Each Division, in approaching the medical men in the province, is requested to include in its communication a specific outline of the privileges which have been extended by the C.M.A. to its members in the C.A.S.F., and invite every Doctor who comes under these provisions to acknowledge receipt of the letter stating that he is taking advantage of it. The Division shall then supply to the General Secretary a list of the medical officers from the province who come under the provisions of the resolution and who have accepted it in writing. It is the duty of the Division to satisfy itself as to whether the medical officer concerned fully qualifies according to the terms of the resolution."

Will you please let us have, not later than December 31 next, the list of names of Doctors in your province who qualify under the terms of the above resolution.

Thanking you, I am

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

After considerable discussion it was moved by Dr. J. R. Corston, seconded by Dr. H. K. MacDonald, and carried unanimously, that this meeting concur in the resolution of the Executive of the C.M.A., as quoted in Dr. Routley's letter of November 12, 1940, dealing with exemption of members serving in the Armed Forces from C.M.A. fees for the year 1941, and further that that part of the conjoint fee which ordinarily would go to the Medical Society of Nova Scotia be also remitted on the same terms.

The second item of business was a letter received from Dr. G. R. Johnson, Honorary Secretary of the C.M.A., Alberta Division. The letter follows.

Dr. Harry G. Grant
Dalhousie Public Health Clinic
Halifax

February 5, 1941.

Dear Doctor Grant:

The outlines of the provisions of the Federal Income Tax as set down by Dr. T. C. Routley, General Secretary of the C.M.A. and forwarded to all Secretaries of Divisions has the following clause, which seems to us rather unfair to the Registered Medical man who is employed by a Clinic or group and paid a salary but who supplies his own car, books, Medical Society Fees, annual dues and other incidental fees to carry on his practice.

The wording of the clause referred to is as follows: "Professional men under salary contract. For 1939 and subsequent years the salary of professional men will be taxed in full without any deductions other than those specified in the Income War Tax such as charitable and patriotic donations and payments to superannuations or pension funds. In particular, the cost of operating an automobile, including depreciation thereon, and the annual fees paid to governing bodies, will not be allowed."

Obviously this is meant for those medical men serving in Government Departments where all facilities are provided and no personal obligations exacted.

We believe that a strong protest should be registered with the Federal Income Tax Department through the General Secretary and have the now accepted ruling altered, so as to protect the medical man who does provide the above-named expenses from the salary received.

A copy of this letter is being sent to the General Secretary of the C.M.A.

I am

Yours very truly

(Sgd.) George R. Johnson
Hon. Secretary
C.M.A. Alberta Division

It was moved by Dr. D. M. MacRae, and seconded by Dr. H. W. Schwartz, that Dr. T. C. Routley, the General Secretary of the C.M.A., be notified that this meeting is in accord with the sentiments expressed by the C.M.A., Alberta Division, as received in the letter from the Honorary Secretary. This motion was carried.

The next item had to do with preparations for the annual meeting to be held at Kentville on July 9 and 10. The President, Dr. Campbell, asked the Committee for suggestions about the meeting. One suggestion was that the Army, represented here by Lt.-Col. Jones, D.M.O. for No. 6, be invited to contribute to the programme.

The meeting suggested that Dr. Campbell, the President, appoint a Programme Committee of three members, and that the three members appointed, together with himself and the Secretary, constitute the Programme Committee.

It was suggested that Dr. Allan R. Morton, the Health Officer of the City of Halifax, be asked to make a contribution.

It was also suggested that Dr. A. F. Miller of Kentville and his staff at the Sanatorium be invited to contribute.

The Secretary was instructed to get in touch with the Manager of the Hotel at Kentville to secure rates, and also to make sure that the hotel would set aside sufficient rooms to take care of the meeting.

At the end of the meeting the President, Dr. Campbell, entertained the group with supper.

Meeting adjourned at 10.30 p.m.

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2 CHRONICLES 12, 13—And Asa in the thirty and ninth year of his reign was diseased in his feet, until his disease was exceedingly great: yet in his disease he sought not to the Lord, but to his physicians. And he slept with his fathers, and died in the one and fortieth year of his reign. (C. 914 B.C.)

DEMOCEDES—Of the School at Crotona, founded by Pythagoras, a "*state physician.*" Scheme of public medical service dated from second half of 6th century, B.C.

Plato indicates that the state physicians were selected yearly, and at end of year had to come before a court of review to give record of service and answer any charges preferred. Only men of eminence etc., selected.

GALEN—*Reasons for a man writing a book*: "Firstly, to satisfy his own friends; secondly, to exercise his best mental powers; and thirdly, to be saved from the oblivion incident to old age."

OSLER—"I heard the well known medical historian, the late Dr. Payne, remark that the basis of medicine is sympathy and the desire to help others, and whatever is done with this end must be called medicine."

PLINY—(Holland's Translation, 1601)—"That whosoever professeth himself a physician, is straightwaies beleeved, say what he will: and yet to speare a truth, there are no lies dearer sold or more dangerous than those which proceed out of a Physician's mouth. Howbeit, we never once regard or look to that, so blind we are in our deeper persuasion of them, and feed our selves each one in a sweet hope and plausible conceit of our health by them. Moreover, this mischief there is besides. That there is no law or statute to punish the ignorance of blind Physicians, though a man lost his life by them: neither was there any man known, who had revenge of recompence for the evil intreating or misusage under their hands. They learne their skill by endangering our lives, and to make proofe and experiments of their medicines, they care not to kill us."

A Matter of Simple Arithmetic

There are still many Doctors in Canada who ask the question, "Why should I belong to the C.M.A.?" Many have not pursued this question to the point of providing themselves with answers which would prompt them to become members of the Association.

A subject, perhaps not a pleasant one, but one which is engaging the attention of most members of the medical profession at this time, is Income Tax. Several years ago the Canadian Medical Association in cooperation with the Department of Income Tax for Canada, produced a memorandum to guide the medical profession in the completion of income tax returns. It was the duty and privilege of the Canadian Medical Association to make every endeavour to have all legitimate exemptions to which the profession were entitled admitted as expenses. While the memorandum of eight years ago has been modified, having regard to the country's need of increased funds, the most recent announcement of the Federal Income Tax Department on the subject still takes cognizance of many expenses entailed in the practice of medicine. For example:

1. A physician is allowed up to $100 exemption for fees paid to governing bodies and medical associations.
2. The complete write-off of medical books purchased within the year of purchase.
3. The complete write-off within the year of purchase, of instruments costing $50.00 or under.
4. A very reasonable yearly write-off of instruments costing more than $50.00.

If these four items alone are taken into account as concessions which were granted the medical profession by the Income Tax authorities and a reasonable amount of credit be given the Canadian Medical Association for having secured such concessions, it will be found that a Doctor who is obliged to pay any income tax has been saved more dollars than the cost of membership fees in his local, provincial and national medical associations.

"What do I get out of the Canadian Medical Association?" When figuring out *your* income tax this year, note the items referred to herein and calculate what the saving has been to *you*. A little simple arithmetic should prompt many a Doctor in Canada who is not now supporting his medical organizations to hasten to remedy that omission on his part.

The annual fee of the C.M.A. is $8, and is collected by all the provincial medical associations from those who, in the opinion of the Provincial body, are qualified and who want to be members. When you are invited by your provincial association to pay this fee along with that levied by the province, please remember that it is the cheapest and most valuable insurance you can buy. It should be a matter of simple arithmetic for you to determine that the Associations are protecting your livelihood.

To the Secretaries of Divisions Re Income Tax

Dear Doctor:

This letter is to report upon a lengthy conference I had in Ottawa with C. F. Elliott, Commissioner of Income Tax for Canada, when the following matters were discussed:

(1) *War Guests*—The war guest children from Great Britain now domiciled in private homes in Canada may be divided into:

(a) those brought out under Government auspices; and

(b) those brought out privately.

Provision has been made under the Federal Income Tax Act whereby foster parents who provide homes for children brought out under Government auspices may claim an exemption from income of $400 per year for each child, in a like manner to the ruling which obtains in respect to a taxpayer's own child of twenty-one years of age and under. This ruling, however, *does not apply* to children brought out privately.

It would appear that a fine distinction has been made here; and especially would this seem to be so where a foster parent did not know that the income tax provision would be applicable in one case and not in the other. The Commissioner points out that there is a difference in the two cases, namely, that one may be regarded as cooperating with the Government while the other is strictly and entirely a matter of charity or good will, whichever one may wish to call it, independently proffered in a like manner to other money which is dispensed by the individual privately and of his own free will. Whether or not one is prepared to agree with the interpretation which has been made, the fact remains that a ruling has been handed down that taxpayers who have in their homes war-guest children who have not been brought to this country under Government auspices may not claim any exemptions for federal income tax purposes in respect to the maintenance of such children.

(2) *Depreciation of Earning Power*—The suggestion came from one Division that it would not be unreasonable for the medical profession to be allowed a certain annual deduction from income as a write-off against the gradually declining earning power of a physician, it being argued that this earning power is limited, and that, once completely dissipated, all earning is stopped, in contradistinction to the continuing income which may accrue to an individual in retirement who has devoted himself to the building up of a business enterprise.

While the Commissioner quite agreed that earnings in the medical profession and in some other professions cease with the individual's ability to serve, yet he could not see how it would be possible to set up against this eventuality any sum or sums which could be regarded as properly deductable for income tax purposes. This is a subject requiring further study.

(3) *Salaried Doctors*—In the income tax regulations (1940), issued recently to members of the medical profession, it is stated that salaries paid to Doctors shall be taxable in full. A large number of complaints have been received by the Association to the effect that this regulation is not fair to the salaried Doctor who is obliged to keep a motor car and incur other expenses incidental to the performance of his duties. The Commissioner stated that it was not

the desire of the Government to collect taxes on expense money and that the remedy lay in salaried doctors having their contracts changed to provide for:

(a) salary for services rendered; and
(b) allowance for legitimate expenses incurred in providing that service.

To illustrate, let us take the case of a salaried doctor who requires the use of a motor car in discharging his duties. It may be presumed that, in setting the salary of the Doctor, due recognition was given to the fact that it was necessary for him to provide and operate a car; but, if the whole amount paid to him be declared as salary, then it is all taxable; whereas if the cost of operating the motor car is looked upon as an expense item and paid for as such, it is not salary, and, therefore, is not taxable.

It is recommended that each salaried doctor concerned have his case reviewed by his employer in order that the expenses to which he is entitled may be deducted from his total income and paid to him as expenses, leaving the remainder of his income to be paid to him as salary for services rendered, upon which latter amount he will be taxed.

Yours sincerely

T. C. Routley
General Secretary

25,000 VITAMIN A UNITS U.S.P. XI SQUIBB NOW AVAILABLE IN 2 MINIM CAPSULES

As a result of the demand for a highly potent source of vitamin A unaccompanied by vitamin D, E. R. Squibb & Sons, New York, have added Vitamin A Squibb to their already extensive line of vitamin products. Vitamin A Squibb is supplied in tiny capsules of approximately 2 minims, each containing not less than 25,000 U.S.P. XI units of vitamin A derived from fish liver oils. The labelled potency is assured by biological tests.

For some time physicians have been asking for a highly potent source of vitamin A—a source making possible the administration of quantities of vitamin A (without increasing the intake of vitamin D) much greater than that afforded by plain halibut liver oil as now supplied—yet keeping the dosage volume at a minimum. There are several conditions in which such a product is particularly indicated. These include:

1. Increased requirement.
2. Decreased intake.
3. Impaired intestinal absorption—a condition not infrequently associated in infancy with cretinism, celiac disease, fibrosis of the pancreas and congenital obliteration of the bile duct.
4. Metabolic disorders, as in diabetes mellitus in which the ability of the patient to convert carotene present in foods into vitamin A is greatly reduced.
5. Treatment of conditions due to marked vitamin A deficiency.

In severe vitamin A deficiency, especially in the presence of impaired intestinal absorption, four capsules of Vitamin A Squibb are the suggested daily dose; in diabetes mellitus, Vitamin A Squibb may be used as a diet supplement with one capsule being taken three times a week.

Vitamin A Squibb is supplied in bottles of 50, 100, 250 and 1,000 capsules.

Case Reports

DEMENTIA PRAECOX—SINGLE TYPE

PSYCHIATRIC SURVEY

Mr. F. H.

Examiner: Mr. M. Raphael—September 12, 1940

1. Extracts from Admission Forms—

Patient was admitted to hospital yesterday. The admission forms state that a change in behaviour was first noted in February, 1940. He became very restless and morose, did not enjoy himself in the company of others or talking to anyone and could not stay at one job. He has had various attacks with intervals of normality. Complains that he could not remember things. Has been heard to say that he might "do something to someone sometime."

On admission to hospital, patient was noted to be correctly orientated; his memory on casual observation appeared to be normal. He was very quiet, apparently a little bit depressed emotionally. His thinking has a hypochondriacal trend; he has vague complaints about pains in the head and peculiar feelings other places. He has not given any trouble.

2. Appearance and Behaviour—

White male of twenty-two years; average height; well developed; no obvious abnormalities; good color and nutrition. Dressed not too neatly. Quite willing to talk about his mental condition. No irritability; attention good; consciousness clear; speech normal; no gestures.

3. Orientation—

Personal—Age twenty-two; birthday, April 23, 1918; residence, Hants County, N. S.; occupation, farm hand and lumberjack; church affiliation, United Church.

Temporal—This is Monday, September 2, 1940. (Correct). Came to Nova Scotia Hospital on August 29, 1940.

Spatial—This is the Nova Scotia Hospital in Dartmouth, Nova Scotia. Orientation at present is good.

4. Memory—

Family History—Both parents living and well; father, seventy-two; mother, sixty-six; father works on his own farm; mother does housework; father and mother do not drink. Six brothers and four sisters; oldest forty-three; patient is youngest child. One brother, age forty-three, has a "weak heart;" another brother, age twenty-seven, drinks a great deal. No history of nervous disorder, convulsions, drugs, etc. Brothers are farmhands or lumberjacks. Three of his sisters are married, one sister is a clerk in a store.

Family History—Born April 23, 1918; place of birth, Hants County. Walked at two years; went to school at six years. Accidental blow on head at age of fifteen rendered him unconscious for about one hour. Appendectomy, August, 1938. Tonsillectomy, June, 1940. No history of disorders of infancy or childhood.

Education—Attended school from six to sixteen; reached Grade VIII; stopped attending school because he was needed on the farm; he remained in Grade VI for two years.

Retention of School Knowledge—Although he claims he does not remember very much about what he learned at school, questioning revealed a fair amount of retention. He could remember dates in history, yet showed a surprising lack of knowledge concerning the name of the county next to Hants—that is King's County.

Economic—Worked on his father's farm and as a lumberjack in the woods.

Habits—Smokes about two or three cigarettes a day. Until this past spring he drank occasionally, but has not done so recently. Between the ages of eighteen and twenty he engaged in acts of sexual perversion of the nature of pederasty. This stopped two years ago. He went out with only two girls up to the present time. He had sexual relationship with a girl this spring for the first and only time. He masturbates occasionally.

Marital—Not married.

Court Record—None.

Make-Up—The above-mentioned acts of sexual perversion worry him a great deal, even though he has not acted in such a manner for the past two years. He has always been quite seclusive, and has frequent blue spells. At present he says he likes to be by himself—not associate with other patients. He is not very religious. The only thing he is interested in is farming. He has never read very much and does not like listening to the radio.

Medical—None of O.D.C. Blow on the head at the age of fifteen (unconscious one hour). Appendectomy in August, 1938; tonsillectomy in May, 1940.

History of Present Illness—One day last March while working in the woods every thing went blank" for about five minutes, being unable to remember ho he was or where he was. Last Wednesday (August 23, 1940), he went by automobile to Truro in search of a job. Two male companions accompanied him. On arriving in Truro he again experienced a period of amnesia, lasting about five minutes. This made him decide to return home. His companions remained in Truro. On the way home there was a similar attack. He talked the matter over with his mother and decided to come to the Nova Scotia Hospital for treatment.

5. IDEAS AND JUDGMENT—

The patient has definite ideas of unworthiness in matters pertaining to relationship with individuals of the opposite sex. He feels he is not good enough to go with a girl. At the same time he states that he "cannot bear the sight of a girl."

He remembers that one night last spring he dreamt of hunting for deer. Just as he was about to shoot a deer it turned into a man whom he knew. A week before coming to the Nova Scotia Hospital he had some petty squabble with one of his brothers. In the course of this argument he told his brother that he would shoot him. The dream about shooting the deer and saying that he would shoot his brother has influenced him to such an extent that he is afraid that some day he may harm someone.

He reveals good insight as he realizes that ideas such as he has are abnormal. He states that his head feels heavy, "as if there is something pressing on it." Whenever he takes a bath, he has the feeling that he is going to drown. He believes his mental condition is getting worse each day.

6. HALLUCINATIONS—None.

7. Emotional Tone—

Throughout the interview and from observation on the ward it was evident to the examiner that the patient was considerably depressed and worried.

8. Thought Processes—

Attention was good. He replied readily to questions asked. Associations were fair. No retardation of thought processes. No confusion evident. Speech was normal in amount.

9. Motor Status—

Normal psychomotor activity. No outbursts of excitement.

Abstract—

This patient came here voluntarily to secure treatment for a mental condition which he recognizes as abnormal.

Physical Examination—There is possibly some cardiac enlargement as determined by percussion. The blood pressure 148/80 is higher than it should be in one of his age.

Condition on Admission—Depressed, worried; afraid some day he may harm someone.

Psychiatric Survey—This reveals that in the past the patient has engaged in acts of sexual perversion; that he has had periods of amnesia; that he is worried about what he believes is a homicidal tendency. He is seclusive and cannot find anything other than farming to interest him. He has a hopeless attitude about his condition.

Diagnosis—I believe that this is a case of Dementia Praecox, simple.

This case was presented at the Staff Conference held on September 16th, 1940. The family history, personal history, history of previous illness and the present illness were reviewed.

Interview

When interviewed patient was noted to be correctly oriented. Memory good, except for the periods of amnesia previously described. No evidence of hallucinations. He suffered more from vague feelings of unreality and ideas than from actual delusions.

Discussion

Mr. Raphael—"I believe he is Dementia Praecox, Simple type."

Dr. Hopgood—"I believe he is Dementia Praecox."

Dr. Murray and Dr. MacKay—Agreed to Dementia Praecox, Simple type.

Dr. MacKay—"Patient does not have the hallucinations or delusions common to the paranoid type, neither does he show catatonic symptoms. The silly erratic behaviour of the hebephrenic is not present. By a process of elimination he seems to be of the simple type."

Mr. Raphael—"There is some cardiac enlargement but this is compensated for—no treatment is indicated."

Dr. Hopgood, Dr. Murray and Dr. MacKay—Agreed that this cardiac enlargement does not exclude the possibility of Insulin Therapy.

Because of the patient's insight, the fact that his illness is comparatively

recent, and on account of his age it was decided that Insulin Therapy should be started in spite of the slight cardiac enlargement present.

Diagnosis—Dementia Praecox, Simple type.

Treatment—Insulin Therapy.

DEMENTIA PRAECOX—HEBEPHRENIC TYPE

PSYCHIATRIC SURVEY

Mr. A. K.

Examiner: Mr. G. W. McElman—November 12, 1940.

1. Extracts from Admission Forms—

Patient was a sapper in the 1st Field Company, Royal Canadian Engineers. On July 20, 1940, at 6 a.m. patient was found on the square preaching a sermon. He became acutely maniacal when interfered with. He had delusions of persecution, showed restlessness, irritability, talkativeness, obstrusiveness, loss of memory, defects in judgment and confusion.

Patient was brought to hospital under military guard. Arrived with only two medical certificates and had to return to Halifax for statement. He was carried into the hospital by five or six soldiers and resisted to the best of his ability.

2. Appearance and Behaviour—

Patient is a male, white, and appears to be in his early thirties. Dresses very carelessly; walks slowly, limping with left leg. He is of a rather slight build; appears to be fairly well nourished, and is rather pale. At times he chuckles to himself or smiles for no apparent reason or when he is being interrogated.

His attention is fairly good, and he appears to be trying to cooperate, but is unable to remember. He will start to answer questions and suddenly stop, as if information were suddenly withdrawn. He does not appear to be at all irritable at present, and is happy in his present surroundings. States that he might like to go home for a few days, but would not want to stay.

No abnormal gestures.

3. Orientation—

Personal—Patient states his name is A.K. He cannot say how old he is but that he was born in Shelburne County on September 18, 1908 (statement September 30, 1908), and resided there previous to enlisting in the Army. His religious affiliation is Baptist. His trade was mechanic.

Temporal—He did not know the date but he knew it was 1940. He cannot remember the date of admission, but thinks he has been here three and a-half months.

Spatial—He knows he is in a mental hospital in Dartmouth, N. S., but does not know the name of the hospital.

4. Memory—

Patient's memory for both recent and distant events is extremely poor.

Past life history not complete and was obtained with great difficulty.

Patient states he was born in Shelburne County in 1908. He lived there the first six years of his life. Of this period he can tell nothing. At the age of six years he moved to Boston; four years later he moved to Cambridge. At the age of seventeen years he started to work. Worked in Cambridge until eight years ago when he returned to Shelburne County, where he has resided ever since.

Family History—Father died at the age of thirty-eight years of pulmonary tuberculosis. Mother was living (fifty-two years of age) when he enlisted. Does not know if she is still living. Siblings—six. Two sisters living and well, thirty-eight and thirty-six years of age. (Note mother's stated age). One sister died at age of three years—diphtheria or influenza. One brother twenty-nine years of age, truck driver. One brother drowned. Father had pulmonary tuberculosis and cardiac disease. There was renal disease on paternal side of family. No history of epilepsy, but mother's people were of a" nervous" disposition.

Education—Patient went to kindergarten in Boston; attended school to third grade in that city and then moved to Cambridge, where he continued his education. Patient was forced to repeat seventh grade. This, he states, was due to the fact that he had some abscessed teeth and had to stay home from school. He was "miserable," according to his statement. Patient is very indefinite about further education, but states he went to night school, where he studied mathematics. Retention of school knowledge appears to be fairly good.

Economics—Patient states he started to work at the age of seventeen years. His first job was delivering mail in Cambridge. Patient is very uncertain about his employment but states he was in the checking department. Later he was employed as a mechanic in "The Institute of Technology" in Cambridge for nine years. He was discharged from this job because times were slack and men were being laid off. Eight years ago he returned to Shelburne County, where he has resided until time of enlistment which, he states, was in August, 1940. For past eight years he has had no permanent employment but has worked as a repair man, as a laborer and doing other odd jobs.

Habits—Patient states he has never used alcohol to excess. He smokes about fifteen cigarettes a day. His favourite amusement was the "moving pictures." He spent most of his spare time reading "adventure fiction." He likes football and baseball—spectator only. Participates in no form of sports.

Marital History—He married in East Boston. Wife's name was G. N. Four children, oldest twelve years (patient is not certain); youngest five years. Married life has been as happy as the average. Most of the marital difficulties were financial. Sexual life entirely satisfactory.

Court Record—None.

Make-Up—Patient will not specify any particular make-up. Says he makes friends very slowly. His financial status has always been such as to make it impossible for him to associate with those with whom he would like to associate. He prefers male companions and is subject to "blue spells." He has no periods of elation. He is not very religious; attends church occasionally.

Medical—Mumps and measles with good recoveries; pneumonia twice; no serious accidents. In hospital once with an abscess in ear.

Previous Attacks—None.

Present Illness—At first patient stated he could not remember anything

about his sickness. He then stated that it started after his second inoculation. He describes his condition as dreams. He thought he was fighting the enemy. He could see fighting about him but could not hear anything. He thought his "small army from his home" had been defeated and he was left alone behind the rest as a sacrifice. At another time he was in barracks. There was an "internal spy ring"—everyone was spying on him. They were shooting traitors and they were trying to shoot his heart out. (When patient made this statement, he got up suddenly from where he was sitting and left the room. About one and one-half minutes later he returned and took his seat. This was the only time in the entire conversation when the patient seemed at all excited). He says he can remember being restrained in bed. He has had no such "dreams" for the past two months.

5. Ideas and Judgment—

Patient says his sickness is "mental nervousness," but I do not think he has real insight into his condition at present. Patient appears to be perfectly content to remain where he is.

6. Emotional Tone—

Patient's chief difficulty throughout interview was inability to remember. This appeared to embarrass him at times and he would react with a smile or a chuckle.

7. Thought Processes—

Patient's attention was very good; association was good but a little slow at times. Patient's train of thought was slow and blocked with an occasional flight of ideas. Speech was normal.

8. Motor Status—

With exception of the one occasion previously mentioned, patient remained seated during interrogation but would move about on chair when unable to remember. About the ward he does not appear to be excited and seems willing to do anything he can to help. Appears to like to be around when doctors are on the ward.

Abstract

The patient was admitted to hospital in a maniacal condition following sudden onset of condition while he was in barracks.

Physical Examination—Essentially negative.

Laboratory Reports—Kahn, negative. Slight Leucocytosis. Moderate degree of anaemia.

Throat Culture—Negative for B. Diphtheriae. Streptococci, Vincent's Spirochaete's.

Psychiatric Survey—Patient admitted in a maniacal state with delusions of persecution and visual hallucinations. Violence necessitated restraining. Maniacal condition gradually subsided.

At present patient seems to be free of delusions and hallucinations, but memory is very faulty. He appears to cooperate to the best of his ability. Judgment and insight are poor. Motor status is comparatively normal.

Tentative Diagnosis—Dementia Praecox, Hebephrenic Type.

This case was presented at the Staff Conference on November 20th, 1940. The family history, personal history and history of present illness were first reviewed.

Interview

Patient was not interviewed as the ward he was in was under quarantine.

Discussion

Mr. McElman—"I do not think he will ever completely recover. I would make a tentative diagnosis of Dementia Praecox, Hebephrenic type. He has very little insight."

Dr. Hopgood—"I think he is Dementia Praecox, probably Hebephrenic. The fact that he has shown some improvement is in his favor, but hebephrenics do not do well under insulin, so the prognosis is doubtful."

Dr. Murray—"I agree with the diagnosis. I also feel the prognosis is poor, although there may be a social recovery."

Dr. MacKay—"The important features of his case appear to be—sudden onset; peculiar, senseless, fantastic behaviour; and indifference. A manic depressive as silly as he is at the present time would show more mental confusion. The sudden onset makes one think more of katatonia, but on the whole the factors are definitely those of the hebephrenic type."

It was agreed that Insulin might be of some benefit in his case.

Diagnosis—Dementia Praecox, Hebephrenic type.

DEMENTIA PRAECOX—PARANOID TYPE

PSYCHIATRIC SURVEY

Miss M. McN.

Examiner: Mr. M. Raphael—October 29, 1940.

1. Extract from Admission Forms—

The admission forms state that the patient exhibited (a) excitement; (b) restlessness; (c) talkativeness, but to superiors rather than to companions or inferiors; (d) exclusiveness on some occasions, though on others obstrusiveness; (e) decisiveness rather than indecision, and (f) defects in judgment. She has had delusions and hallucinations of a religious nature.

The patient was quiet and well-behaved on admission.

2. Appearance and Behaviour—

White; female of thirty-six; average height; well developed; no obvious abnormalities; good color; nutrition fair. Dressed neatly; quite willing to talk about mental condition. No irritability; attention good; consciousness clear; speech normal; no gestures.

3. Orientation—

Personal—Sister M. G. McN. Age, thirty-six; birthday, March 29, 1904; residence, Lawrence, Mass., U. S. A.; occupation, teaching Sister, Catholic Church.

Temporal—This is Saturday, October 26, 1940 (correct). Came to Nova Scotia Hospital two weeks ago, October 12, 1940 (correct).

Spatial—This is the Nova Scotia Hospital in Dartmouth, N. S.

4. MEMORY—

Family History—Mother living and well, aged seventy-two; does housework; resides in Cape Breton. Father dead; died in 1919 of angina pectoris. One sister and seven brothers living. One sister died in 1918 of influenza during pandemic. One girl and one boy died in infancy. The patient's only sister suffered a nervous and physical breakdown in 1924. She also has "lung trouble" and arthritis. The seven brothers are employed as railroad brakeman, priest, electrician, office worker, farmer, laborer, and rancher. There is no alcoholism or drug addiction in the family.

Personal History—Patient was born on March 29, 1904, in Cape Breton. Nothing unusual about development in infancy. When she was about six or seven she was very afraid of dark places and thunderstorms. By the age of eighteen she had overcome these fears. Appendectomy was performed in 1930.

Education—Attended school from eight to twenty. From 1923-1925 attended Mount St. Vincent Normal College, as a noviciate in the Order of Sisters of Charity of Halifax. She found school difficult; only got certificate in High School.

Retention of School Knowledge—Good. Memory of history, geography, arithmetic, above average.

Economic—Employed as a parochial school teacher from 1926 to present.

Habits—Does not smoke or drink; plays the piano; reads a great deal, especially biographies. Prefers classical music rather than jazz.

Marital—Not married.

Court Record—None.

Make-Up—The patient is not seclusive. She enjoys being in the company of others. Very rarely has blue spells. On only one previous occasion in 1937 she had what she describes as a general breakdown, both physically and mentally, necessitating hospitalization for about nine weeks. (Five weeks at St. John's Hospital, Lowell, Mass., and four weeks at Halifax Infirmary.) She claims that the religious life she led as a Sister was a terrible strain for her. She only associates with one or two other patients in the ward.

Medical—O.D.C., with good recovery. At the age of five injured herself with an axe, which injury was almost fatal from blood loss. Appendectomy in 1930. Glands on left side of neck excised in 1930 (reason for excision unknown).

History of Present Illness—The patient states that her present illness seems to be a return of all the sufferings of her life. This return she states began in 1937, manifesting itself in the above mentioned physical and mental breakdown of that year. Recovery from this was slow but uneventful.

In August of 1940, while the patient was "in retreat," she developed an infection of the hard palate of the mouth. This lasted for about two weeks. She was weakened by this infection, but in spite of that she decided to attend a teachers' convention in Boston. During the convention she realized she was becoming more easily fatigued than before. Nevertheless, she attended all sessions of the convention and returned home on the 30th of August. When she got home to Lawrence she began preparing for school.

On October 3rd she experienced an alternating dull and sharp spasmodic pain in left lower quadrant of abdomen, necessitating bed rest. She suffered terribly from this pain, frequently screaming because of its severity. The diagnosis was "spasmodic colic" (to use the patient's words). She remained

in bed for about a week. About three days later after playing the organ to teach her children the Ave Maria, she began to feel the presence of "something" in the room, the nature of which she could not determine. She thinks she heard a whistling sound, too. That night about ten o'clock she began moaning, and all the other Sisters came in. She knew what she was doing, but there was no inclination to control herself. The next day, while engaged in sewing, she again felt the presence of something in the room. She felt impelled to sing the Ave Maria. On completion of the singing of this hymn the feeling that something was present left her.

That evening, October 8, she was sent to Halifax in the company of two other Catholic Sisters. She was admitted to the Halifax Infirmary on October 9. Once again while at the Halifax Infirmary there was an episode similar to above mentioned (i.e., the feeling of something present in the room and the singing of Ave Maria). On October 12 the patient was admitted to the Nova Scotia Hospital.

5. Ideas and Judgment—

The patient is sure that she will get well again. She states that she feels better now than at any time since she "entered" the Sisters of Charity in 1923. She is convinced of the miraculous nature of her experiences attributing them to God and (Our Lady) the Blessed Virgin.

All the sufferings, both physical and mental, that the patient experienced in her lifetime were responsible for the present nervousness. In order to recover from this nervousness the patient believes that it is the Divine purpose to have her relive these sufferings. Only in that way will she be restored to health. She emphatically states that she would like to go back to her work as a Sister of Charity.

6. Hallucinations—

On several occasions in the past the patient has seen visions of the Blessed Virgin. When she says that she would feel the presence of something in the room she is not sure whether or not she saw anything. She is inclined to believe that she saw something but is unable to describe what it was but she is not *positive*, however, that she saw something. One time while at St. John's Hospital in Lowell (Nov. 11, 1937) she saw a vision of a Catholic Sister hanging on the Cross.

7. Emotional Tone—

Throughout the interview the patient seemed quite content with her present status. She was not depressed or worried. She reiterated time and time again that God was taking care of her and that her present condition was an expression of Divine Will.

8. Thought Processes—

Attention good. Replied readily to questions asked. Associations good. No retardation of thought processes. No confusion evident. Speech normal in amount.

9. Motor Status—

Normal psychomotor activity. No outbursts of excitement.

Abstract

The patient was admitted to the Nova Scotia Hospital on October 12,

1940, because she had exhibited restlessness, talkativeness, defects in judgment, delusions and hallucinations.

Patient was quiet and well behaved on admission.

Physical Examination—This examination was essentially negative.

Psychiatric Survey—This reveals that the patient experienced considerable difficulty in acquiring her education and in carrying on the duties of the religious life which she had chosen for herself. She believes that the physical and mental strains she experienced in the past seventeen years (i.e., since 1923), were responsible for the present breakdown.

The delusions and hallucinations she has are of a religious nature. She believes she will get well again.

Diagnosis—I believe that this is a case of Dementia Praecox, Paranoid Type.

This case was presented at the Staff Conference held on October 30th, 1940. The family history, personal history and history of previous illness were reviewed.

Interview

Patient talks freely of visions she saw of the Virgin Mary. Says these are simply caused by her trying to imagine them. Denies ever hearing voices. (There has been no indication of mental confusion since her admission to hospital).

Discussion

Mr. Raphael—"I have made a diagnosis, but I would like to hear the discussion first."

Dr. Hopgood—"I think she is a Paranoid, Dementia Praecox. She apparently was not altogether satisfied with her work, and found it harder than she expected. The present attack is fairly recent. I do not know if it is a continuation of the illness she had two years ago."

Dr. Murray—"I agree with the diagnosis. The similar attack in 1937 with apparent recovery is very interesting."

Miss MacKay—"I imagine the patient is Dementia Praecox."

Dr. MacKay—"If she were a housewife I would say she was Dementia Praecox, Paranoid type, but in a religious person of her nature one should not forget the possibility of hysteria. It is probable that she wanted to see a vision of the Virgin Mary and she imagined that she was seeing her. However, if her illness becomes more severe, it is likely to be along schizoid lines. I would make a tentative diagnosis of Dementia Praecox, Paranoid."

Mr. Raphael—"My diagnosis was Dementia Praecox, Paranoid type."

Treatment—

Mr. Raphael—"I think Insulin Therapy would be beneficial. It would help her physically."

Dr. Hopgood—"She has fair insight. Insulin would probably help her; the history of the previous attack is against it."

Dr. Murray—"I agree that she should have Insulin Treatment."

Dr. MacKay—"I agree she should have Insulin. She is improved, but is likely to have a further relapse, and the next time it may be too late for treatment."

Diagnosis—Dementia Praecox, Paranoid type.

Treatment—Insulin Therapy.

S. O. S. from the R. A. M. C.

Below is given a copy of a letter to Dr. T. C. Routley, General Secretary of the C.M.A., from G. C. Anderson, Secretary of the British Medical Association, which has been forwarded to this office.

CENTRAL MEDICAL WAR COMMITTEE

BRITISH MEDICAL ASSOCIATION

Tavistock Square
London, W.C.1
24th December, 1940

My dear Routley:

This is in the nature of an S.O.S. There is an urgent need for more men for the R.A.M.C. Can you help? Have you any young unmarried men who would contemplate taking a commission in the R.A.M.C.? I enclose details of the rates of pay. Candidates would join as Lieutenants and would get the rank of Captain after twelve months' service.

We want at least 100 from Canada if they can be spared. The date of their appointment to an Amergency Commission would be the date of their embarkation in Canada and the cost of their passage to the United Kingdom would be borne by the War Office.

I am sending you this appeal at the express request of the military authorities in this country. The War Office has communicated with the military authorities in Canada on the subject and with particular reference to the medical examination of candidates and their interview as to suitability for a commission in the R.A.M.C.

To enable Canadian medical men to join the R.A.M.C., a special Order-in-Council has been promulgated to permit of their registration with the G.M.C. in this country for the period of the war, although they will not be allowed to engage in ordinary practice in this country unless, of course, they have a degree registrable here. The G.M.C. will want to be satisfied that the qualifications of the men whose names are submitted, are such as would be accepted by the G.M.C. and this is where the Canadian Medical Association comes into the picture. In other words, we shall want you to vouch for any man you are able to send for service with the R.A.M.C.

No medical man from Canada will be accepted for the R.A.M.C. unless he has come through your hands to me. Will you please treat this matter as urgent and let me know as soon as possible if you can spare a number of young unmarried men and if so, how many. The need for their services is particularly urgent.

I assume that the Canadian military authorities will get in touch with you in regard to the medical examination and interviewing of candidates to determine their suitability both physically and personally to hold a commission in the R.A.M.C.

Yours sincerely
(Sgd.) G. C. ANDERSON
Secretary

Dr. T. C. Routley
184 College Street
Toronto

Information regarding pay, allowances, transportation, and so on is on file at this office.

(Sgd.) H. G. GRANT
Secretary

Personal Interest Notes

A WEDDING of much interest throughout the province took place on Saturday afternoon, February 22, when Frances Elizabeth, only daughter of Mrs. Martell and the late Rev. W. R. Martell, became the bride of Lieutenant George Herman Murphy, M.D.,R.C.A.M.C.(A.S.), younger son of Dr. and Mrs. G. H. Murphy, of Halifax. Mrs. E. F. Crease was matron of honour and the groom was supported by his brother, Dr. A. L. Murphy. Following the ceremony a reception was held at the Nova Scotia Hotel and the bride and groom left by plane for a wedding trip to Montreal.

Congratulations to Dr. and Mrs. J. A. Donahoe of Barrington Passage on the birth of a daughter at the Yarmouth Hospital on March 13.

Dr. and Mrs. Walter K. House and small son, who have recently come to Halifax from New Waterford, have purchased the Mitchell residence on Oxford Street, and moved into their new home the first of March.

Dr. E. F. Moore of Canso is at present a patient at St. Martha's Hospital, Antigonish, with an infected arm.

A group of representative members of the services, the medical and nursing professions, the Red Cross and other organizations pledged themselves to assist in every way possible in the operation of a blood donor scheme in the province, at a public meeting held at the Nova Scotia Hotel in Halifax on March 11.

Dr. C. H. Best of Toronto, co-discoverer with the late Sir Frederick Banting, of insulin, addressed the meeting, telling of the method Canadian doctors have evolved since war broke out of preparing dried blood for the use of service men primarily, and civilians as well.

Dr. and Mrs. G. A. Dunn of Pictou are at present on a visit to Montreal and Toronto.

Twenty-one nurses from the Maritimes and Newfoundland received their diplomas on March 6 at the graduation exercises of the Halifax Infirmary School of Nursing at the Nova Scotian Hotel. Dr. A. L. Murphy addressed the graduates, also Dr. J. V. Graham, Dr. G. H. Murphy and Mayor W. E. Donovan.

A tuberculosis clinic was held at the Dawson Memorial Hospital, Bridgewater, from February 25 to 28, with Dr. J. S. Robinson, Yarmouth Divisional Medical Health Officer, in charge. One hundred and eighty-five reported for examination.

Dr. H. R. Ripley of the Nova Scotia Sanatorium, Kentville, recently spent a short vacation in Halifax.

Dr. A. Calder of Glace Bay was a recent visitor in Halifax.

Dr. and Mrs. J. R. Cameron have recently moved to Middle Musquodobo.t, where Dr. Cameron has taken over the practice of Dr. C. H. L. Baker, who recently enlisted.

Dr. R. H. Stoddard of Halifax, who has been ill, has recovered and resumed his practice.

From the Dalhousie Public Health Clinic:

"I would like to have these two boys intoxicated."

Another similar letter spells the word in a different manner: "acknockulated."

DALHOUSIE MEDICAL LIBRARY

The library is still without a copy of the first three issues of the NOVA SCOTIA MEDICAL BULLETIN, 1922. Subscribers are urged not to throw away any copies of these, or other earlier numbers, even if they are worn or soiled. The library will be glad to receive donations of odd numbers or files of any medical journals. Requests come frequently from medical libraries in the United States, for Canadian publications, and we feel that we should be in a position to supply them.

Through the Medical Library Association Exchange, Canadian libraries have received generous aid in completing files of journals and we are glad to be able to return these favours by passing on all the duplicate material that we can spare. Another use we make of extra copies is to lend out single copies instead of bound volumes. It is more convenient to keep the bound volumes accessible for use in the library, whenever we have unbound duplicates, and in this way we prevent wear and tear, as well as carriage charges.

There is a demand also for the early numbers of *Dalhousie Medical Journal*, especially volumes 1 and 2, 1936 and 1937.

THE DOCTOR'S HAND BAG

(The Health League of Canada)

Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, has said that 85 per cent of human diseases are of the type that the general practitioner can handle with the amount of equipment that he can carry in his handbag.

Now Dr. Hugh Cabot, in his book, *The Patient's Dilemma*, comments that "this statement never was true and that it is less true to-day than it ever was." In order to find out which of these views was correct, five doctors of Winslow-Salem tabulated an average of 200 consecutive patients each, making 1000 in all. Of the 1000 patients, 848, or 84.9 per cent, had been cared for without any other equipment than the contents of a handbag. A modern doctor's bag contains at least a blood pressure apparatus, a stethoscope, a hypodermic syringe, an otoscope, an ophthalmoscope, a transillumination light, scalpels and gauze, a blood-counting apparatus, glass slides, a pleximeter,

tongue depressors, a haemoglobin scale, Wassermann tubes, culture tubes, and a few other odds and ends.

The lowest proportion of patients cared for unaided by an indiv dual doctor in the investigation referred to was 82 per cent, the highest 89 per cent. The average of 84.8 per cent is close enough to 85 per cent to allow Dr. Fishbein to win out.

It must be remembered that the remaining small margin of 15 per cent which the contents of the doctor's handbag will not take care of include cases of arthritis, beyond cure, mental cases and those with chronically poor health that no scientific medical attention will cure.

Comparatively helpless in their efforts to effectively combat the common cold the medical profession can do little except advise their patients to remain in bed for a few days. Though scientists have devoted years of patient research to studying colds, no specific cure has yet been developed for this most common of all diseases. In fact, we of this enlightened age are little wiser than our forbears, whose cold remedies are aptly described by an anonymous poet:

In days of old to cure a cold
The neighbour women ran
To torture men with flaxseed tea
Stewed in a two-quart pan.
The willing tribe would then prescribe
What each considered best,
From castor oil to patent soil,
Thick-smeared upon the chest.

From chin to knees, with poultices
Front areas and back,
Upon my bed they burned me red
And then with ipecac
And quinine pills and fruit squills,
Fig syrup, senna tea,
And comomile, in neighbour style,
They hourly doctored me.

In days of old a compress cold
Was grandma's pet device,
But good Aunt Sue would add thereto
A Spanish onion slice.
The grease of goose was then in use
And 'till the coughing ceased,
'Tis truth I write, by day and night
My front and back were greased.

As I recall when I was small
To cure a common cold,
Till I was rid of it they did
Whatever they were told.
And looking back upon that stack
Of means to make me well,
I marvel now that I somehow
Still live the tale to tell.

—*Bridgetown Monitor*, March 12, 1941