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Vol. XVII. HALIFAX, NOVA SCOTIA, NOVEMBER, 1905. No. 11

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THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVII. HALIFAX, N. S., NOVEMBER, 1905. No. 11

Original Communications.

THE GROWTH AND ORGANIZATION OF THE MEDICAL PROFESSION IN NOVA SCOTIA.*

By D. A. CAMPBELL, M. D., Halifax.

(Concluded.)

HALIFAX.

A fleet of transports, with 2,576 immigrants, of which 1,546 were adult males, sailed for Chebucto Bay, under the command of Hon. Edward Cornwallis. New Englanders also came in considerable numbers, and contributed largely to the success of the undertaking. The plan of the town was quickly made, building lots were assigned to the settlers, and before winter closed in all were under shelter. A little later a German colony was planted at Lunenburg.

In 1758 Louisburg was captured by General Wolfe, and Quebec in 1759. With British rule thus assured immigrants from New England and elsewhere soon began to flow into the country and to occupy the fertile lands and the best fishing stations, so that by 1770 there was an estimated population of 13,000 in the Nova Scotia of that day.

During the progress of the war between England and the revolted colonies of New England, many adherents of the Royal cause were driven from their homes and sought refuge in Nova Scotia. After the evacuation of Boston about two thousand refugees came to Halifax with the British forces. When the war closed large numbers of Loyalists withdrew from the United States, the greater part settling in Ontario and Nova Scotia. They consisted chiefly of the middle and upper classes, and were an intelligent and enterprising body of men, of sterling character. They diffused themselves quite generally among the older colonists, and also laid the foundation of new settlements in widely scattered parts of the province.

Among the 2,500 settlers who came to found Halifax in 1749 there were twenty eight medical men. Eleven of the number were accompanied by their families, which indicates that they, at least, came with the intention of staying in the country. All, probably, were surgeons, thrown out of employment at the termination of the war with France, who were thus willing to accept a free trip to America and a grant of two hundred acres of land. How bitter must have been their disappointment when they beheld for the first time an unbroken expanse of forest. and realized that this was the home upon which they had based great hopes. Some found employment in connection with the hospital which had been established, but this did not last long, as the home authorities complained to Cornwallis that he supported too many surgeons and apothecaries. Only three out of the twenty-eight appear to have had the courage to face such future. These remained with the other colonists, shared their hardships, and achieved some measure of success. The names of the three were Robert Grant, John Steele, and Alexander Abercrombie. These were the pioneers in medicine in Halifax. Grant became a member of the House of Assembly; and Abercrombie, when he died twenty-eight years later, was deeply lamented, both for his medical skill and his benevolent disposition. The fate of the other twenty-five is unknown.

Only one physician accompanied the 1,500 German colonists who settled at Lunenburg, and it is uncertain whether he remained in the country. The New England and North of Ireland settlers, who came to the province prior to the Revolutionary War, were usually able to obtain medical aid. The missionaries, who regularly visited

the sparsely settled and remote districts, had some medical knowledge. At some points the garrison surgeons looked after the sick. A few physicians came from New England and engaged in practice in the more thriving districts, Of these latter the professional knowledge and skill may not have been great, but they were usually resolute, enterprising men, and useful members of the community in which they lived.

A large number of medical men accompanied the Loyalists. They, were well qualified. The majority had served as surgeons during the war and their influence in improving the status of the medical profession was marked, owing to their number, skill, and strong personality. In respect to the effect of the Revolutionary War on the fortunes of physicians and surgeons, Sabine remarks:

"The physicians who adhered to the Crown were numerous, and the proportion of Whigs in the profession of medicine was probably less than in either that of law or theology. But unlike persons of the latter callings, most of the physicians remained in the country and quietly pursued their business. There seems to have been an understanding that though pulpits should be closed, and litigation be suspended, the sick should not be deprived of their regular and freely chosen attendants. I have been surprised to find from verbal communications, and from various other sources, that while the 'Tory doctors' were as zealous and as fearless in the expression of their sentiments as Tory ministers and Tory lawyers, their persons and their property were generally respected, in towns and villages where little or no regard was paid to the bodies and estates of gentlemen of the robe and surplice. Some, however, were less fortunate, and the dealing of the Sons of Liberty were occasionally harsh and exceedingly vexatious. A few of the Loyalist physicians were banished; others, and these chiefly who became surgeons in the army or provincial corps, settled in Nova Scotia or New Brunswick, where they resumed practice."

I feel sir, that this address bids fair to become too long, and there is still much ground to be covered. It seems desirable, therefore, that I should present the chief remaining facts of this subject in a summary form, and for this purpose it appears best to select certain important points, and to group the facts around those dates.

1749-1790.

The first date I have chosen is 1790, as we have an estimate of the population for that year. Prior to that date the population fluctuated very considerably; afterwards it steadily increased. The estimated population of Nova Scotia, in 1790, was about 35,000. The number of practitioners in the province at that time, as far as I have been able to ascertain, after considerable research, was thirty-five, a very large number when we consider the slender resources of the inhabitants and the limited extent of the settled area. The presence of so many practitioners at that early period is explained by the circumstances that fully one-third of the number held permanent appointments in connection with the military establishments at Halifax, Windsor, Annapolis, Shelburne, and Sydney—appointments which they had received as a partial compensation of the losses they had sustained by Revolution. Their official duties were light, and gave them ample time for general practice. After the founding of Halifax about nine-tenths of the physicians who came to Nova Scotia came from New England, and of the thirty-five practitioners in 1790 fully three-fourths were Loyalists. The latter did much to create that ingrained respect and loyalty towards the profession which is a characteristic of Nova Scotians, and this was accomplished by the individuality and force of character of those men as well as by their professional skill. The inscription on the tombestone of Dr. John Haliburton, in the old St. Paul's Cemetery, might not unfittingly be applied to each one of them:

> "If unshaken loyalty to his King, steady attachment to his friends, active benevolence to the destitute, and humble confidence in God, can perpetuate his memory, he will not be forgotten."

1790-1828.

After 1790 no distinctive event stands out from which we can look back upon the growth of the profession, until the year 1828, when an Act to regulate the practice of medicine was passed by the legislature. During this period of thirty-eight years the population had risen from 35,000 to 150,000—an increase largely due to an extensive immigration from the Highlands of Scotland. The older settlements had

made substantial progress, and afforded an improved field for practice. The number of medical men had increased from 35 to 65; but the ratio to population had fallen from one in about 1,000 to one in about 2,300.

Two of those in practice in 1790 still survived—Jonathan Woodbury, of Annapolis, who came to the province as early as 1763, and Joseph Norman Bond, of Yarmouth, a veteran of the Revolutionary War, who enjoys the distinction of being the first medical man to perform vaccination in Nova Scotia. This was in 1802.

The additions to the ranks of the profession, during this period, were principally British graduates, who brought with them the traditions and customs of the profession in Great Britain. Many of them were retired army and navy surgeons, who had seen considerable service, and were accustomed to order, dicipline, and regulations. Their personal influence proved a potent factor in improving the status of the profession; their intimacy both with their conrades in active service and with the practitioners of the province became a means of diffusing throughout the country a kuowledge of the advances and improvements in our art, at a time when communication was slow and uncertain, and professional periodicals were still in the stage of infancy.

During this period a few medical men also came from the United States. About 1800, we note the appearance of native Nova Scotians, who had studied either in Great Britain or in the neighboring republic. Towards the close of this period there was a decided increase in the number of these. The first Nova Scotians were: Samuel Head, of Halifax, son of Dr. Micheal Head, who came from Ireland to the province shortly after 1856: David B. Lynd, of Truro, a graduate University of Pennsylvania; Robert Bayard, of Cornwallis, a graduate of Edinburgh, better known in New Brunswick than in his native province; and W. B. Almon, of Halifax, also an M. D. of Edinburgh, and son of Dr. W. J. Almon, who first came to Halifax during the Revolutionary War. All of these were in practice in 1810.

The preamble to the Medical Act, and a subsequent amendment, point to the presence of a number of unqualified practitioners, especially in districts where medical aid could not be easily obtained. Many of these were men who had gained some knowledge, either

through apprenticeship or a partial course at some college. Generally speaking, they were a deserving class, and should not be regarded in the same light as quacks and pretenders.

The early practitioners had to encounter many hardships and difficulties, except in the more populous districts. Many of the roads were mere bridle paths through the forest. Streams had to be forded. Water carriage, when available, was regarded as a boon. In the winter, snowshoes were often necessary to complete a journey. Accomodation was very poor; domestic comforts were few; medical periodicals did not exist, and libraries were limited to a few volumes. The serious emergencies of a mixed practice had to be surmounted single-handed. Yet, in spite of all these disadvantages educated men toiled through long years, serving well their generation, and adding their quota to the slow but steady advancement of their profession.

Another point worthy of note is that, owing to the scarcity of educated laymen, and the absence of lawyers outside of Halifax, the doctors also rendered service to the public in the capacity of magistrates, judges of the Inferior Court of Common Pleas, prothonotaries, sheriffs, judges of probate, and they were frequently elected to the House of Assembly. This added to their labor and perhaps their income, and widened the sphere of their influence. It may be affirmed with justice that no other class gave more useful service to the public than the physicians; nor do the the best men of the past suffer by comparison with the leaders of to-day; and they have left us patterns of humanity and energy well worthy of imitation.

1828-1854.

The next important step in the progress of the profession was the formation of the Medical Society of Nova Scotia in 1854. This association grew out of, or rather was an expansion of, the Medical Society of Halifax, which had been formed in 1844.

Between 1828 and 1854 the population had nearly doubled, chiefly through natural increase, and the number of practitioners had risen from 62 to 120. An analysis of the list of practitioners in 1854 indicates that more than one-half of them had been born in the province, Of the total number 50 per cent. had been educated in the United States, 35 per cent. in Great Britain, and 17 per cent. were provincial

licentiates. During this period the medical supply reached its lowest ebb, because but few practitioners came from abroad, and the cost of a complete medical education in a foreign country was greater than many Nova Scotians could afford. Quackery became prevalent and offensive. The petitions of medical men to the legislature had been disregarded, and the conviction became general that the only way to secure a remedy was by united action; hence the formation of the Medical Society of Nova Scotia.

1854-1872.

The next period, extending from 1854 to 1872, when a new Medical Act of great importance was secured, is characterized by a less rapid expansion of the population, owing to the fact that the era of emigration from the province had begun. But for the people who remained there was a better medical supply.

The new medical society soon made its influence felt. For some years its efforts were concentrated upon safe-guarding the interests of the profession and the promotion of measures to improve the public health. In 1856 the old Medical Act was amended, and new provisions were added to repress unqualified practice. A tariff of fees was framed; a code of ethics adopted; better remuneration for public services was secured; health legislation was improved, and an act for the collection of vital statistics was obtained.

The union of the provinces in 1867 widened the outlook of the profession; and the new order of things was promptly signalized by the formation, that year, of this Canadian Medical Association. And here permit me to refer to the fact that the honor of first presiding over the deliberations of this important organization was accorded to a Nova Scotian, a gentleman of high standing in the profession, but one whose widely-recognized pre-eminence as a political leader and constructive statesman of high standing has caused his professional career to be almost forgotten—I refer, of course, to the Hon. Sir Charles Tupper. And I cannot omit mention of the second president of this association, also a Nova Scotian, and the ablest practitioner in the porvince, chosen for that place of honor because of his sterling character, public spirit and successful professional career, one who fortunately is still with us, an inspiring influence for all that is noble and good—I refer, of course, to Hon. Dr. Parker.

In the same year, 1867, the Medical Society of Nova Scotia was

reorganized. Up to that time the society had held all its meetings in Halifax. It was then decided to hold the annual meeting at different points in the province, with the view of securing the more hearty co-operation of members in the various parts of the country.

In 1867, also, a medical school was founded in Halifax in connection with Dalhousie College. At first nothing more than a short preparatory course, during the summer months, was aimed at. The venture met with success, and in 1870 it was decided to establish a full course of study and to confer degrees. This project encountered considerable opposition at first, and was not approved by the Medical Society. The supporters of the medical school took advantage of a strong and growing sentiment in the profession in favor of a more prolonged period of study than was required in the schools of the United States, from which the great majority of students obtained a qualification; and they took steps to secure the adoption of a new Medical Act, succeeding in 1872. The existence of a medical school within the province lessened materially the force of the objection raised in the legislature that the cost of a more prolonged period of study would restrict competition, and seriously affect the medical supply of the more sparsely settled districts. The propriety of founding a school at that time has been fully proved by the important part which it has played in promoting and maintaining a greatly improved system of medical education.

1872-1905.

Before considering the Medical Act of 1872, mention may be made of some minor events which have resulted in good. The Nova Scotia branch of the British Medical Association, formed in 1887, which meets at Halifax during the winter months, and the Maritime Medical Association, formed in 1891, which holds its annual meeting alternately in the three capitals of the Maritime Provinces, have greatly promoted harmony and good feeling, as well as mutual improvement. The MARITIME MEDICAL NEWS, founded in 1888, has been of material benefit to the various associations by preserving in an accessible form a record of their proceedings, and of their more valuable contributions.

The medical legislation in 1872 is of so much importance that I trust you will pardon me for giving an account of various steps leading to it. By medical legislation I mean, of course, enactments designed to regulate the study and practice of medicine, it being

generally conceded that the state has full power in this respect. The basis of medical legislation is the necessity of affording protection to the people against ignerant persons and pretenders. The intention of such legislation is to secure a standard of professional education to be exacted of every one who is desirous of engaging in the practice of medicine, and such standard is obtained in various ways needless to specify.

The first step was taken while the military element in the profession predominated, and was perhaps suggested by the Medical Acts of Upper and Lower Canada. The Medical Act of 1828 is very brief, and is entitled, "An Act to Exclude Ignorant and Unskilful Persons from the Practice of Physic and Surgery." Its substance is as follows: No person shall demand or recover any fee or reward for medical or surgical aid unless he has a diploma from some college legally authorized to grant the same, or of having been examined in respect to his professional capacity by judges to be appointed by the Governor-in-Council." The Act being simple in character and adapted to the wants of that period, had some influence in restraining irregular practice, and it afforded partially instructed and deserving men already in practice a chance to obtain a legal qualification.

Next came the Act of 1856, promoted by the Medical Society of Nova Scotia. It provided for the registration of qualifications in the office of the Provincial Secretary. In addition to being unable to recover fees for services, unregistered persons were prohibited from holding provincial medical appointments, and were also liable to a fine of £5 for practising. Persons with defective qualifications could still become duly qualified by passing an examination before a board of examiners. This Act, like the previous one, was moderate in its provisions, and free from objectionable featnres. It remedied some defects which practical experience had shown to exist in the former measure.

The Act of 1872 conferred the privilege of self-government, as its provisions secure to representatives of the profession full control of all matters relating to medical education, registration and discipline. The Act has since been frequently amended, but its essential features remain unchanged, and as they are similar to those of other provinces, further explanation is not necessary. But the composition of the

governing body, and its policy in respect to some questions, demand brief consideration.

The profession as a whole is not incorporated in Nova Scotia as it is in Ontario. The Act makes provision for a body corporate, called the "Provincial Medical Board," consisting of thirteen qualified medical practitioners, of not less than seven years' standing—seven to be appointed by the Governor-in-Council for life, and six to be elected triennially by the Medical Society of Nova Scotia. No other provision is made for collegiate representation, and there is no annual tax as in other provinces, the revenue being obtained wholly from examination and registration fees.

Until quite recently the requirements for registration differed in one important respect from those in other provinces, inasmuch as submission to a professional examination was not required from holders of diplomas from reputable schools, obtained after a sufficient course of study. Instead of examination the board insisted upon a rigid compliance with all its regulations relating to the preliminary examinations, period of study, and course of study—tests which effectually excluded applicants from schools of doubtful repute. This policy enabled the board, while maintaining the status of the profession, to keep an "open door" for licentiates from other provinces—a courtesy which so far has met with no reciprocal recognition. At the same time honest men from schools of good repute were spared "vexatious penalties of mind and body."

The principle of state examination was adopted a few years ago, not through conviction of its merits or necessity as a test of professional fitness, but from a desire to co-operate with other provinces in a general scheme of reciprocity. For the past three years an examination in the practical subjects has been demanded from all applicants for license, and the day is probably not far distant when the policy of the board, in this respect, will be adopted by other provinces, as it is now very generally recognized that medical boards and councils have not the requisite equipment, and can scarcely provide competent and independent examiners, to conduct examinations in the scientific subjects on the lines of the more recent methods of instruction.

The Act of 1872 proved an important factor in causing a diversion of students from American to Canadian schools.

The ever-increasing proportion of Canadian graduates added yearly to the Medical Register is a marked feature of this period, and is worthy of special notice. An analysis of the Medical Register of 1875—thirty years ago—shows that of the whole number of practitioners, 78 per cent. were American graduates, 14 per cent. were British graduates, 2 per cent. were Canadian graduates, and 6 per cent. were Nova Scotia licentiates. A similar analysis of the Register of 1904-5 gives widely different results. Of the whole number, 53 per cent. were Canadian, 44 per cent. were American, and 3 per cent. were British graduates. The change in favor of Canadian schools is still more strongly illustrated by an analysis of the additions to the Register from 1895 to 1904. Of the number added, 85.5 per cent. were Canadian, 14.2 per cent. were American, and 0.3 per cent. were British graduates. During the year 1904-5 the additions to the Register were exclusively Canadian graduates.

The predominance of the American graduates, numerically, has come to an end, but their influence, always exerted for good, will be felt for years to come; and it is pleasing to observe that the many evils which resulted from a lowering of the standard of medical education in the United States did not sensibly affect the status of the profession in Nova Scotia. This has been due in some measure to our geographical isolation, but chiefly to the circumstance that, from the earliest period down to the present time, the students from this province who went to the United States to obtain a qualification, have almost invariably selected the best schools in Boston, New York and Philadelphia.

The burden of maintaining and improving the status of our guild in this province, and throughout our great Dominion, is now fairly placed on the shoulders of Canadian graduates.

I fear, Mr. President and gentlemen, that I have rather overtaxed your patience, but trust that I have made it clear that our profession in this part of Canada has had a long and ever-widening history, and hope I have shown, by the citation of definite facts, that the profession in this province has, to say the very least, fully kept pace with the general progress of the country.

EIGHTEEN CONSECUTIVE CASES OF OPERATION FOR PERFORATED GASTRIC ULCER.*

By F. M. Caird, F. R. C. S. (Edin.), Surgeon Royal Infirmary, Edinburgh.

Addressing, as I have the honour to do, a body of brother practitioners, I have sought to find a subject of general interest to all. I, therefore, direct your attention to personal experiences of a consecutive series of eighteen cases of perforated gastric ulcer, and in doing so crave pardon for inflicting upon you so much that is well known and commonplace.

We are ignorant of the direct cause of gastric ulcer. The ulcer may pursue a symptomless course, and there may be perfect health until the disastrous rupture into the peritoneal cavity takes place, and even then the diagnosis may be obscure. As a rule, however, there are very definite indications which lead us to a correct conclusion. A history of indigestion can nearly always be obtained, either of recent date and comparatively mild, or prolonged and intermittent. The dyspepsia is associated with pain after food and with vomiting, which often gives relief. The more classic evidences of gastric ulcer, hæmatemesis and melæna, are usually lacking. Perforation may occur at any time, and under any circumstances, and is favored by muscular strain. Sudden intense pain, referred to the umbilical region, gives warning of the perforation. The patient becomes faint and collapsed, has to lie down, and generally vomits. As a rule the passage of flatus ceases, and symptoms simulating those of obstruction may arise. Occasionally there is a movement of the bowels.

The initial condition of shock varies in degree and prolongation. Generalized abdominal pain is felt; the abdomen becomes board-like and rigid, no longer participating in the respiratory wave. The most useful indication of danger is found in the shabby, rapidly quickening, pulse. Respiration increases and the temperature has a tendency to rise. On palpation the abdominal wall is hyperæsthetic, and marked local tenderness is evinced in the epigastric region and above the pubis. There may be diminished liver dullness.

*Address in Surgery delivered before the Canadian Medical Assoc., Halifax, Aug. 1905.

Rectal examination sometimes reveals tenderness, but there is rarely bulging in the pouch of Douglas. There is not any difficulty or pain experienced during micturition. Careful notes should be taken when the patient is first seen. On re-examination it may be found that the liver dullness has entirely disappeared. More especially is this noticed after the patient has been lifted or moved. The general symptoms tend to become rapidly aggravated and merge into those of general peritonitis.

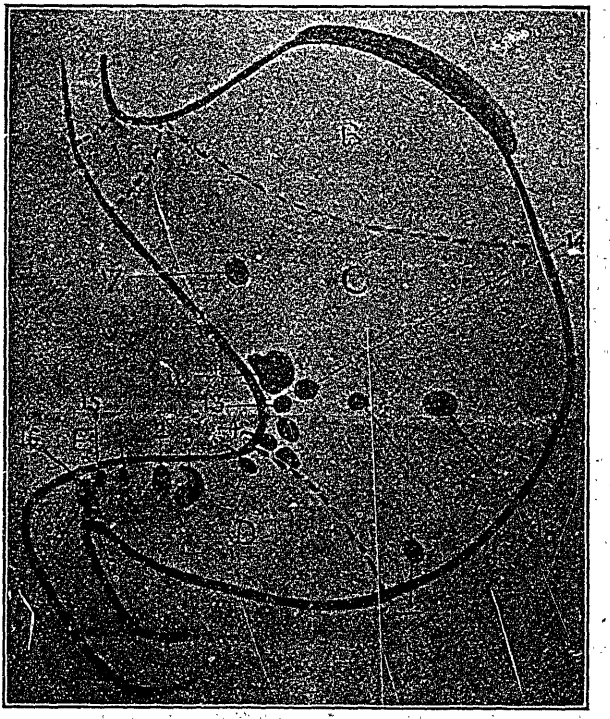


Diagram of stomach to show sites of perforation: A., Cardiac Portion; B., Fundus; C., Middle: D., Pyloric Portion; E, Pylorus. The figures refer to the cases 2, 7, 15, 16 on the posterior aspect of the stomach.

Perforation of gastric ulcer, acute appendicitis, acute pancreatitis, and the rupture of carcinomatous ulcers of the intestine may mimic each other. Influenzal gastric pains, and the gastric colic associated with adhesions have occasionally led the surgeon astray. A small exploratory incision may be required to clear up a diagnosis in doubtful cases.

The salient features which determine operation are the sudden onset of painful symptoms, the previous history of gastric ailment, the localized epigastric and supra-pubic tenderness, along with the abdominal rigidity and changes in the extent of the liver dullness. To this we may add the progressive frequency of the pulse rate.

Perforations leading to acute symptoms occur mainly on the anterior aspect of the stomach where there is less chance of adhesion to neighboring structures. They are most frequent towards the lesser curvature and the pylorus. There may be more than one

CASE 14 (a.)—Mass of lymph, uniting liver and stomach; perforation hidden.

perforation. The ulcer varies in type from the characteristic small sharply cut terraced form, with comparatively healthy surroundings, to the large ragged rent in the midst of a chronic indurated perigastritis with œdematous serosa.

It would appear that as the acrid acid stomach contents escape into the peritoneal cavity that the whole serous membrane reacts, and rapid effusion of an alkaline nature takes place which neutralizes the acid secretion. The greater portion of the fluid found at operations

is due to this source. Blue litmus paper acquires a deeper tint by contact with it, and is not reddened till close to or at the margin of the perforation.

The fluid abounds in greatest quantity in the vicinity of the rupture under the diaphragm. It accumulates markedly in the pouch of Douglas, and is there associated with the characteristic supra-pubic and rectal tenderness. In posterior perforations it may be encysted in the lesser omental sac. The more dependent portion of the collections become rapidly purulent.

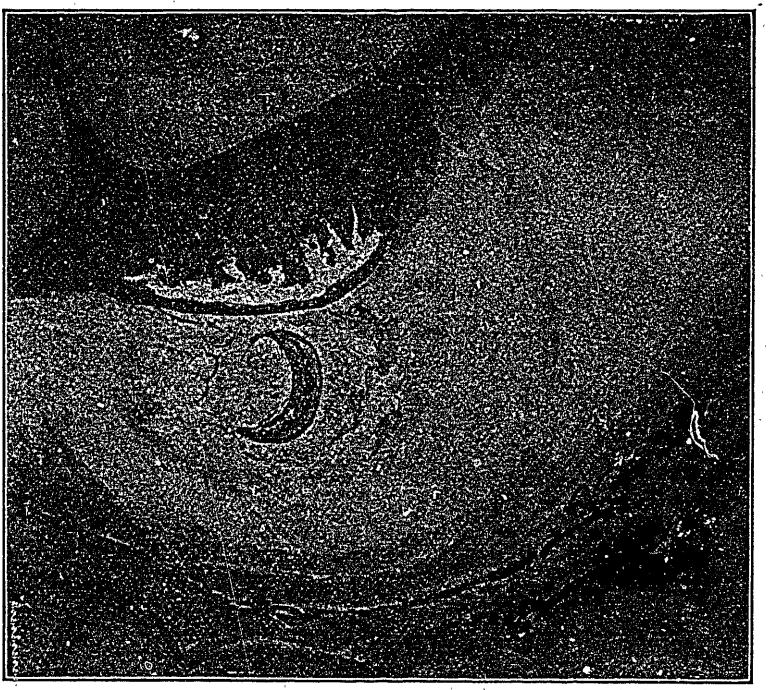
CASE 14 (b).—Liver and lymph raised, exposing the perforation "X."

In perforated gastric ulcer we are already confronted with septic infection. We cannot therefore avail ourselves of the measures introduced by Mikulicz, the injection of nucleinic acid to create a prophylactic leucocytosis. As yet the method recently applied by the genius of Bier, in treating successfuly acute and septic inflammation by means of local congestion is not available.

Our treatment at present consists of performing laparotomy, which enables us to prevent the further escape of gastric content. It allows us not only to get rid of what has already escaped, but in addition to

cleanse the peitoneum by careful washing out. It enables us to close the rent and to establish free drainage.

To do all this a general anæsthetic is required. When once the nature of the case is established it is wise to get free access by an extensive incision. We are guided in our search for the aperture by the lymph in its vicinity, by the nature of the escaping fluid, and the direction from which it wells. On identification the ulcer may be

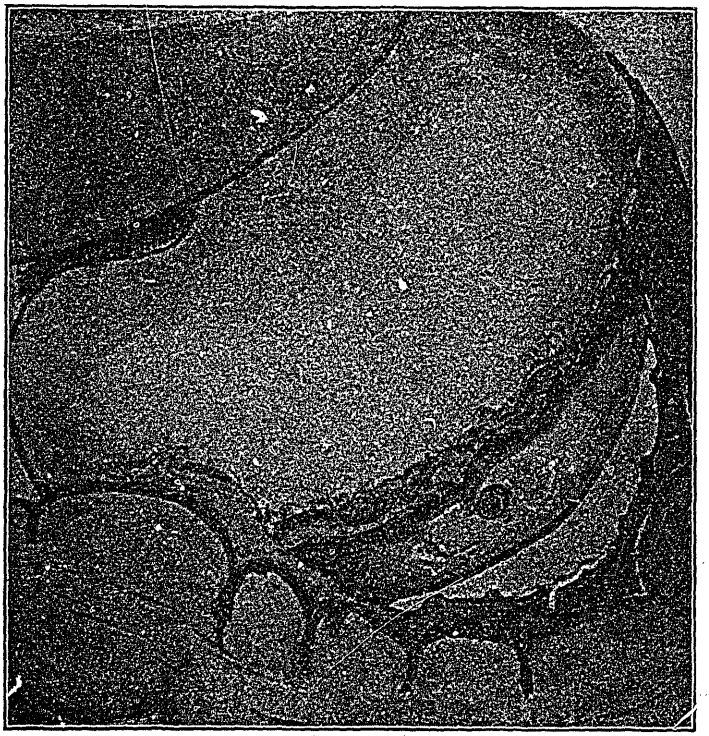


CASE 3.—Large anterior perforation, pyloric portion of stomach.

plugged with iodoform gauze, and we at once thoroughly wash out the abdominal cavity with sterilized salt solution. A counter opening should be made above the pubis and the glass nozzle of a douche introduced while the ulcer is being closed. Excision of the ulcer is not to be recommended. It means loss of time and loss of blood without corresponding gain.

Where there is much perigastritis with unyielding or a friable tissue, a series of interrupted Lembert sutures (silk) may be introduced at some little distance from the margin of the ulcer and tightened up en

masse. Over these a second series may be required. Occasionally a preliminary stitch or two may be used to transfix the whole thickness of the ulcer, and so diminish its size. A trace of iodoform may be rubbed in to favor plastic repair. If a gastro-jejunostomy be required it is now porfomed. The flushing out should be completed by douching every peritoneal recess till the saline returns perfectly clear. Finally the abdominal wound is closed. We have always left a large



CASE 7.—Posterior perforation exposed by opening lesser sac.

Keith's tube in the pouch of Douglas, and have generally drained the site of perforation with a Mikulicz tampon and drainage tube.

The head of the patient's bed should be raised about six inches in order to favour the gravitation of any discharge from the dangerous absorptive region of the diaphragm towards the less susceptible pouch of Douglas.

Recovery is frequently uneventful. The chief factor affecting the issue is the nature of the organisms liberated within the peritoneal cavity and the power of tissue resistance to the toxins evolved. Fortunately we do not meet with organisms of excessive virulence within the stomach, and when there is no stagnation or fermentation of the gastric contents, the highly acid nature of the gastric secretion which we so frequently meet in such cases, inhibits the growth of most microbes. An additional source of sepsis may be due to the

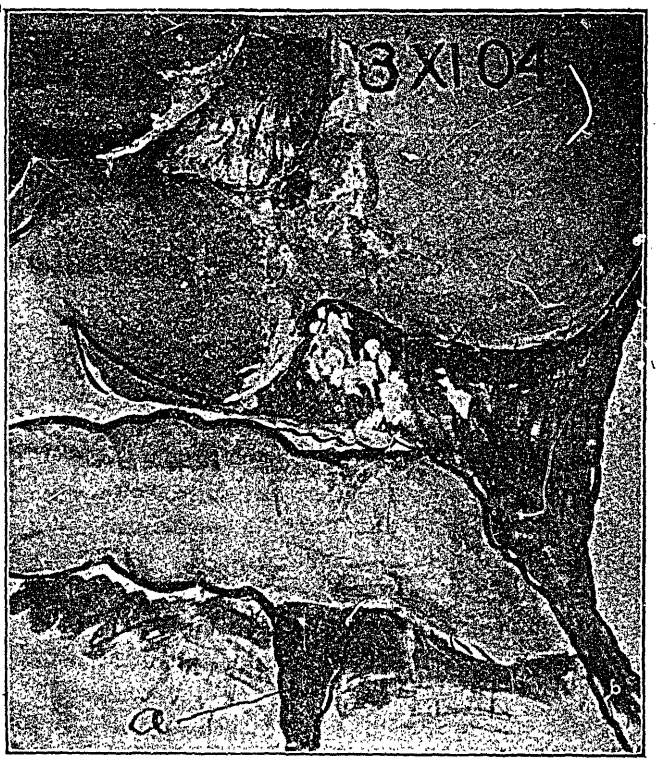
CASE 4.—Perforation near lesser curvature, early hour glass contraction of stomach.

damage inflicted by the gastric extravasation on the visceral peritoneum, permitting the passage of intestinal organisms. Hence the value of a speedy recognition of the serious nature of the lesion, and the success which is likely to crown an early operation.

Naturally the size and position of the perforation, the date and the nature of the last meal, and the amount of material which escapes into the peritoneum are obviously of moment.

The chief prognostic is the pulse. A rate of 120 is to be feared, 130 and over to be dreaded. Temperature is of less value. The course after operation may be full of anxiety, requiring the exercise of

extreme watchfulness and care. The pronounced thirst due to the loss of fluid by the peritoneal effusion may be allayed by rectal salines administered every four hours. The urine should be carefully examined and morphine given as indicated. If the pulse fail in strength and fullness and increase in rate, intravenous saline transfusion is most beneficial. One litre may be given, and when improvment is mantained thereafter for a couple of hours, even if there be a



CASE 14.—Second perforation in Case 4, fourteen months after last operation: marked hour-glass contraction; omental bands adherent to vicinity of umbilicus "A," and to lateral aspect of abdominal wall "B."

subsequent flagging of the pulse, transfusion may be freely repeated with every prospect of success.

Vomiting, if severe, persistent or accompanied by hæmatemesis, is best combatted by gastric lavage.

There were eighteen cases, thirteen female and four male. The patients varied in age. Most were between twenty and thirty years; the extremes were twelve and a half and seventy-one.

Three to twenty hours had elapsed between perforation and operation in fourteen cases; of these eight recovered, six died. Between twenty-one and thirty hours, two recovered, one died. One case recovered fifty hours after rupture.

The rapidity of the pulse as a prognostic is emphasized when we observe that in five of the fatal cases the pulse was over 130 before operation. We lost, however, one where the pulse was only 112, but the patient was seventy-one years old.

There were seven deaths in all; four females and three males. It was impossible to save Case 9 whose omentum was already gangrenous, or Case 16, with uræmia due to advanced congenital cystic disease of the kidneys.

It will be seen that the mortality is not excessive, and that an early diagnosis may do much to render operation for gastric ulcer highly successful. There is no reason why the judicious country practitioner should not act in emergencies, and by a comparatively simple operation, not in itself dangerous, save lives that otherwise might incur still greater risk were they sent to a distant hospital.

Some points in regard to history, leucocytosis, micro-organisms, and after complications, may be ascertained from the accompanying table. The plates serve to illustrate the appearance and position of the perforations. It would ill-become us in this section to meet without paying our tribute of reverence to the memory of our late Professor Mikulicz Radecki of Breslau.

In Mikulicz, the alert glance, so full of sunshine, the deft, dainty yet powerful hand proclaimed the artist. His wondrously versatile scientific work, his earnest quest of truth, his whole life history breathed forth the catholic spirit of a true humanity.

A pupil of Billroth, a follower of the principles laid down by Lister, he was the pioneer and perfecter of aseptic methods. Carried off in the day of his strength by that disease, cancer of the stomach, the fell ravages of which he had himself done so much to mitigate, he has left an enduring fame as a great surgeon.

	Name, Age, Occupation. Date of Operation. Event.	Previous History.	Onset.	Provisional Treatment.	Condition Prior to Operation.	Local Condition.	Operation.	Aftercourse.
1	Mr. W. L.; 21; cabinet maker; 16, xii, '01; 26 hours; recovered.	Indigestion, several years, pain across stomach for 3 weeks.	Sudden, 2 hours after hearty breakfast, severe pain causing him to fall down; vomited shortly after and later twice or thrice	Opium by mouth, and morphine.	P. 100; T. 108.8; R 26; pain and tenderness over recti, especially tender above and to right of umbilicus; liver dullness less, quite gone within an hour; rectal tenderness.	Small ulcer, anterior near pylorus; perigastric clear fluid and lymph.	$CHCl_3$; upper part of abdomen dried out; pelvis washed out; drainage.	Good recovery.
2	Miss A. G., 23; domestic servant; 14, x, '02; 50 hours; recovery.	Two years' ago, pain after food and anæmia; well since.	Sudden pain at left costal margin, left shoulder and axilla, when lifting a couple of pails; had to lie down; vomited once blackish fluid	Whiskey; poultices.	P. 125; T. 99; R. 26; tumid abdomen; general tenderness, maximum at left costal margin.	Large ulcer near pylorus on posterior wall.	Ditto.	Good recovery.
3	Miss L. T., 22; domestic servant; 21, iv, '03; 4 hours; recovered	Five years indigestion; hypogastric pain for 3 days.	Sudden.		P. 126; T. 100.6; R. 30; general acute tenderness; no liver dullness.	Large ulcer on anterior wall near pylorus and lesser curvature; much clear fluid, lymph and potato.	Whole peritoneal cavity dried out; drainage.	Good recovery.
4	Miss M. Y., 21; housemaid; 22, ix, '03; 24 hours; recovered.	Three years' dyspepsia; hæmatemesis at New Year; passed blood by rectum from 17th to 20th September.	Sudden, violent pain and vomiting; action of bowels this morning.	Morphine.	P. 128; T. 100.6; R. 24; Great abdominal pain, felt also in chest and shoulders; rigid abdomen; general tenderness pronounced above umbilicus; liver dullness much diminished.	Small round ulcer, anterior, near lesser curvature, five inches from pylorus; slight tendency to hour glass contraction.	Ditto.	Good recovery; symptoms again came on; fresh rupture, 3, xi, '04; see Case 11.
5	Mrs. W., 37; 25, xi, '03; 17 hours; died.	Indigestion all her life; great tea drinker; during last six months increased pain radiating from the back to the abdomen, relieved by vomiting.	Sudden pain and collapse.		P. 145; T. 103; R. 40; very tender tumid abdomen; no liver dullness.	Large ulcer anterior aspect of pylorus.	Laparotomy with cocain and adrenalin; $CHCl_3$ in small amount; posterior gastro-jejunostomy since pylorus was narrowed after suture of ulcer; ditto.	Improved somewhat; than had to be transfused; died twelve hours after operation. Sectio: Roughening of diaphragmatic pleura. no leakage at sutures.

	Name, Age, Occupation. Date of Operation. Event.	Previous History.	Onset.	Provisional Treatment.	Condition Prior to Operation.	Local Condition.	Operation.	Aftercourse.
6	Miss McE., 25; 31, i, '04; 18 hours; died.	Old indigestion.	Sudden, severe pain.		P. 124; T. 99.8; R. 36; does not look very ill; terder epigastric and supra-pubic regions; groins less so; rigid abdomen.	Small perforation, anterior, near lesser curvature.	CHOLs; hole peritoneal cavity washed out; drainage.	Did well till following afternoon, when pulse rose, coffee ground vomiting came on; pelvis washed out; result negative; died 18 hours after operation.
7	Miss N. B., 25; domestic servant; 20, ii, '04; 10 hours; recovered.	For some years pain and vomiting afer food; very anæmic during last 2 months; has vomited after every meal last week.	Awakened by sudden epigastric pain and bilious vomiting; bowels have acted once.		P. 102; T. 100.2; R. 24; abdomen rigid; general tenderness, marked in epigastrium; liver dullness slightly less; some rectal tenderness; leucocytes 7000	Small ulcer, posterior, near greater curvature in lesser sack distended with fluid; no fluid in general cavity.	Ditto.	Sickness and hæmatemesis next day; stomach washed out; vomiting ceased; transfusion necessary at night; good recovery.
8	Mrs. H., 40; 13, iv, '04; 6 hours; died.	Pain after food and vomiting for some time.	Sudden epigasgastric pain and collapse.		P. 140; T. 100.8; R. 40; abdomen rigid and exceptionally tender.	Small ulcer, anterior aspect cardiac end midway between the curvatures.	Ditto.	Transfused at intervals of 4 to 6 hours; she held her ground for 24 hours and then sank, 32 hours after operation. Sectio: general peritonitis.
9	Mr. M. Y., 48; laborer; 26, x, '04; 24 hours; died.	Eight years indigestion; pain and vomiting after food; intemperate; a daughter died of perforated gastric ulcer.	Sudden vomiting of and passage of black matter at stool; acute epigastric pain.		P. 132; T. 97; R. 30; fixed abdomen, tender, especially over pubis; no liver dullness.	Small clean cut ulcer near posterior aspect of pylorus; coffee ground like fluid in peritoneum; gangrenous omentum.	Distended stomach emptied with trocar and canula removed gangrenous patches; ditto	Transfused after operation; broncho-pneumunia, purulent sputum rise of temperature; death on 7th day.
10	Miss Y, 27; 18, x, '04; 17 hours; recovered.	Has been under treatment for gastric neuralgia; pain after food.	Sudden epigastric pain and vomiting.		P. 120; T. 100; liver dullness diminished.	Small ulcer near lesser curvature and pylorus.	Ditto.	Good recovery.
11	Miss M. Y., 22; housemaid; 3, xi, '04; 19 hours; recovery.	See former history Case 4; good health since operation for perforation; quite recently pain after food and vomiting.	Severe abdominal pain and vomiting.		P. 104; T. 98.4; R. 24, at 11 a. m.; did not look ill; slight abdominal pain and tenderness; abdominal respiration; liver dullness normal; at 3.30 p. m, P. 110, T 101, R. 28; liver dullness gone.	Ulcer near o'd site; marked hour-glas contraction; many omental adhesions and bands.	Ditto; posterior gastro-jejunostomy.	Good recovery.

	Name. Age. Occupation. Date of operation. Event.	Previous History.	Onset.	Provisional Treatment.	Condition Prior to Operation.	Local Condition.	Operation.	Aftercourse.
12	Miss B. K., 21; 19, xii, '04; 48 hours; died.	Epigastric pain after meals, shooting to back and shoulders, followed by vomiting of undigested food, eighteen minutes duration; better for a year, worse for last 12 months.	Severe epigastric pain and vomiting.		P. 168; T. 100.2; R. 32; whole abdomen very tender tumid; no liver dullness.	Large ulcer near middle of lesser curvature; much fluid; flakes of lymph and food stuff.	$CHCl_3$; peritoneum washed out; drained.	Death.
13	Miss H., 34; 17, i, '05; 9 hours; recovered.	Two years ago had for two months pain after food; good health since; 14 days ago slight return of pain.	Sudden severe epigastric pain.		Pulse 100; T. 100; R. 28; anxious expression, rather rigid abdomen; pain in hypo-gastric and left hypochondriac regions; maximum tenderness between umbilicus and ensiform cartilage and above pubis; liver dullness gone.	Small ulcer near lesser curvature towards cardiac end; œdematous extra peritoneal tissue.	Ditto.	Good recovery.
14	Master A. P., 12½; 15, ii, '05; 12 hours; recovered.	Pain after food for last 12 days, and slight cold.	Felt very ill; no great tenderness; vomited but passed a quiet night.	Hot fomentations.	P. 130; T. 101.2; tender abdomen; no liver dullness.	Small punched out near middle of lesser curvature.	Ditto.	Signs of right basal pneumonia on 3rd day, on 8th day both lungs affected; P. 126, T. 103, R. 48; after an anxious time got well; oxygen inhalation.
15	Mr. T. W., 71. dairyman; 14, iv, '05; 9 hours died.	Three years ago an attack of vomiting, pain and constipation; one year ago a second; was an umbilical and double inguinal hernia.	Sudden sickness and vomiting of reddish material.	Opium.	P. 112; T. 98; R. 36; tenderness above and below umbilicus; liver dullness diminished.	Posterior aspect of pylorus, large ulcer; gas, fluid and gastric contents in quantity.	Ditto.	Died 8 hours after operation. Sectio: peritonitis, suturing intact.
16	Mr. J. F., 32, laborer; 5, v, '05; 18 hours; died.	Intemperate; no data.	Sudden abdominal pain; distension.		P. 136; T. 98; R. 40; patient had a peculiar dazed look; was not clear headed and had dusky complexion.	Ulcer on anterior aspect of pylorus; much fluid; pure cultures colon bacillus.	Ditto.	Rapid sinking; symptoms of uræmia; bladder empty. Sectio: Advanced congenital cystic disease of both kidneys, cysts in pancreas and mesentery, hypostatic congestion both lungs, peritonitis.

	Name. Age. Occupation. Date of operation. Event.	Previous History.	Onset.	Provisional Treatment.	Condition prior to Operation.	Local Condition.	Operation.	Aftercourse.
17	Miss C. K., 35; 3, iv, '05; 13 hours; recovered.	For last 14 years intermittent attacks of sharp pain after meals in epigastrium and between the shoulders; vomiting since Xmas; well till last night; drinks much tea.	Susden epigastric pain and vomiting.		P. 120; T. 99; R. 26; abdominal tenderness; liver dullness less.	Ulcer anterior aspect; cardiac portion, 2½ inches from lesser curvature; cultures from near rupture gave many colonies of streptococcus pyogenes, and a few of staphylococcus aureus; from the pouch of Douglas, pure culture staphylococcus pyogenes.	$CHCl_3$; peritoneum washed out; drained.	Left sided pleurisy; aspirated 10th June; Frænkel's pneumococcus; improvement; empyema followed; resection of rib; strept. pyogenes; still draining; abdomen dull.
18	Mrs. C, 29; 29, vii, '05; 14 hours; recovered.	For several years pain after food, relieved by meal; well since rch.	Sudden sharp shooting pain epigastric and umbilical regions and down left upper arm; it passed off completely but returned worse in 6 hours.		P. 140; T. 100; R. 24; pinched look; knees drawn up; tense painful abdomen; most tender in left hypochondriac and iliac regions; liver dullness normal; leucocytosis 8,000.	Large ulcer middle of anterior aspect rather nearer greater curvature; much gastric content and fluid; bacillus of colon type in culture from pouch of Douglas and from near stomach; from latter site also a few cultures of a streptococcus.	Ditto.	Good recovery.

"McCURDYS MUST BE FED."

Some time ago we asked a fee
  Which we believed was fair,
From each insurance company
  For risks upon the square;
But, strange to say, we were opposed
  By reasons strongly plead,
But now the solemn truth's disclosed—
  "McCurdys must be fed."

The holders of the policy
  'Twas said we'd victimize,
"If we insisted on such fee,"
  "Could not be otherwise."
"The Great Insurance Institutes"
  "To bankruptcy'd be led,"
But these were merely idle bruits,
  "McCurdys must be fed"

We thought our honest toil deserved
  At least a fair reward,
Our loyalty has never swerved
  Insurance companies toward;
Yet whilst these companies get rich
  We heard the wolf's prowl dread,
And quite forgot at such a pitch,
  "McCurdys must be fed."

But since the late developments
  Across the "Border Line,"
We see ourselves as malecontents
  On hist'ry's pages shine
We used to think we were ill-used
  Until new light was shed
Upon confusion worse confused.
  "McCurdys must be fed."

As M. D.'s we're content to starve,
  A philanthropic view,
Or, better yet, we try to carve
  Our way to fortune through.
But that we asked e'en righteous fees
  It never shall be said
At the expense of poor McC's—
  "McCurdys must be fed"

Our wives and children, "God's own poor,"
  Who with us e'er abide,
It matters little to secure
  'Gainst ills on every side,
So long as clever, cool McC.'s
  Finds asses to be bled.
"Go straight to Sheol if you please,"
  "McCurdys must be fed."

Poor Mc's! To starve is pitiful,
  We've been there in our craft,
But never with the strenuous pull
  That hundred thousand graft.
Men talk of Hades, say 'tis hot,
  It may be so, and red,
But whether it is hot or not,
  "McCurdys must be fed."

M. A. H.

OPENING OF THE PAYZANT MEMORIAL HOSPITAL.

The Payzant Memorial Hospital was opened at Windsor, N. S., on the afternoon of October 24th, in the presence of a large number of spectators.

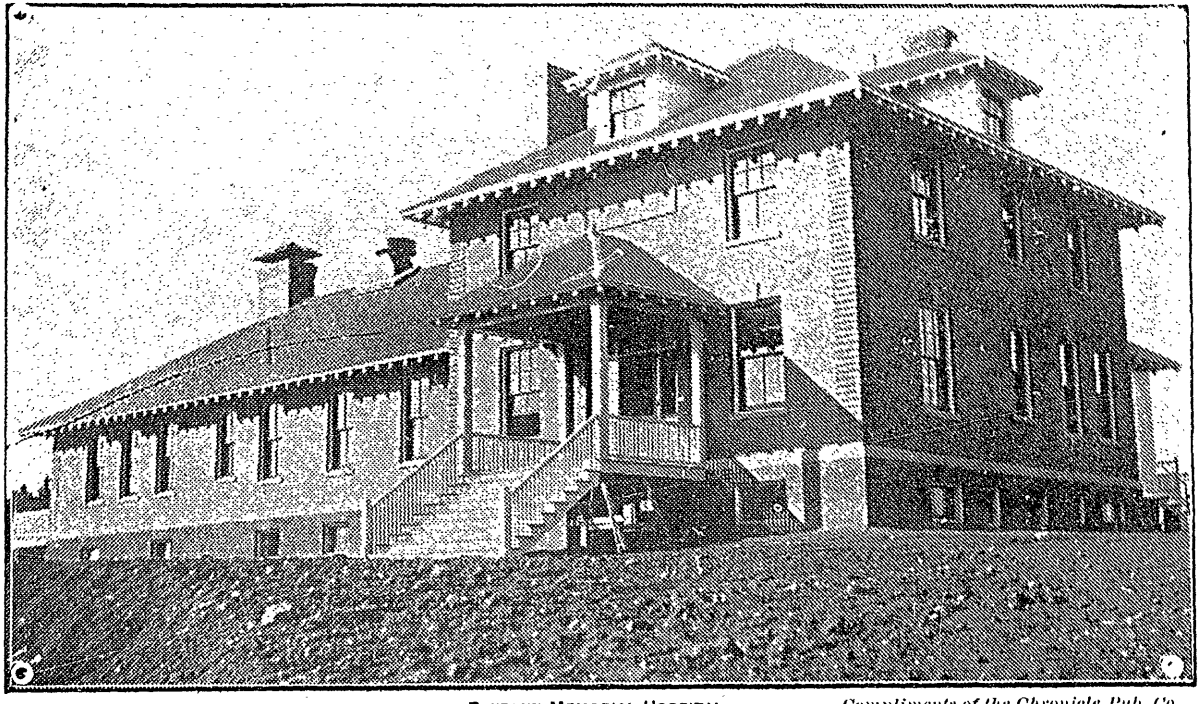
Mayor Arthur Armstrong expressed his pleasure in having present Hon. G. H. Murray, the Premier of the Province.

Speeches were delivered by Premier Murray, Attorney-General Drysdale, and Dr. J. B. Black, M. P., who has taken great interest in the building of this well equipped hospital.

The Payzant Memorial Hospital was established by a bequest of $20,000 in the will of Godfrey P. Payzant. Mr. Payzant founded the late Commercial Bank of Windsor, and was its first president, and continued president up to the time of his death, a period of thirty years. This bank was incorporated with the Union Bank of Halifax on the 31st day of October, 1902.

By the 39th clause of his will Mr. Payzant devised the sum of $20,000 to the corporation of the Town of Windsor, to assist in building, maintaining and supporting an hospital for the sick, diseased and suffering of all classes, as soon as a like sum of $20,000 was raised by the corporation. If this additional sum was not obtained in seven years after his decease, his executors were directed to pay over and divide the $20,000, share and share alike, between Godfrey Payzant and Charles Bradshaw Paulin.

It was owing to the Premier's generous liberality, in connection with the Attorney-General, that the grant of $14,000 was made by the legislature of Nova Scotia. Without that grant the institution could not have been built.



PAYZANT MEMORIAL HOSPITAL.

Compliments of the Chronicle Pub, Co,

THE

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Editorial.

LIFE INSURANCE COMPANIES AND THEIR EXAMINERS.

The principal subject of discussion at the annual meeting of the Medical Society of Nova Scotia, held in Lunenburg, in July, was the fee for examination in life insurance. Interest and importance were lent to the discussion from the presence of distinguished officials of the life insurance companies, and when the President of the Life Insurance Officers Association declared that the insurance companies could not afford to pay a fee of five dollars to their examiners, he was listened to with the respectful attention which his earnestness and urbanity deserved. The members of the Society felt that Mr. Hilliard spoke from conviction, but the arguments which satisfied him were unconvincing to them.

We shall not here attempt to investigate the data or the arguments which the insurance corporations marshal in their own support. We simply assert what we believe to be the truth, that there is not a medical man in the maritime provinces who does not believe that a five dollar fee is quite possible for the companies.

Any one who has given attention to the vast increase in the extent of life insurance of late years, who considers the balance between premiums and claims, and who may have knowledge of the princely incomes secured in agencies and commissions, must hesitate to accept the view of those who hold that a five dollar fee is impracticable. If

any doubt did exist in the mind of any one, we think it should be dissipated by the revelations of the past few weeks as to the business of life insurance in the United States. And if a New York company, paying such colossal salaries and commissions as we read of, can still have enough money left to pay its examiners a five dollar fee, it is surely a reflection on the business capacity of those companies who confess themselves unable to do so.

But it is from the professional and not the commercial standpoint that we should consider the question of the fee. The custom of increasing the fee according to the amount of the policy is radically wrong. The examiner seems to be regarded, to a certain extent, as a partner in the transaction; the bigger the policy the bigger his share. But why, if this view is adopted, should the fee stop at five dollars? A policy for fifty or one hundred thousand would then be a very pretty windfall for the examiner. But the examiner is not a partner; he is an officer of the company, and not salaried, but paid for work done; and his work is the same, whether the policy be one thousand or one hundred thousand. Or it should be the same, for it is pretty well recognized now that the examination of the urine, sometimes paid for as an extra, should be an essential part of every examination. This custom of an increase in fee, depending simply on increase in value of policy is derogatory to the profession, as indicating that thoroughness of work depends upon the financial interests at stake, whereas it is the glory of the profession that it treats the mechanic and the millionaire alike, to the best it has.

The fee for examination should be a fixed fee, irrespective of the amount of insurance applied for. Of course, if in the event of a very large risk, a company desires any special, or repeated examination, this should also be paid for in the ordinary way. We are emphatically of opinion that the fee should be five dollars. If the work is hurriedly and carelessly done it is a farce, and had better not be done at all. If it is well done the fee should bear the same footing as the ordinary consultation fee. The company is not content with the opinion of its examiner. It expects him to make a searching enquiry into the heredity and the medical history of the applicant, and to put to him questions of the most personal character, as well as to make the ordinary physical examination. We suppose the chief medical officer of the company desires to see in clear statement the grounds on which his colleague has arrived at the conclusion that the

applicant is, or is not, suitable. The transaction is thus of the nature of a consultation between the chief medical officer and a colleague.

An examination and written statement of this kind considering everything at stake, as regards the company, the applicant, the examiner, and the community of insured persons, is a very important proceeding and certainly equal in value to an average consultation. And it is because the recognized fee for a consultation is five dollars thst we consider this should also be the honorarium for an examination and report in the case of a life insurance policy.

The discussion at Lunenburg ended in the adoption of a motion that "the minimum fee for life insurance examination throughout Canada should be five dollars."

Owing to the fact that the Canadian Medical Association was to meet in Halifax this year, and that the Nova Scotia Society had met for business purposes only, the representation was not large, and it was thought by some that action should be deferred until next year; but the motion was passed by a large majority, and we hope that when the question comes up again as it will at the annual meeting next year, this decision will receive the unanimous endorsation of a fully representative meeting.

At the annual meeting of the New Brunswick Medical Society, held also in July, one of the chief subjects of discussion was that of life insurance fees, and a motion was carried that the fee be five dollars.

But as matters are at present, no action taken by the Medical Society of Nova Scotia can bind its members to a definite scale of fees, except in an ethical sense. The County Societies, in drafting their constitutions, may make membership depend upon adherence to their tariff of fees, but, sad to say, we have only four or five county societies.

The key to the situation is in the hands of the individual members. It is evident that if the profession, as a whole, stand together for the five dollar fee, it will be paid, as it is in other places.

There is another point in the relation of the examiner to the company which we think is open to criticism, and this is the customary letter of inquiry addressed to one medical man asking for private information about a colleague. The usual formula is to the effect that "Dr. A., having applied for the position of examiner in our company, has referred us to you and we shall be pleased etc., etc," Now, in a a great majority of cases, Dr. A. has not applied for the position, but

the agent of the company has applied to him to examine some one for life insurance. And Dr. A. very naturally, when asked for a reference, names a friend. Is it likely the friend will say anything injurious to his trusting colleague? And yet he is not infrequently asked to give private information as to character and habits and to answer such a question as "Is Dr. A., addicted to the use of intoxicants?" Well, if Dr. A. is so unfortunate as to share poor Charles Lamb's "insuperable proclivity," the candid friend will either sophisticate the term "addicted," or he will throw the inquiring letter into the waste basket. The whole enquiry can be boiled down to this: "is your friend, who has referred us to you for a character, fit or unfit to act as our examiner?" Fancy any one putting such a question! It is evident that under the present system every qualified medical man is competent to act as an examiner, and if asked for references the dignified course would be that of an independent-minded friend of ours, who refers his questioner to the Medical Register.

(Since this editorial was put in type, we received a poem entitled "McCurdys must be Fed," written by a versatile member of the profession in this province. Being apropos to the subject we have much pleasure in inserting the poem in this issue.)

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

The annual meeting of this Branch was held in the City Council Chamber, on October 11th, 1905, the President, Dr. C. D. Murray, in the chair.

The Secretary read the annual report, which was received and adopted.

The report of the Treasurer, Dr. G. M. Campbell, showed the Branch's finances to be in good conditlon. This report was, on motion, received and sent to the auditors, Drs. Doyle and Walsh, who reported it correct.

It was moved by Dr, Trenaman, and seconded by Dr. Farrell, that a vote of thanks be conveyed to Dr. G. M. Campbell for his successful carrying out of the Treasurer's duties.

The election of officers for 1905-6 resulted as follows:

President—Dr. W. H. Hattie.

Vice-President—Dr. James Ross.

Treasurer—Dr. G. M. Campbell.

Secretary—Dr. J. R. Corston.

Council—Drs. Ross, G. M. Campbell, Doyle, Hogan, C. D. Murray, Trenaman and Hawkins.

It was moved by Dr. Trenaman and seconded by Dr. Hawkins that a vote of thanks be tendered the retiring Secretary, Dr. Farrell, for his work during the past year. Carried.

It was moved by Dr. Walsh and seconded by Dr. Corston that a vote of thanks be tendered the retiring President, Dr. Murray. Carried.

It was resolved that the appointment of a representative on the General Council and the Parliamentary Bills Committee be deferred until a future meeting.

It was moved by Dr. G. M. Campbell and seconded by Dr. Walsh, that the annual dues for the present year be fixed at six dollars and eight cents. (i. e. one guinea, Carried.

It was moved by Dr. C. D. Murray and seconded by Dr. Trenaman that the annual dues of the Secretary and of the Treasurer be remitted by the Branch for the ensuing year.

It was arranged that the next meeting should be of a clinical nature, and be held at the Victoria General Hospital.

October 25th.—Meeting held at the Victoria General Hospital, the President, Dr. W. H. Hattie, in the chair.

The minutes of the annual meeting were read and adopted.

The programme for the year, as drafted by the Council, was read. The following contributions to the programme were promised:

"A discussion on Immunity," by Drs. L. M. Murray, Doyle, et al., for January 17th.

"A Therapeutical paper," by Dr. Goodwin, for January 3rd.

The clinical programme for the evening was as follows:

Case for diagnosis, shown by Dr. D. G. J. Campbell. Boy, aet. 11 years, admitted to hospital on August 9th, with complaint of pain in lower part of abdomen, swelling of face, and an obstinate ulcer on the shoulder. His urine has shown much blood and granular casts from the first. His facial expression suggests adenoids. There has been a variable amount of abdominal distension. The splenic dulness extends to within one finger's breadth of the umbilicus. Blood, 4,500,000 reds, 4,800 whites, the differential count pointing to splenic anæmia. The patient had been operated upon on August 24th by Dr. Armstrong, of Montreal, when considerable enlargement of the left kidney and great splenic enlargement were found. His condition has not changed since admission. He is now on iodide treatment, with mercurial inunctions.

Dr. Campbell asked for suggestions and questions regarding the case.

Dr. L. M. Murray said that he had found nothing pathological in the kidney except hypertrophy. He thought that the boy's appearance suggested hepatic cirrhosis, which would account for the splenic enlargement, the underlying cause being probably syphilis.

Dr. C. Dickie Murray noted the presence of Hutchinson's teeth, and thought that hereditary syphilis would account for all of the symptoms.

Dr. Chisholm also inclined to the diagnosis of congenital syphilis, with possibly a growth in the liver causing portal obstruction, the splenic enlargement being thus accounted for. The kidney condition

might be due to blocking of the vena cava, although in such cases there would usually be swelling of the lower extremities.

Dr. Ross noted scars from leg ulcers, and agreed that Hutchinson's teeth were present. He recommended mixed treatment, the mercury to be given by hypodermic injection.

Drs. Goodwin, Murphy, Doyle and Hattie also took part in the discussion, the concensus of opinion favoring the diagnosis of hereditary syphilis.

Dr. Campbell, in conclusion, remarked that Mr. Caird had seen the case, and had recommended "mixed treatment," and that the patient was getting it at the present time.

Case of "Congenital Talipes" shown by Dr. Chisholm. Young man, aet. 19 years. Deformity had been corrected nine years ago, but had gradually returned. The points of special interest were the considerable amount of hypertrophy about the ankle joint, and a perforating ulcer on the outer aspect of the foot. Dr. Chisholm thought that amputation was indicated, and that the choice of method lay between Sedilott's modification of Symes', and an amputation of the leg at the junction of the middle and lower thirds. He favored the latter situation, as an artificial foot, necessary in either case, would be of more use when adjusted at that point.

Dr. Ross thought that as a general principle, every scooped out ulcer should have iodide treatment, but agreed that in this case there were special indications for amputation.

Dr. D. J. G. Campbell, speaking of the diagnosis of syphilis, thought that the Justus blood test was too little used.

Dr. Hattie spoke of the possibility of the ulcer in this case returning in the heel flap if amputation were done at the ankle joint.

Dr. Chisholm, in reply, said that he would not anticipate such a result. He agreed with Dr. Ross' views concerning iodide treatment.

He then reported a case of "Perforation of the Stomach," which had been diagnosed and sent in by Dr. Doyle. Dr. Hogan had operated immediately, assisted by Drs. Chisholm and Murphy. The perforation, resulting from a gastric ulcer, was sutured through and through with catgut, then with mattress sutures by Halsted's method, and finally by Lembert's sutures. The case, more than forty-eight hours after operation, was doing well, and Dr. Chisholm considered her prognosis fair.

Dr. D. G. J. Campbell spoke of the advantages of a vaginal drain in female cases of peritonitis, stating that Dr. Cullen, of Baltimore, habitually used it, also keeping the patient in the sitting posture for several days.

Dr. Doyle thought that the fact that this patient was menstruating at the time would contraindicate the use of a vaginal drain. He said that the pain had radiated to the back, between the shoulders, from the first, and that this, together with the absence of hepatic dulness. had been very suggestive to him of perforated gastric ulcer.

Dr. Murphy said that Dr. Hogan had irrigated the abdominal cavity with several gallons of saline solution, making another incision suprapubically for this purpose.

Case of "Enlarged Prostate," shown by Dr. Murphy.—An elderly colored man. He had done a suprapubic prostatectomy according to the method of Freyer, keeping a catheter in for six days, and a suprapubic drain for twenty-six days, on account of the foul condition of the bladder. The patient still has the suprapubic opening, but can urinate without difficulty.

Dr. Murphy made a plea for more frequent operation in these cases. He exhibited the removed prostate, which had been of the size of an egg when fresh.

Case of "Movable Abdominal Tumour," shown by Dr. Murphy. Middle-aged woman. Tumour first noticed in hypochondrium, when it was as large as an egg. On admission it was loose; easily palpable, and as large as two fists. Left kidney was not discoverable in its normal place. Blood count, normal. Diagnosis, hydronephrosis.

Operation—The incision was made in the left semilunar line. Nothing was found, and this was closed; another being made over the left kidney, which was nearly seven inches in length. A nephropexy was done, and now the patient is doing well, being kept lying on the affected side and on her back for six weeks after operation. The left kidney can now be felt in its normal position.

Case of "Tumour involving the Inferior Maxilla,"—Shown by Dr. Chisholm, who had seen it in consultation with Dr. Hogan. There was then, within the mouth, a ragged ulcer in the tumour, with greyish base and ragged, hardened edges, extending up over theramus of the jaw towards the tonsil. The unanimous diagnosis had been inoperable carcinoma, but iodide treatment was given as a forlorn hope, and with such good results that he now thought her prognosis

good. Dr. Chisholm presented this case as a notable instance of the wisdom of giving iodide treatment whenever there is the remotest chance of syphilis being present.

Dr. Ross, speaking of iodide dosage, said that in one case this year he had given as much as 350 grains of potassium iodide three times daily for gummatous ulceration of the tibia. The patient was a delicate looking young man who weighed only about one hundred pounds.

Dr. Doyle recalled a case which had been in hospital in 1897, of a fungating growth on the lip, greatly resembling carcinoma, which had cleared up on potassium iodide.

Discussing Dr. Murphy's kidney case, Dr. Doyle asked whether the daily amounts of urine had been noted. Dr. Murphy replied that they had not, but that the patient had never noticed any abnormal amounts herself.

Dr. Lessel mentioned a case under his care at the Halifax Dispensary of syphilitic ulceration of the foot and leg, with an enormous amount of fibrous swelling, which was cleaning up on ten grains of potassium iodide three times daily.

After concluding remarks by the President, the meeting adjourned, after which the members were pleasantly entertained at an oyster supper, when their wants were efficiently looked after by Mr. Kenney and Dr. Puttner.

EXHIBITORS AT THE CANADIAN MEDICAL ASSOCIATION MEETING.

The display of snrgical instruments and appliances by both The Chemists' and Surgeons' Supply Company, Ltd., and J. H. Chapman, of Montreal, elicited much praise. These firms handle nothing but one quality, and that the highest grade.

The exhibit of Burroughs, Wellcome & Co., of London, likewise engaged considerable attention. Their high-class pharmaceutical products are universally known, and their Canadian representative, Mr. Nevin, Montreal, was ever busy in giving information to enquirers. A handy memorandum book, also containing views of Halifax, and an interesting history of pharmaceutical progress, etc., was presented to each member.

The Gadola Chemical Co., represented by W. A. Simson, Phm. B., of this city, showed the different preparations of cod liver oil put up by this firm, viz, Amor's Essence of Cod Liver Oil and several combinations. The process of extracting the oil, with other information, was explained by Mr. Simson, who deserves success in his enterprise. A cod weighing forty-nine pounds cleaned attracted more than ordinary interest.

Mr. Charles Roberts, of Montreal, was on hand with J. B. Lippincott's standard works, and naturally received numerous orders.

B. Lindman, whose truss has received high enconiums from numerous surgeons of Canada, explained the many features of this appliance.

Charles E. Frosst & Co. were intending exhibitors, as space had been engaged. At the last moment, however, Mr. Frosst found it impossible to be present, but insisted on paying his contribution for space taken. This firm is already well and favorably known throughout all of Canada.

The Kress-Owen Company, of New York, had a neat display of their well-known antiseptic preparation, Glyco-Thymoline. Each member received a large bottle, which was specially made for the meeting—Canadian Medical Association being stamped on each.

Personals.

Dr. J. F. Pineo, formerly of Chester, N. S., is now located a Bennington, New Hampshire.

Dr. W. F. Smith of this city has returned after an absence of six months spent in London. The doctor devoted considerable time to diseases of children at the Great Ormonde Street Hospital.

Dr. Lewis Thomas has taken the office on North street formerly occupied by Dr. H. S. Jacques.

Dr. D. T. C. Watson, formerly of Gillispori, Labrador, has opened an office on Agricola street, this city.

Dr. G. D. Turnbull was obliged to leave Yarmouth on account of ill-health and is now located in the city of Calgary. Dr. Turn-

bull is confining his practice to diseases of the eye, ear, nose and throat. We are pleased to state that his health has rapidly improved since going west.

Dr. E. Douglas, who was unfortunate in having his lower jaw fractured at a recent football game, has entirely recovered from his injury, which is the second time he has sustained a like injury. Dr. Douglas is located on Robie street, in the house formerly occupied by Dr. Doull.

Dr. M. G. Archibald, formerly of Upper Musquodoboit, is now located at Kamloops, B. C.

Dr. Jane Heartz-Bell has lately returned from a few weeks visit to some of the New York hospitals.

Dr. M. W. Macaulay, formerly of Thorburn, is now located at Edmonton, Alberta.

Obituary.

Dr. Frank Buller.—The death of Dr. Frank Buller, Canada's noted specialist in diseases of the eye and ear, occurred on the 11th of October. He was born at Campbellford, Ontario, in 1844, and graduated in medicine in 1869. After acting as surgeon in the Franco-Prussian war, he devoted considerable time to post-graduate study in Germany and England, and then returned to Canada and commenced practice in Montreal. Dr. Buller soon became recognized as one of the greatest specialists in diseases of the the eye in North America, and was an able clinical teacher in McGill University for thirty years.

Dr. A. P. Landry.—At Eel Brook, Yarmouth, on the 6th inst., the death of Dr. Landry occurred after an illness of six weeks. Dr. Landry was an ardent Conservative and several years ago was an unsuccessful candidate for the local legislature. A daughter is a nurse at the Victoria General Hospital, and a son is a student of the Halifax Medical College.

Dr. J. A. MacKenzie.—The death of Dr. John Alexander MacKenzie, which occurred on the 12th of October, at the Nova Scotia Hospital, of which he had for ten years been Assistant Medical Superintendent, took from the profession a useful and valued member.

Dr. MacKenzie was born at St. George's Channel, West Bay, C. B., on the 12th of October, 1865, so that his death occurred on the fortieth anniversary of his birth, and strangely enough on the second anniversary of his marriage. He received his literary education at Pictou Academy, obtained his medical degree from the College of Physicians and Surgeons of Boston in 1892, and afterwards spent nearly a year at hospital work and special study in London. He joined the staff of the Nova Scotia Hospital as Assistant Physician in November, 1893, and in June, 1895, was promoted to be Assistant Superintendent. This position he held until his death, which resulted from appendicitis, after an illness of a very few days, an operation having proved to be without avail.

Dr. MacKenzie was a man of singularly genial and happy disposition, keenly appreciative of the humorous, kindly and sympathetic, diligent and conscientious. His work at the hospital was characterized by a careful and methodical attention to every detail. He was a great favourite with the patients, who could always expect from him a bright smile and a cheery word. His death will prove a great loss to the institution with which he was associated for so many years.

While not a frequent contributor, Dr. MacKenzie wrote a number of excellent papers, dealing usually with some abnormal mental condition. We have had the opportunity of publishing several of these papers in our pages, notably one on "Thrombosis of the Left Middle Cerebral Artery," published in April, 1899, and one on "Mental Disturbances of Puberty and Adolescence," published in December, 1903.

Two years before his death, Dr. MacKenzie married Miss Mabel Gentles, of Dartmouth. Besides his widow, a mother and two brothers survive him. He left no family.

To those so sadly bereaved by his death, we extend cordial sympathy.

Book Reviews.

Merck's 1905. Manual of the Materia Medica. Published by Merck & Co., New York. This is a ready-reference pocket book containing names of the chemicals and drugs used in modern medical practice. This little book will be found of much value as a handy guide and time-saver. It likewise gives a table of therapeutic indications, poisoning and its treatment, the metric system, and a concise chapter on urinalysis.

THE LATE DR. J. A. MACKENZIE.

The Delineator for December. For colorwork, presswork and general beauty and usefulness, tho December *Delineator* is conspicuous among the Christman magazines. Eight paintings by J. C. Leyendecker, illustrating and interpreting the Twenty-third Psalm, is the most extensive color feature of the number, but a painting by Alphonse Mucha, accompanying a poem, "The Mother of Bartimeus," by Theodosia Garrison, is fully as notable as an art work. The short fiction of the number comprises stories by Hamlin Garland, John Luther Long, Gilbert Parker, and Alice Brown. The opening chapters of a new serial—a woman's club store—"The President of Quex." are given; it is said to be in the nature of a reply to "The Evolution of a Club Woman," which created great interest in the magazine last year. There is also the continuation of "At Spinster Farm," articles on Brass and Copper Utensils in "The Collector's Manual" and the Child at Play in "The Rights of the Child." A series of illustrated papers under the title, "Some Heroines of Shakspere—by their Impersonators," also begin in this number with Eleanor Robson on Juliet. The pastimes for children are filled with the spirit of the season, and there is an abundance of matter of housewifely interest.

Therapeutic Notes.

SANMETTO IN IRRITABILITY OF THE PROSTATE AND IN PRE-SENILITY.—I have used Sanmetto in several cases during the past five years and have yet to be disappointed in results. Have found it particularly valuable in cases of irritability of prostate gland with decreased sexual power.

Cleveland, Ohio. Jno. T. Henderson, M. D.

A Louisville physician has recently written the manufacturers of LISTERINE DERMATIC SOAP:—"Received your sample of Listerine Dermatic Soap, a piece of which I lathered and rubbed with unguent. hydrarg. and found that as a result I had a most esthetic mixture for the skin demanding mercurials.

"In giving X-Ray treatments I have long felt the want of such a soap, as it is cleansing, cooling and antiseptic. Just the thing for acne, lupus, etc."

NOTES ON A CASE OF PERIMETRITIS. Hukam Chand, C. M. S., Surgeon Delhi Hospital, Delhi, India:—

1 was called to see a female patient in the city on October 12th, 1904. On arrival I found her with fever, temperature 102°, tongue coated, pulse rapid, bowels costive, urine scanty and high colored, plain and tenderness over the hypogastic region as well as in both iliac fossae, vagina hot (as told by native *dhai*) but no discharge. On palpation the uterus was found hard and on inquiry it was found that the present complaint was due to abortion and exposure to cold. I diagnosed the case as perimetritis associated with ovaritis and prescribed:

(1) Calomel gr. $\frac{1}{4}$. One every three hours.
(2) Antikamnia & Heroin Tablets. One every four hours.
(3) Turpentine stupes over the seat of pain.

(4) Liquor Morphia, 15 minims at night, *if no sleep.*

Oct. 13th.—Pain less than before, had a good sleep for four hours. Continued the same treatment.

Oct. 14th.—Pain less than the previous day, had good sleep without morphia.

Oct. 15th.—Pain considerably less, patient could walk with the aid of stick. Good sleep. Continued same treatment but stopped turpentine stupes.

Oct. 16th.—Very slight pain remaining, patient weak, otherwise well. Stopped calomel, prescribed castor oil, oz. 1, and continued antikamnia & heroin tablets as before.

Oct. 17th.—No pain at all. Bowels moved twice. Prescribed tonic mixture. Patient getting well.

REMARKS.—In my opinion the recovery of this case was due to the analgesic and antipyretic properties of antikamnia & heroin tablets. They are worth a trial in such conditions.—*Practical Medicine*, March, 1905, Delhi, India.

SAL HEPATICA VS NATURAL MINERAL WATERS.—The superiority of Sal Hepatia over the natural mineral waters that are specially recommended in the uric acid diathesis and the various forms of constipation is clearly shown by the following facts:—By commingling lithium and sodium phosphates in proper proportions with certain of the "bitter water" salts, as represented by Sal Hepatica, a compound is secured that is superlatively more active than either lithium or sodium salt alone, or, indeed, than any natural mineral water or any combination that can be effected. Recognizing this, the most eminent practitioners latterly have taken to prescribing Sal Hepatica in preference to the natural waters, with the result that the remedial action of the latter is enhanced, the untoward manifestations accruing reduced to a minimum, and their palatability materially increased.

Sal Hepatica is very effective in limiting and reducing the amount of uric acid formed within the circulation and excreted by the kidneys, and is very freely absorbed and taken into the blood and as rapidly (along with the chemical products formed) eliminated by the excretory ducts or organs as is readily demonstrated by its presence, after a brief course thereof in perspiration and urine, the latter more particularly being doubled or trebled as to quantity and rendered decidedly alkaline.

The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901,

UNDER THE AUSPICES OF THE CANADIAN MEDICAL ASSOCIATION.

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enrol themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $2.50 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

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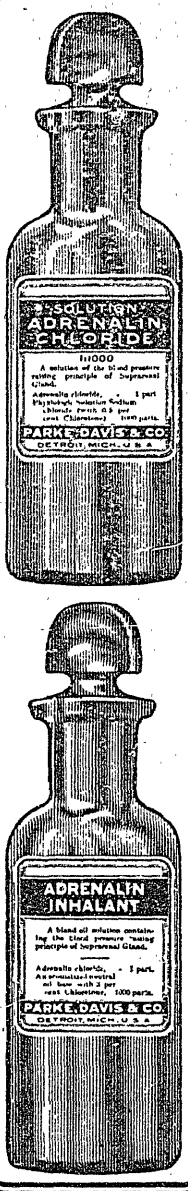
Hay Fever



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