The modern expansion of surgery is apt to make us lose sight of certain men who have been absorbed into the general picture so completely that the original significance of their work is obscured. George Edgeworth Fenwick (Fig. 1), one such figure in the history of Canadian surgery, was born in Quebec in 1825. His family had come out from England a few years before. He had some medical experience in the Marine Hospital at Quebec and graduated at McGill University, Montreal in 1847. He had completed the usual course in 1846 but was just under the age necessary for the granting of the degree. In the interval, he accepted an appointment as apothecary at the Montreal General Hospital (Fig. 2).

The Hospital had just completed its first quarter-century and Fenwick’s debut as one of its future notable figures was not auspicious. Within a few months he was reprimanded by the Committee of Management, which then had very direct disciplinary powers, for keeping a dog in his room: “to the annoyance of the servants, besides being a great nuisance in the institution, after having been civilly warned to put it away . . . The Committee further resolved not to allow Dr. Fenwick any separate table for his meals, as being incompatible with the interests of the institution.”

Fenwick resigned at once, with a quickness of temper that was to become familiar to his friends. His abilities, however, were soon recognized. It was to him some years later, in 1884, that the young Thomas Roddick came one morning on his way from Newfoundland to study medicine in Edinburgh. As they sat talking a telegram came in appealing to Dr. Fenwick for help in a shocking train accident on the Richelieu River Bridge. Roddick begged to be allowed to go with him and was told to come along. Later, on Fenwick’s persuasion, he decided to take his training at McGill University.

In those days, medicine and surgery were practised together. The distinction between the surgeon and the physician was not formally recognized in the Montreal General Hospital before 1881. Fenwick, however, was a surgeon by instinct even as Osler was a physician. His surgical experience was largely gained in the pre-antiseptic days, when he would operate regularly in the same old, crusty, black frock coat. But he was one of the first in Montreal to adopt Lister’s antiseptic methods, being convinced by Roddick’s lead where some of his colleagues were sceptical. He had the advantage of a sound anatomical training, from teaching experience, and he was content to do little rather than more. His students were continually urged always to look after their own dressings, but he would know when to leave his patients alone. As Dr. Shepherd said of him: “He would operate and then not bother much.

*Reprint address: 138 Dunrae Avenue, Montreal 16, Que.
about the case; perhaps he would go away for a day and yet the patient would get well. Others were too solicitous—never tired of meddling—like digging up a seed to see if it was growing, and the cases of such doctors usually died.\footnote{2}

His judgment and independence of mind appear in his pioneering work on excision of the knee joint for chronic inflammatory conditions (Fig. 3). In his monograph on the subject,\footnote{3} he dwells at length on the then-much-disputed question of amputation versus excision and arthrodesis of the joint. It was his constant preoccupation to save the limb if at all possible, and to do so he did not hesitate to undertake procedures both new and formidable. Some of the 28 patients in whom he did excision and arthrodesis were operated on before antiseptic precautions were taken, and he obtained results as good as those in British and Continental hospitals; he lost only two. Yet, in his opinion, much of the credit was due “to the better feeding and housing of the working class in Canada”.\footnote{3}

There is little doubt that in this field he was a leader in widening the scope of wisely conservative surgery. He describes with obvious delight his first excision, done in 1865 in a boy of 18 who had traumatic arthritis of the left knee of seven years’
standing. Five years after the operation the patient revisited Montreal. He had walked from New York to Albany for the fun of it, and had no trouble with his leg.

He dwells in detail on the accurate fitting together of the ends of the bones, to ensure good union, and describes especially the careful use of the saw on the epiphyseal surfaces. Incidentally, he mentions the advice of an older teacher to practise sawing on a broom handle or walking stick. He said that one student followed this advice to the extent that it was impossible to keep a whole broom or walking stick in his father’s house.

But Fenwick still was a general surgeon. The Montreal General Hospital has photographs of some of the immense tumours of the neck that he dissected out—reminiscent of Conan Doyle’s story in “Round the Red Lamp” (Fig. 4). He also gained a name as a “lithotomist”, and had a large collection of calculi. He would watch anxiously over these and his carefully preserved joint specimens when they were passed round the class in a clinic.

His wider interests are reflected in his appointment to the presidencies of the Canadian Medical Association and the Montreal Medico-Chirurgical Society, and in his membership in the College of Physicians and Surgeons of Quebec. He was on the teaching staff of McGill University for 25 years, being Professor of Surgery for 15 years. Among his papers preserved in the library of the Royal College of Physicians and Surgeons of Canada, are certificates of his membership, at the age of 22, in La Société Médicale Marianopolis (1846), and in La Société Pathologie Monte Regio (1849), as well as in the Natural History Society of Montreal. He was probably the oldest volunteer surgeon in Canada, and was connected with the Montreal Battery to his latest days, having seen service with it in the Fenian raids of 1866 and 1870. As editor of The Canada Medical Journal he occupied for several years an important place in medical journalism of the day. One can trace in his editorial writings the same impulsive fervour that he showed in his surgical work.

It is pleasant to notice the degree of affection with which he was universally re-
garded. He was quick-tempered, as we have seen, and could be irascible, but no one was ever long angry with him, even if he kept them waiting for appointments, as he did so often as to gain the title of “the late Dr. Fenwick”. To Osler he was “that old darling” (the Osler Library preserves his notes of Fenwick’s lectures on surgery). One of his pupils, Dr. Casey Wood, gives us a picture of “the genial old man driving about Montreal in his fur coat and blowing his nose à la Stentor, with an array of bandana handkerchiefs”.*

Practical and exact professionally he was improvident to a degree, often only sending out his bills when pressed for money.

*From Dr. Wood’s letter of September 10, 1919 to Sir William Osler with which he was sending Fenwick’s copy of Religio Medici. Wood had picked it up in a Montreal book-store, with Fenwick’s book-plate in it.

THE FIRST NEPHROURETERECTOMY
In 1896, H. A. Kelly wrote the following description:

The patient suffered from frequent spasms of the bladder of such intensity that she passed most of her time in a squatting posture in bed, screaming with pain...

A vaginal examination showed the right ureter to be normal, while the left was large, thick, and rigid, apparently about 1 cm. in diameter, and so exquisitely sensitive that only the gentlest pressure could be made upon it. Its surface was also irregular and exhibited depressions at periods. The enlarged ureter could also be located through the abdominal walls at the pelvic brim, and traced above that point by following a well-marked line of tenderness.

I catheterized the ureters and obtained a few c.c. of a clear brown acid urine from the right side...but nothing escaped from the left side after waiting some ten minutes; then upon manipulating the catheter a little, it was felt to pass through a resistant area...and suddenly the urine began to flow so freely that in a few minutes about 90 c.c. of pale lemon-coloured alkaline urine escaped, loaded with pus and containing "tubercle bacilli"...

I determined to extirpate the left kidney with its ureter, and to this end made an incision in the left side 16 cm. long, outside of and parallel to the umbilical line. The muscles were divided, the peritoneum opened, and the viscera displaced to the right so as to expose the enlarged ureter lying on the psoas muscle. I then traced the ureter up to the kidney, which was cystic; the kidney was slowly enucleated from its bed. The renal vessels were finally tied with four fine silk ligatures and the kidney completely detached. The large hard ureter was next freed from its cellular bed from above downward to the pelvic brim;...

His friends once collected $1000 to help him out when he was suffering over a severe illness. The signatures of the contributors (also in the Royal College library) read like a roll call of the medical profession in Montreal. He at one time spent $600 on a piano and used the rest for a trip. He said he had always wanted a piano and here was his chance.

He died of cerebral hemorrhage on June 26, 1894.

REFERENCES

1. Montreal General Hospital: Minutes of Committee of Management, November 17, 1848.
2. Shepherd, F. J.: Reminiscences of student days and dissecting room, privately printed, Montreal, 1919, p. 15.

The detachment of the ureter became more difficult after it was freed from the common iliac artery and vein; at a point 4 cm. below the pelvic brim where the ureter turns forward, it was surrounded with such dense cellular tissue that I decided not to encuncate any further...so I tied the ureter on the floor and cut it off, leaving wedge-shaped flaps, and removed the kidney with the entire abdominal portion and one-half the pelvic portion of the ureter.

The mucosa of the lower end beyond the ligature was sterilized with the thermo-cautery and the flaps approximated with fine silk sutures and dropped...a strip of gauze...was laid from the brim of the pelvis down into the loin and brought out. It was not necessary to unite the peritoneal wound beside the colon, because the natural adhesions were good.

The long abdominal incision was then closed with interrupted silk-gromut sutures. The gauze drain...was removed on the fifth day. When the sutures were removed the union was perfect and there was no suppuration at any point.

This procedure, the first nephroureterectomy recorded, was performed on March 30, 1893 by Kelly, who at that time was the Professor of Gynecology at Johns Hopkins University. The operation was described before the Surgical Section of the American Medical Association in May 1893, but the manuscript was lost and the paper was not published at that time. It appeared in the Bulletin of Johns Hopkins Hospital three years later, along with two other descriptions of patients with nephroureterectomies.—Reservitz, G. B.: A historic review of nephroureterectomies, Surg. Gynec. Obstet., 125: 853, 1967.