



Room for a view

## The rookie

He sat slumped in the back seat of a small car, under the yellow glow of the emergency department entrance. We pulled him out and threw him onto a stretcher. It was 2 am, the night suddenly coned-down and focused.

“He’s not breathing, let’s go.” We dashed with the gurney through the automatic doors, past the triage desk and into the resuscitation room.

Under the bright lights Stuart, as I’ll call him, revealed himself. He was young — 20 years old, it would turn out — blond, athletic-looking, but with blue lips and ashen skin. He still had a pulse; his pupils were pinpoints. A plastic airway was slipped into his mouth. A mask was placed over his face and oxygen bagged into his lungs. His chest rose and fell with each ventilation; his colour turned a healthy pink. I relaxed;

we were in control; he would live.

He was disrobed to his underwear, which was soaked with urine. An IV line was jabbed into an engorged vein in his arm, leads were placed on his chest, and an oxygen saturation probe was clipped onto his finger. He was a rookie, it seemed: only a few fresh track marks in his right arm.

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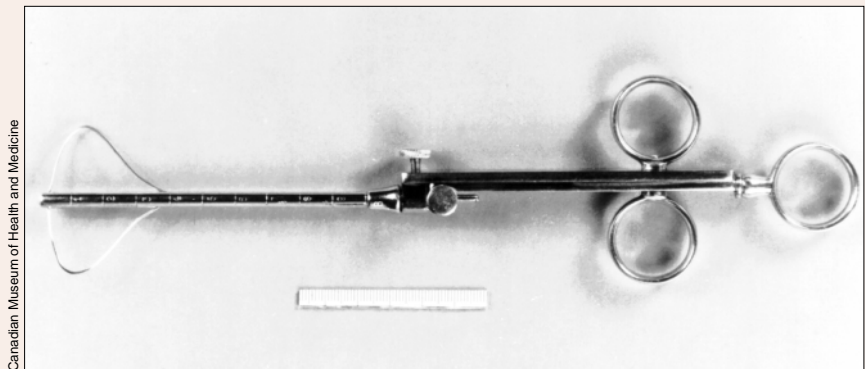
Image of the profession

## The leucotome

The instrument pictured here was designed by Dr. Kenneth G. McKenzie in the 1940s to bring precision to prefrontal leucotomy, or lobotomy. It is part of the exhibition *Brainwork*, now on view at the Canadian Museum of Health and Medicine in Toronto to mark the 75th anniversary of neurosurgery in this country. McKenzie received the first Canadian appointment in that specialty at the Toronto General Hospital and the University of Toronto in 1923. His contemporary in the field, Wilder Penfield, took up an appointment at the Royal Victoria Hospital and McGill University five years later.

The fact that Egas Moniz, the Portuguese neurosurgeon who introduced frontal leucotomy in 1935, was awarded the Nobel Prize in medicine in 1949 may be jarring to modern sensibilities. Felicity Pope, curator of the Canadian Museum of Health and Medicine, notes: “By today’s standards, lobotomy is seen as a dark episode in neurosurgery’s past. In its heyday ... it met the needs of doctors, patients’ families and asylum superintendents. From the patients’ point of view it was less satisfactory.”

In 1946 McKenzie reported in



**The McKenzie leucotome, shown with the cutting loops exposed. Made by Down Bros., UK, circa 1945. The instrument was passed through the frontal lobes to the orbital plates via burr holes made through the top of the patient’s skull.**

*CMAJ* improvement or recovery in 23 of 27 consecutive patients who had undergone bilateral frontal lobe leucotomy to treat apparently intractable psychiatric illness, ranging from manic depression to schizophrenia and marked by “pathological fear” manifested as “anxiety, agitation or impulsive behaviour.”<sup>1</sup> By his death in 1964, McKenzie’s view had changed: “the availability of tranquillizing drugs [has] reduced the importance of this drastic, irreversible procedure.”<sup>2</sup> Reporting on a five-year study in which 183 patients who had undergone leucotomy were matched with controls, McKenzie disclosed the unexpected finding that there was no significant difference between the two groups in rates of hospital discharge and concluded that “pre-

frontal leukotomy [did] not produce any rate of remission beyond that to be expected without the operation.”<sup>2</sup>

*Brainwork* is on display at the Toronto General Division of The Toronto Hospital, in the College Wing Lobby, 101 College St., Toronto. For information call 416 340-4800 x1899, or email [fpope@torhosp.toronto.on.ca](mailto:fpope@torhosp.toronto.on.ca)

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### References

1. McKenzie KG, Proctor LD. Bilateral frontal lobe leucotomy in the treatment of mental disease. *CMAJ* 1946;55:433-9.
2. McKenzie KG, Kaczanowski G. Prefrontal leucotomy: a five-year controlled study. *CMAJ* 1964;91:1193-6.