THE BULLETIN

OF

The Vancouver Medical Association

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VANCOUVER MEDICAL ASSOCIATION
PROGRAMME FOR THE FIFTY-THIRD ANNUAL SESSION

Founded 1898; Incorporated 1906

REGULAR MONTHLY MEDICAL MEETINGS

First Tuesday—General Meeting—Vancouver Medical Association—T.B. Auditorium. Clinical Meetings, which members of the Vancouver Medical Association are invited to attend, will be held each month as follows:

Second Tuesday—Shaughnessy Hospital Staff Meeting.

Third Tuesday—St. Paul's Hospital Staff Meeting.

Fourth Tuesday—Vancouver General Hospital Staff Meeting.

Fifth Tuesday—(when one occurs)—Children's Hospital Staff Meeting.

Programme of General meetings will be circularized monthly by the Executive Office of the Vancouver Medical Association Programme of Clinical meetings will be displayed weekly on bulletin boards prepared for that purpose and placed in the Vancouver General, St. Paul's and Shaughnessy Hospitals.

VANCOUVER GENERAL HOSPITAL

Regular Weekly Fixtures in the Lecture Hall

Monday, 8:00 a.m.—Orthopaedic Clinic.

Monday, 12:15 p.m.—Surgical Clinic.

Tuesday—9:00 a.m.—Obstetrics and Gynaecology Conference.

Wednesday, 9:00 a.m.—Clinicopathological Conference.

Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.

Friday, 9:00 a.m.—Paediatric Clinic.

Saturday, 9:00 a.m.—Neurosurgery Clinic.
edition, 1950.

ST. PAUL'S HOSPITAL

Regular Weekly Fixtures

Tuesday—9-10 a.m.	Paediatric Conference
2nd Tuesday of each Month—11 a.m.	Tumor Clinic
Wednesday—9-11 a.m.	Medical Clinic
2nd and 4th Wednesday—11-12 a.m.	Obstetrics and Gynaecology
Thursday—11-12 a.m.	Pathological Conference (Specimens and Discussion)
Friday—8 a.m.	Clinico-Pathological Conference (Alternating with Surgery)
Alternate Fridays—8 a.m.	Surgical Conference
Friday—9 a.m.	Dr. Appleby's Surgery Clinic
Friday—11 a.m.	Interesting Films Shown in X-ray Department

SHAUGHNESSY HOSPITAL

Regular Weekly Fixtures

Tuesday, 8:30 a.m.—Dermatology.
Wednesday, 10:45 a.m.—General Medicine.
Wednesday, 12:30 p.m.—Pathology.
Thursday, 10:30 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

BRITISH COLUMBIA CANCER INSTITUTE

Tuesday, 9:00 a.m. to 10:00 a.m. (weekly)—Clinical Meeting.

B.C. SURGICAL SOCIETY

Spring meeting—April 25th, 26th, 1952.

THE BULLETIN

Publishing and Business Office — 17 - 675 Davie Street, Vancouver, B.C.

Editorial Office — 203 Medical-Dental Building, Vancouver, B.C.

The Bulletin of the Vancouver Medical Association is published on the first of each month.

Closing Date for articles is the 10th of the month preceding date of issue.

Manuscripts must be typewritten, double spaced and the original copy.

Reprints must be ordered within 15 days after the appearance of the article in question, direct from the Publisher. Quotations on request.

Advertisements

Closing Date for advertisements is the 10th of the month preceding date of issue.

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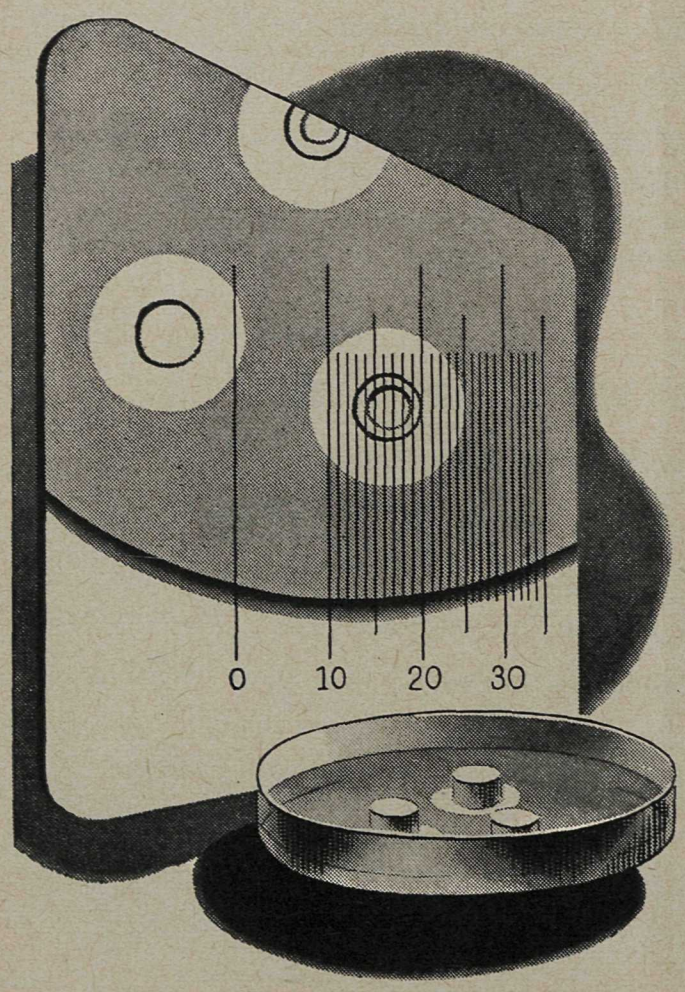

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"Penicillin remains a pharmacologic curiosity because of its almost completely innocuous character. No toxic effects of the dose-related type have been reported; this is the more remarkable in view of the enormous number of persons (literally millions) who have received the drug."[3]

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Literature available upon request.

MERCK PENICILLIN PRODUCTS

1. Pratt, R. and Dufrenoy, J., *Antibiotics*, J. B. Lippincott Company, Philadelphia, 1949, p. 30.
2. Keefer, C. S., *Postgraduate Medicine* 9: 101, Feb. 1951.
3. Goldstein, A.: Antibacterial chemotherapy, *N. England J. Med.* 240: 137-147, Jan. 27. 1949.

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VANCOUVER HEALTH DEPARTMENT

STATISTICS — OCTOBER, 1951

Total population - estimated	397,140
Chinese population - estimated	6,282
Other - estimated	640

	September, 1951	
	Number	Rate per 1000 pop.
Total deaths (by occurrence)	321	9.7
Chinese deaths	5	9.5
Deaths, residents only	290	8.7

Birth Registrations—Residents and Non-residents:
(includes late registrations)

	September, 1951	
Male	371	
Female	439	
	810	24.5

Infant Mortality—residents only

	September, 1951
Deaths under 1 year of age	7
Death rate per 1000 live births	11.6
Stillbirths (not included in above item)	10

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	September, 1951		September, 1950	
	Cases	Deaths	Cases	Deaths
Scarlet Fever	24	—	9	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Chicken Pox	18	—	15	—
Measles	17	—	9	—
Rubella	4	—	11	—
Mumps	14	—	15	—
Whooping Cough	1	—	23	1
Typhoid Fever	—	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	7	1	6	—
Tuberculosis	37	5	36	13
Erysipelas	—	—	1	—
Meningitis	—	—	—	—
Infectious Jaundice	—	—	—	—
Salmonellosis	1	—	18	—
Salmonellosis Carriers	—	—	—	—
Dysentery	25	—	3	—
Dysentery Carriers	—	—	—	—
Tetanus	—	—	—	—
Syphilis	11	—	20	2
Gonorrhoea	159	—	210	—
Cancer (Reportable Resident)	98	58	92	61

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Rapid and Prolonged . . . .

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This new product of the Laboratories is prepared as a stable dry powder which requires no refrigeration. By the addition of an appropriate volume of sterile water, a free-flowing aqueous suspension is readily and quickly obtained. The aqueous suspension is ready for immediate intramuscular injection using a 20-gauge needle.

HOW SUPPLIED

1-dose vial— 400,000 International Units
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10-dose vial—4,000,000 International Units

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DEPOT FOR BRITISH COLUMBIA

MACDONALD'S PRESCRIPTIONS LIMITED

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The Editor's Page

To all our readers, we extend compliments of the season, and our best wishes for 1952.

This new year bids fair to be one of destiny for the British Columbia Medical profession. For there will be many adjustments and changes in our domestic affairs—and out of these we shall all hope to see improvement in many particulars, and a strengthening of our position, with the public and amongst ourselves.

It has long been felt by medical men in British Columbia that we should be more closely linked with the whole Canadian profession, and that this would best be done by closer affiliation with the Canadian Medical Association. This body has ably represented the profession for many years and anything we can do to give it greater strength, and to increase unity, will be for the benefit of all of us who practice medicine in Canada.

Some years ago the British Columbia Medical Association became a Division of the CMA—in name at least. But its constitution was a loosely-designed affair—and many felt that it was insufficiently precise and flexible—that it did not give adequate representation to all sections of the profession—the word used was that it was not "democratic" enough. Everyone knows what he means by this word—but his meaning is not always the same as that given by his neighbour. Personally, we think the word is overworked, and often used incorrectly—but the general idea of it is good.

So a new constitution was drawn up and adopted, and now the machinery is there, and it is up to all of us to set it to work, and to make it possible for it to work.

A recent vote taken by the College of Physicians and Surgeons through its Council, has shown that the majority of those voting, and so a majority of the profession, wants this new body to undertake the business of the profession, its economics, its contracts and agreements with various bodies—to handle its public relations in fact.

This imposes, of course, a great responsibility on the B.C. Division. But it also imposes a great responsibility on us, all the members of the profession. We are sure that all of us will accept loyally the decision of the majority, and abide by it with all sincerity and goodwill. We believe that the B.C. Division is competent and willing to do the job—but our support, moral and financial, are essential to its success. And, having called on the Division to do this work, we must back it up in every way.

And we would say one more thing—that we must be patient, and having given our confidence, must retain it, and give the Division adequate time to do its work. For the problems that confront us as a profession are many and difficult. They cannot be solved by any easy, ready made decision or by violent action—they can be solved by patience and goodwill, and a determination to deal fairly with all concerned. No matter who is responsible for the conduct of our economic affairs, that organization has a stupendous task ahead of it. But if we all pull together, and work together, there is no doubt that we shall succeed, and be all the stronger for the effort. We shall have added to our own stature and made our contribution to the economic status of the whole Canadian medical profession.

LIBRARY HOURS:

Monday, Wednesday and Friday	9:00 a.m. — 9:30 p.m.
Tuesday and Thursday	9:00 a.m. — 5:00 p.m.
Saturday	9:00 a.m. — 1:00 p.m.

The Library has been most fortunate in having been presented, by Dr. W. C. Gibson, with a reproduction of the "Edwin Smith Surgical Papyrus" together with a translation of it by Professor J. H. Breastead. We print below the letter that accompanied this very fine gift and the Library Committee's letter of thanks and appreciation.

1690 Westbrook Crescent,
Vancouver, B.C.
October 14, 1951

The Chairman,
Library Committee,
Vancouver Medical Association.

Dear Sir:

I am sending along a copy of Prof. Breasted's translation of the Edwin Smith Papyrus for the library, as a small memorial to my father-in-law, Dr. Walter S. Baird, who spent his life here in General Practice and who would have been delighted with the new Academy both as a building and as an idea.

I hope that this earliest historical document relating to scientific medicine may be of interest to the members and may stimulate others to bring to the Academy Library what they undoubtedly have languishing on their shelves at home! Having seen good collections turn to dust for lack of circulation I would stipulate that this volume, together with any others I may send you in the future, should be available to anyone anywhere.

May I take this opportunity of telling you how much my laboratory owes to your library and its librarians during the past year in getting our research programme under way.

Yours sincerely,
(sgd) Wm. C. Gibson.

November 21st, 1951

Dr. W. C. Gibson,
1690 Westbrook Crescent,
Vancouver 8, B.C.

Dear Doctor Gibson:

Your recent generous gift to our library of the "Edwin Smith Surgical Papyrus" translated by Professor J. H. Breasted has been most gratefully accepted and may I, on behalf of the Library Committee and members of the Association, thank you very sincerely for these valuable volumes.

This translation is, indeed, one of the greatest, both in historical and medical importance. The Committee realizes that this work is now out of print and extremely difficult to obtain, and for this we feel all the more indebted to you for your kindness and thoughtfulness in presenting it.

The volumes will be inscribed as a memorial to Dr. Walter S. Baird and will find a place for all time in our library which now has its own home in an atmosphere we can all enjoy.

Yours sincerely,
(sgd) John L. Parnell, M.D., Secretary,
Library Committee.

EDWIN SMITH SURGICAL PAPYRUS

As a short historical note on the above work, we can do no better than quote from the Foreword and General Introduction:

"The science of surgery has made such revolutionary progress during the last two generations that there might seem to be a greater gulf between the surgeons of the American Civil War and those of the present than there ever was between the surgery of the ancient world and that of the American Civil War. Nevertheless, the fundamental transformation in the field of surgery, as in medicine, resulting from the earliest recognition of natural causes as distinguished from demoniacal possession, occurred in ancient times. Superstitious views of the universe, involving belief in demoniacal possession, especially among the ignorant, have persisted into modern times, as illustrated in the Salem witchcraft, or even in the case of an educated man like Increase Mather, once president of Harvard University. It is strikingly illustrated in the conditions among which Mormonism arose only a century ago in western Pennsylvania and New York State. It is obvious, therefore, that the transition from superstition to a scientific point of view cannot be placed at a fixed date.

In this document, therefore, we have disclosed to us for the first time the human mind peering into the mysteries of the human body, and recognizing conditions and processes there as due to intelligible physical causes. The facts in each given case of injury are observed, listed, and marshaled before the mind of the observer known to us, and in this papyrus we have the earliest known scientific document.

While the copy of the document which has come down to us dates from the Seventeenth Century B.C., the original author's first manuscript was produced at least a thousand years earlier, and was written some time in the Pyramid Age (about 3000 to 2500 B.C.). As preserved to us in a copy made when the Surgical Treatise was a thousand years old or more, a copy in which both beginning and end have been lost, the manuscript nowhere discloses the name of the unknown author. We may be permitted to conjecture, and it is *pure conjecture*, that a surgical treatise of such importance, appearing in the Pyramid Age, may possibly have been written by the earliest known physician, Imhotep, the great architect-physician who flourished in the Thirtieth Century B.C. In that case the original treatise would have been written over thirteen hundred years before our copy of the Seventeenth Century B.C. was made . . .

"Mr. Edwin Smith, after whom the papyrus is named, went to Egypt about the year 1858. He was at that time thirty-six years of age and had studied Egyptian in both London and Paris before proceeding to Egypt. Although as far as it is known he never published anything, it is quite evident from his papers in New York that he had become very fully grounded in the new science, which was then only a generation old. His knowledge of hieratic is praised by the sagacious Goodwin, who says, with reference to the date of the calendar on the verso of the Ebers Papyrus: "The numeral attached to the name of the knid is neither 3 nor 30 — both of which numbers have been suggested — but 9. It is due to Mr. Smith, whose acquaintance with hieratic texts is very extensive, to mention that he pointed this out to me as long ago as 1864, when he communicated to me a copy of the endorsement upon his papyrus." It is

evident from these remarks of Goodwin that Edwin Smith was the first scholar to read correctly the date in this famous calendar . . . In January, 1862, during his stay at Thebes, Mr. Smith purchased the document which is the subject of this book . . .

"As at present unrolled and mounted between glass, the Edwin Smith Papyrus has a length of about 4.68 meters (about 15 feet 3½ inches). At least a column of writing has been lost at the beginning, so that it originally had a minimum length of five meters (about 16 feet 4 inches). The roll has a height of 32½ to 33 centimeters (about 13 inches), corresponding to the usual full-height roll of the period from the Middle Kingdom through the Hyksos Age to the early Empire. It is put together out of twelve sheets of the usual size, about 40 cm. (about 15¾ inches) wide, the first now surviving being unfortunately fragmentary. The eleven joints are admirably done, and in its craftsmanship the roll is an excellent piece of work. It now bears seventeen columns of writing on the recto and five on the verso, all in horizontal lines . . .

"The seventeen columns (377 lines), all that is preserved of this ancient treatise, occupying the front of the Edwin Smith Papyrus, contain 48 cases, all injuries, or induced by injuries (with two possible exceptions). The discussion begins with the head and skull, proceeding thence downward by way of the nose, face and ears, to the neck, clavicle, humerus, thorax, shoulders and spinal column, where the text is discontinued, leaving the document incomplete . . ."

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CANADIAN MEDICAL ASSOCIATION—B. C. DIVISION

October, 1951 — September, 1952

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Pharmacy	Dr. D. M. Whitelaw, Vancouver, B.C.

The profession in this province has voted to have the British Columbia Division of the Canadian Medical Association conduct their economic affairs. It should be stated once and for all (and the doctors will agree to a man) that this is no reflection on the members of the Council of the College of Physicians and Surgeons. These men are universally recognized as leaders in their profession and they are highly respected for their ability and integrity. It is for this reason they have been chosen to take charge of the licensing and the moral and ethical standing of the profession. The change in control of medical economics is purely a matter of organization and terms of reference. The electorate of the College considers the constitution of the B.C. Division more suitable than that of the Council to conduct their business affairs.

The economic committee of the B.C. Division will immediately face many difficult problems. There will be frequent negotiations for higher fees with prepaid health insurance organizations. There is still the unsettled matter of fees paid by the Social Assistance Medical Services to consider. There is the constantly recurring problem of obtaining a more reasonable remuneration for services rendered to the Workman's Compensation Board. Probably the most difficult and most urgent problem is to adjust the alleged discrepancies in fees received by various groups within the profession for work they are doing.

In respect to the last mentioned question it will be apparent that until we can

solve our internal differences we will not be sufficiently strong and united to satisfactorily attack our outside problems. It behooves us all therefore to take a broad, tolerant and statesmanlike view of this matter for the benefit of the profession at large and ourselves in particular.

Since the economic committee of the B.C. Division (under the able chairmanship of Dr. Russell Palmer) has for its objective the improvement in status of the entire medical population they can reasonably expect widespread moral and financial support. This not only applies to individuals but to every medical organization within the province including the Council of the College of Physicians and Surgeons.

The cost of drugs for social assistance cases in this province is rapidly reaching astronomical figures and will probably call for some drastic action on the part of the government in the near future. Although this problem is primarily one which concerns the government and the Pharmaceutical Association, the medical profession cannot escape its share of the responsibility. We naturally believe that these people should receive the best possible treatment but there is a tendency to prescribe expensive medicines wholesale to cases in which the indications may be far from clear and without due regard to their cost to the taxpayer. As responsible citizens it is our duty to curtail this waste as much as possible. —G.J.

RELATIONS WITH THE C.M.A.

The recent vote about Medical Economics in B.C. not only decided whom we preferred to handle Economics, but also stimulated a lot of discussion and thought about the framework and purpose of our various medical organizations. One matter that came up for query was the relation of our B.C.M.A., now officially termed the C.M.A.—B.C. Division, with the national C.M.A. In particular, men wanted to know what the C.M.A. contributed to Medical Economics, and how independent we doctors of B.C. were from the C.M.A. in matters economic, or contrariwise, how much the C.M.A. could or would affect economic decisions on a Provincial level.

Broadly speaking, the activities and policy decisions of the C.M.A., respecting Medical Economics, are restricted to the national scene. The C.M.A. represents the doctors of Canada at Ottawa. Our representatives at Ottawa musta keep continuously informed about the activities of Parliament in regard to Health matters. The Minister of Health, Hon. Paul Martin, has stated that within a few months he will form a Special Parliamentary Committee on Health Insurance. The fires are hotting up. If our representatives at Ottawa were weak or indecisive, if they seemed to proffer only destructive criticism, if they stooped to make 'secret deals' with the politicians — the fault would lie at our door. The C.M.A. is our organization. It is a voluntary association. The strength and effectiveness of the C.M.A. depends upon the weight of a large membership and also, in large part, upon the contributions of moral support and constructive thinking from the Provincial Divisions.

How is C.M.A. policy determined? Have we, in B.C., done our share of the thinking? Can we improve our liaison with the C.M.A. and make our voice more effective?

Major business of the C.M.A. is conducted, and policy determined, by the General Council which meets for two days prior to the Annual Meetings. Interim business, between Annual Meetings, is carried forward by Standing and Special Committees, and directed by an Executive Committee (with one representative from B.C.). Members of the General Council of C.M.A. are elected by their Provincial Association or Division. In B.C. these members are elected by the Board of Directors. This year the number of members from B.C. is eleven. (Names are announced elsewhere in this issue). About a month prior to the Annual Meeting of the C.M.A. the members of General Council receive a detailed agenda with full reports of all Committees. Most of the business and policy debates in General Council stem from the Committee Reports.

In the past, B.C. has been represented on the national scene by very effective individuals, but our composite voice has usually been weak. This weakness was partly a reflection of our disinterest, but also partly due to the haphazard nature of our local organization. This year the members of General Council from B.C. have been chosen from the elected members of the General Assembly. They represent the whole of the Province. Furthermore, it is planned to call a Special Meeting of the General Assembly in May, and one of the principal functions of that meeting will be a consideration of projected C.M.A. business. Our delegates will not be told how they must vote at the Banff meeting, but the will have thought over the business at hand and will know the majority of our General Assembly.

Broad policies and public statements about economic matters that stem from a C.M.A. meeting, may have a direct influence on the activities and attitude of Parliament at Ottawa. Anyone who doubts this statement is advised to study Hansard of June 21, 1951. On this day some publicity about Trans-Canada Medical Services from the C.M.A. Meeting at Montreal, touched off a full scale debate about Health Insurance in Parliament. It makes interesting reading. Politicians seem to agree that when doctors are organized they should be suspect.

Publicity about economics that is derived from a C.M.A. meeting, or from the statements of C.M.A. leaders at Ottawa, is bound to have some effect in the Provinces. If this publicity is baneful we have democratic means of correcting the ills through the General Council. If the publicity is helpful we may have cause to be grateful for the backing of all the doctors of Canada in relation to some local problem. The C.M.A. cannot interfere directly in our Provincial Economic decisions. We may ask and obtain the assistance of the C.M.A., but the B.N.A. act ensures that Provinces have control of medical treatment services other than Public Health. Hence our sad experience with the Weir Health Insurance Act of yesterday, the workings of S.A.M.S. today and the problems of further governmental actions tomorrow, were and are matters for negotiation between the doctors and the legislators of this Province.

Economic activities of the Provincial Division and of the national association should in no way conflict. Strengthen the one and we strengthen the other. We are neither isolationists nor federalists. There is need of a powerful C.M.A. for the national scene, and a well organized, strongly supported divisional organization for provincial affairs. One will complement the other.

—F.T.

PRESCRIBING FOR S.A.M.S. CASES

In the last two years the cost of providing drugs for persons covered by the Social Assistance Medical Services has risen to a very considerable figure. The reasons for this are several and include the larger number of persons eligible for this care and a larger number of visits to the doctor on the part of each patient. These variables do not account entirely, however, for the greatly increased cost of drugs. There has been increased use of drugs which are expensive to provide. In many cases, of course, these expensive drugs are very effective, so that they return the patient to normal health and eliminate expense entailed in continued medical care and the consumption of less effective remedies.

Nevertheless, one cannot fail to be aware that medication is being prescribed which is unnecessary, ineffective and expensive. This particularly applies to practices such as the very potent vitamin preparations two or three times daily over lengthy periods, the injection of liver extract in cases of anaemia other than pernicious anaemia, the injection of penicillin for the treatment of cases of the common cold, the use of glutamic acid where hydrochloric acid would do as well, the use of expensive hormone preparations in the treatment of senile psychoses.

It is inevitable that the cost of providing medical care to old age pensioners and others will increase. It is most desirable, however, that doctors should use the same

restraint in prescribing for their patients as they would in prescribing for their private patients. It is important to remember that the increased cost of caring for this type of patient is borne by the taxpayers of whom the doctor is a prominent representative.

—D.M.W.

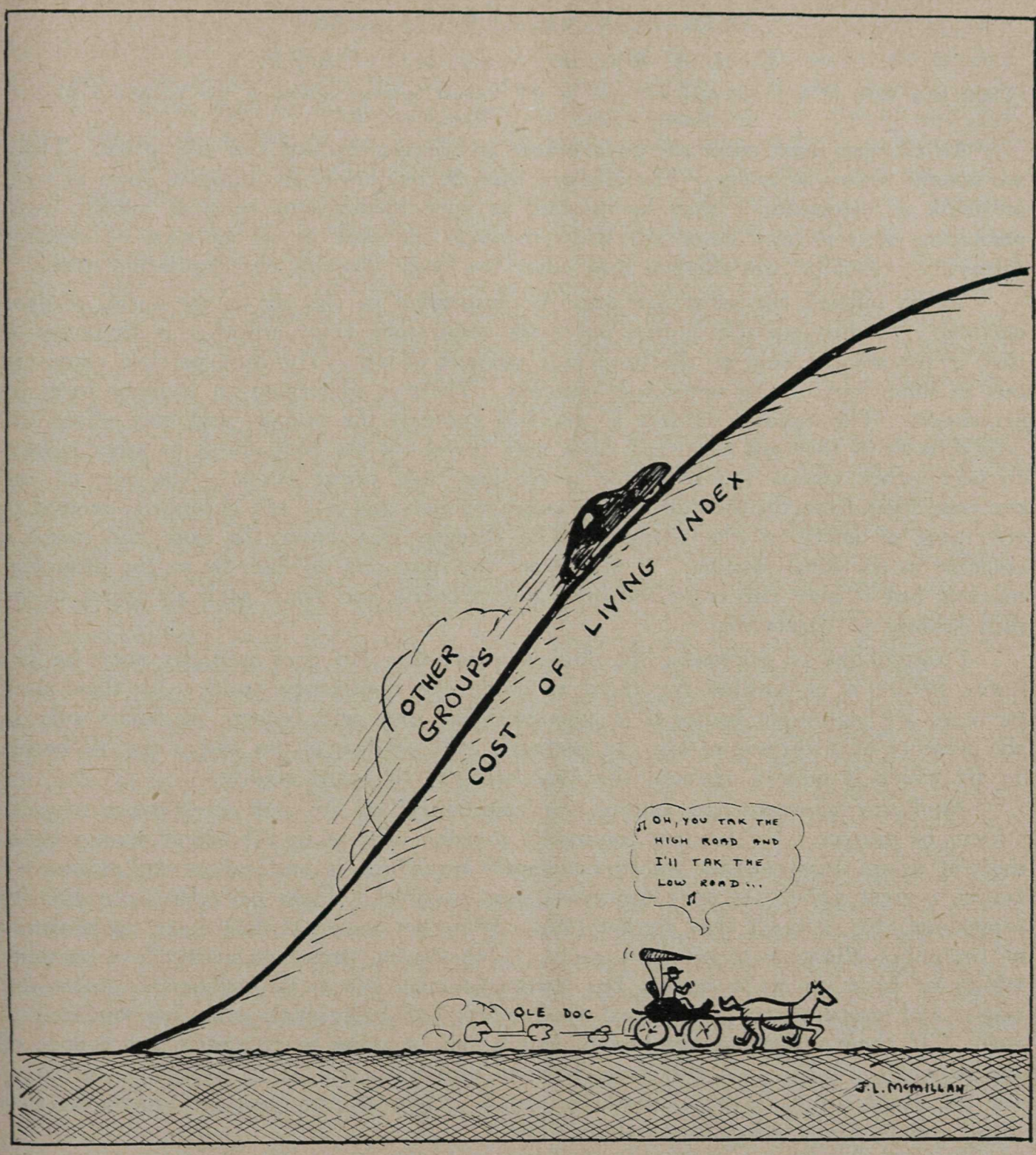
MEDICAL MEN AND MONEY

At the present time, we hear on every side complaints about the cost of this, that, and the other. Doctors' fees come in for their share of this disfavour, but when one goes a little more deeply into these complaints about our charges, they appear to be based far less on the actual cost, than that the doctors are making too much money. In this modern socialized world, the greatest possible sin is to have an income above the average person, so the medical men are looked upon as very undesirable citizens, because, in general, they do average a higher income than any other groups.

In considering medical incomes, there are many points which must be taken into consideration; I do not intend to comment on the frequently expressed statements that doctors have a very long and most expensive training. We must employ a nurse-stenographer, keep up an office in a manner to satisfy our patients and ourselves, buy and maintain much expensive equipment, as well as innumerable other running expenses. All these items cost a great deal under this present high cost of living, so that, as we all realize, doctors who gross less than $12,000 per year are fortunate indeed to keep their ratio of expenses to 50% of their gross income. For those grossing from $12,000 to $25,000 per year, expenses usually run about 40%, while for the few who may be over this figure, expenses rise sharply, because there are assistant doctors to be paid.

Official figures released from time to time by the income tax department, give earnings of various groups. In these figures or calculations, doctors are usually near the top. (In 1949 we followed engineers, architects and lawyers). The medical population of Canada has been over thirteen thousand for the past several years, yet the number of doctors used to compute these high averages was 7,442 in 1947; 6,000 in 1948; and 8,010 in 1949. In other words, if we average the earnings of the top 60% of all the doctors in the country we find a very satisfactory figure. But what of the other 40%? Evidently they haven't an income sufficiently high to be eligible for income tax. And what would happen to this very high average for the medical profession, as quoted, if all the doctors in Canada were included in working it out? Would our profession be near the bottom of the list? Is someone trying to prove that doctors are making too much money, and so only using the top earners, to prove their point? Probably these figures do more than anything else could to prove that generalization in figures about group incomes are absurd.

According to these income tax figures, the 8,010 doctors averaged $9,009 for the year. However, in discussing this, let us be even more generous, and we will assume for the purposes of argument that doctors averaged a gross income of $16,000. I choose this income, because it is obviously higher than a true one. With this income, the doctor's expenses in running his practice will be about forty percent, which is $6,400, leaving a net income of $9,600. For ease of figuring, let us allow him two weeks holiday per year without pay, which leaves 50 weeks at $192.00 per week. This is undoubtedly a good income, and well above the average, but let us look for a moment at how he earns this sum. Everyone knows that the doctor is on call twenty-four hours every day, and that he works long hours, including Sundays. By actual calculation, this average number of hours per week comes to approximately 70. That is, on the usual union rates, 40 hours straight plus 30 hours at double time, or a total of 100 hours per week. This obviously works out that doctors average $1.92 per hour. When one considers that doctors, as very highly skilled labour are working for $1.92 per hour, one wonders how long before the labor unions will be berating them for undercutting pay rates. Certainly, if we were members of any of the recognized



STILL IN THE HORSE AND BUGGY DAYS

unions, there would be loud outcries about this poor wage. No doubt the unions will also be upset at our amount of overtime, and in the future, if state medicine comes to Canada, doctors' hours will be staggered like others, and each doctor will only have a forty hour shift, so that when patients call the central depot for a doctor, they will be sent one who happens to be on duty at that particular hour.

One last point to consider in the doctor's income, is that he is so busy earning this income, that he has not the time to do many little household repairs and gardening, and so must hire someone else to do what is necessary, probably at a cost of $2.50 per hour, while he is earning $1.92 per hour, less the share going to the income tax department. Of course, doctors are big losers in income tax, which, it seems, is specifically aimed at doctors so that one must earn enough to pay this excessive tax, and still have something left for the high cost of living; but that is another story. —L.S.

AIR-BORNE ALLERGENS*

C. H. A. WALTON, M.Sc., M.D., F.A.C.P.

*Third in a series of five addresses delivered at the Annual Summer School of the Vancouver Medical Society, May, 1951, Vancouver, B.C.

An allergen must enter the body before an allergic reaction can take place. There are several routes of entry. The allergen may be swallowed or ingested, such as food or drink or medicine; it may be injected as with medications such as insulin liver, penicillin, etc., it may enter the body through the skin as in the case of contact dermatitis. Finally, the allergen may enter the body through the respiratory tract.

To be inhaled the substance must be suspended in the air in the form of dust particles. A dust particle cannot enter the respiratory tract unless it is air-borne so that it reaches the nose or the lung in a current of air. The dust particle comes to rest in some part of the respiratory mucosa. There it undergoes an aqueous form of extraction. The aqueous extract is absorbed through the mucosa and may affect the cells directly if they are sensitized, or it may travel *via* the body fluids to other tissues. If such other tissues are sensitized a reaction will occur there. The site of the reaction depends on the location of the sensitized cells and it is not necessarily related to the route of entry of the allergen. The allergen may enter the nose and cause a reaction in the nasal mucosa. It may enter the lung and do likewise in the bronchial mucosa, but it may also enter the lung and circulate and reach such an organ as the skin leading to dermatitis.

I would like to emphasize the obvious point that the dust particles must be air-borne before it is possible for them to enter the respiratory tract. As these dust particles are inanimate bodies it is apparent that they will become air-borne only in the presence of a current of air. In perfectly still air dust settles and is not air-borne. In air which is greatly agitated the dust becomes air-borne readily.

Air-borne allergens are among the commonest of all and come from a great variety of sources. As they are commonly invisible, except in a beam of strong light, most of us are unaware that we are constantly breathing, in and out of our respiratory tracts, a great variety of very numerous dust particles. These particles are ordinarily innocuous, that is to say they are not toxic. However, many of them have the property of becoming allergens to sensitive people. No doubt, there are many dust particles which we have yet to recognize, but fortunately for practical purposes we know the origin and properties of many and their effects on individuals who are sensitive to them. If these properties are known much can be done to recognize the source of the patient's trouble and, therefore, how to deal with it. It is, therefore, necessary for the physician to have a knowledge of the origin of the more common offending dusts and to know what to do about them.

Seventy-five years ago Blackley in London demonstrated that he and various other people like himself, suffered from hay fever and asthma during the season of grass pollination. He demonstrated conclusively that he had symptoms only when grass pollen was in the air. He demonstrated the grass pollen floating in the air and he estimated its quantity. He showed that it was in the air only when grass was actually pollinating in June and early July. He also demonstrated that if grass pollen saved from a previous season was placed in his nose or inhaled into his lung in some other season symptoms were produced. Finally, he demonstrated that if grass pollen was scratched into his skin, that an urticarial wheal resulted. This is the classical demonstration of air-borne allergy. Since his time we have learned that the pollen of many plants is allergenic and that it does, indeed, cause symptoms of hay fever, asthma, and some cases of dermatitis in many individuals. It is obvious that such pollen must be air-borne before it can reach the patient. Thus only plants which can produce air-borne pollen are of importance in allergy. Many plants, particularly those with bright flowers, are insect pollinated. Their pollen is too large and sticky and too heavy to be readily air-borne. Such plants are not important in allergy. The rose and the goldenrod are myths in allergy. Plants with small, inconspicuous, ugly and badly scented flowers

do not attract the insects and therefore to achieve cross pollination they much produce large quantities of small, dry, light pollen grains which float in clouds in the air and thus reach other plants. These are the plants which concern us at this time.

These plants may be divided into three groups; the trees, the grasses and the weeds. Such trees as the poplar, willow, elm, maple, ash, alder and the oak in these latitudes, commence pollination usually rather suddenly in late April and continue to pollinate into May. These dates, of course, vary in different latitudes and in different areas. In general, the dates which I refer to are those which apply to the Winnipeg area and the prairies, which area I have studied carefully and know. Whether the dates apply strictly in Vancouver, I am not sure, because as far as I am aware there has been no pollen or suitable botanical study made in this region. It is obvious that if a patient is sensitive to the pollen of any of these trees he will develop symptoms only when that pollen is in the air and can reach him. Therefore, the tree pollen case always has his symptoms at the time the trees pollinate in his region.

The next item in the pollination calendar is the flowering of the various grasses. Generally this starts early in June and increases in intensity into the early part of July, but many species continue to pollinate, though not heavily, throughout the summer. The amount of pollination, of course, varies greatly with climatic conditions. In particular grass pollen is thin-shelled and absorbs moisture very easily. If there is much rain or humidity grass pollen grains absorb moisture, become heavy and fall rapidly to the groundn where they are harmless. In a hot, dry summer, if growth has previously been good, pollination is heavy and bothers the patient a great deal. Obviously, grass pollen is important to the patient only on the dates mentioned.

In the great plains of North America and throughout the Eastern part of the continent, the next pollen season is that of the weeds. Generally this season starts at the end of July and spends through August into September. The dates obviously vary with each region as do the quantity. Again, I have no data on Vancouver and I hope that some day this will be available, but I am informed, and have good reason to believe, that the weeds which produce allergenically important pollen, do not thrive and, in fact, are literally absent from this region. Obviously, the weed pollen sensitive case suffers his trouble in the weed pollinating season. If he has the good fortune to be in an area where weed pollen does not exist, he will, of course, have no symptoms. The farmer who suffers from ragweed asthma or ragweed dermatitis and who moves to Vancouver or Victoria and thereby recovers from his affliction, may credit it to your salubrious climate, when in fact, the climate is not the conditioning factor, but the fact is that he has left his ragweed or other weeds behind him.

In large areas of this continent one hears a great deal of ragweed pollinosis and in truth, some three-quarters of the populated area of the continent suffers to a greater or lesser degree from ragweed. However, ragweed and its relatives do not occur in England or in Europe and as a result many a ragweed sufferer has found relief by crossing the Atlantic to these countries. Many Canadian soldiers discovered this accidentally.

This in brief is the story of pollinosis. Do not worry about the brightly flowered plants or the brilliantly flowered trees, because they cause you and your patient no trouble. The beautifully flowered lilac attracts attention in June, but it is the inconspicuous blossoming grass around about it which in reality causes such misery to the patient. Obviously, a patient suffering from pollinosis has his symptoms only in the season when pollen is in the air and at no other time. If the pollen characteristics of an area are known diagnosis should be simple.

There is another group of air-borne allergens which has some seasonal characteristics and which is somewhat analogous to pollen. These are the spores and cells of fungi or moulds. Any study of the atmosphere will demonstrate dozens of fungous spores. These, of course, vary greatly in each area and depend on local characteristics. In the Great Plains area some of these spores are very numerous and characteristic. Winnipeg has the distinction of being the worse in this regard than even Chicago, although Chicago takes the prize for ragweed.

There are some fungi which produce spores in varying quantities throughout the year irrespective of the temperature or other atmospheric conditions. Such fungi are found outside and also inside buildings. I refer to this group of fungi as the perennial type and it includes such common moulds as yeast, penicillin, aspergillus, rhizopus, mucor, monilia, etc. All of these can be identified and counted in air studies and this is done quite simply by the exposure of suitable culture plates.

There are a number of other fungi which are characteristically seasonal. In Manitoba these seasonal fungi are found thriving after the snow has gone in early Spring and they persist in large quantity until they are heavily blanketed with snow in the late Fall. During winters in which there is very little snow, small numbers of them survive and throw off a few spores throughout even the coldest months, but in general, they only appear in significant amounts in the air in early April, gradually increasing throughout the summer and reaching their height in late September or October, long after the last pollen grain has left the air. They continue to give trouble until thoroughly covered with snow. The three common examples of this seasonal group are alternaria, hormodendrum and helminthosporium. In addition, in agricultural areas we find the spores of rust and smut. Such parasitic spores are very widespread and dense, but their season is very short. In Manitoba the peak of their season may be in July or August and the total season seldom exceeds four or five weeks. Rust and smut can be allergenic and are demonstrated in a few cases, but the other seasonal spores, namely alternaria, hormodendrum and helminthosporium cause the greatest number of allergic reactions and are comparable in their effect to pollen, such as ragweed. The perennial spores also seem to be important, though less strikingly so than the seasonal ones and they occur under many circumstances. Of course, their symptoms tend to be at any time of the year. Exacerbations occur under special circumstances such as the cleaning out of a mouldy basement, the opening of a summer home, etc.

The third type of seasonal air-borne allergens is represented by the scales from insects. While physical allergy to these substances is not common, it does occur in a very severe form under some circumstances. In Manitoba, we have an insect known as the May Fly which occurs along rivers which are rapidly flowing. This fly collects in great quantities in such places as power houses, so that in a sense it represents an occupational hazard and the employees of hydro-electric plants are apt to show sensitivity to these insects and their scales. I mention this relatively uncommon form of allergy to illustrate another aspect of seasonal allergy.

Most of the other dusts I will mention occur throughout the year and are not seasonal in the ordinary sense of that term. However, it is true that there are certain seasonal characteristics for these dusts in that during the colder months of the year they are more troublesome because the habitations, barns and workshops of the patient are closed up for warmth and the dust concentration becomes higher in the confined, slightly ventilated space. Thus, a patient who is sensitive to the family cat may be very much better in the summer when the animal is out more and when his house is more open, that is, the dust density of cat dander in the air at home is less.

Animals, that is haired animals, are a great source of allergenic dust and obviously those animals with which man is most intimately associated are the worst offenders. Cats and dogs which are so common as household pets, produce great quantities of dander. This dander becomes an integral part of the house dust. Whether the animal is in evidence at any particular moment or not, his dust is in the air and the sensitive person inhaling it will manifest symptoms. No animal should ever be permitted in the home of an allergic patient, whether or not sensitivity has been demonstrated. It is well to remember that apart from these two ubiquitous pets, that families very often have unexpected pets such as rabbits, pet rats, hamsters, and so on. Even the old cow-hide rug or the bear-skin, so proudly won hunting, may be a source of trouble. There is much joking about the human animal and his dandruff and whether one can become sensitive to it. I think ordinarily this is a small problem, but it is perhaps of some importance among hairdressers and barbers. Apart from pets, animals on the farm, or in other establishments where they are apt to be kept, are of great importance.

Cows, a horse, animals in a circus, a zoo or a riding academy are all important sources of dander and all cause a great deal of trouble. Birds are another source of dust. The scales from their feathers are highly allergenic. A pet bird or birds in a poultry house, or finally of course the most important of all, the feathers in our pillows, in our eiderdowns and even in our mattresses are a great source of trouble. The allergic child or the child of an allergic parent should not be introduced to a pillow. If he doesn't become accustomed to one he will never miss it and he may be protected from a very troublesome allergy later in life. If he must have a pillow, make it of sponge rubber.

There are certain domestic dusts which are of great importance. House dust itself, is of course, a mixture of many things. It is probably a break-down of textile dust, etc. However, house dust is remarkably uniform allergenically from house to house. It is a very potent allergen and is a great source of trouble to many patients. There are other dusts in the home, textile dust such as cotton lint, the lint from wool, the dust from special forms of mattresses and many other sources. The dust from bathpowder in the bathroom, the dust from insecticides used to kill moths particularly pyrethrum and finally the dust from tobacco.

There are many occupational dusts. In my section of the country grain dust is of the greatest importance. Farmers, elevator operators and other employees of the grain trade are very common sufferers from respiratory and skin allergy due to sensitivity to this very potent allergen. Again, of course, it is a mixture but it is remarkable how uniform allergenically it is from place to place. Of course, the dust from seed, old granaries and from feed, particularly crushed feed, is related to and very much like grain dust. Another occupational dust, perhaps somewhat related, is flour dust. The dust which the miller and the baker inhale when carrying out their normal duties may be the cause of much asthma, rhinitis or dermatitis. An occupational dust of great importance is fur dust; the dust which occurs in the establishment of furriers. Still another is that which arises from hair set or hair wave lotion. Hairdressers are peculiarly prone to this form of sensitivity and it is also seen, of course, among women who are not hairdressers but who work on their own hair and that of their friends. The basis of this particular dust is vegetable gum such as tragacanth, karaya and gum arabic. People who are highly sensitive to fish may develop symptoms if fish is in the same room. Of course, workers in the fish industry are inclined to suffer this way. Much glue as used commercially comes from fish. Dried glue forming a dust is a very potent allergen. Of course, today plastic and other substances are replacing fish glue to some extent and perhaps this particular allergen will become less important.

This brief list is not exhaustive but emphasizes some of the more important members of the group known as air-borne allergens.

SPECIFIC MANAGEMENT OF INHALANT SENSITIVITY

If one accepts as a clinical fact that various air-borne dusts such as have just been described can cause many cases of respiratory allergy, some cases of skin allergy and perhaps even a few cases of migraine, then knowing their properties aids one in making a diagnosis. Diagnosis can be aided by carrying out skin tests. Fortunately, skin tests are highly specific and quite valuable in the diagnosis of inhalant allergy. Generally speaking, skin tests are very simple and as simple as those carried out more or less accidentally by Blackley seventy-five years ago. If the suspected dust is rubbed into a superficial scratch and perhaps moistened by some agent as tenth normal sodium hydroxide, a reaction will occur if the skin cells of the patient are sensitive. The reaction consists of an erythematous flare surrounding an irregular urticarial wheal. The more sensitive the skin the more irregular and large the wheal and/or the erythema. This reaction is accompanied by considerable itching. Such a test is described as the Scratch test.

There are many ways of carrying out skin tests. The scratch technique is still the best and certainly the safest. Given a reasonably pure sample of the dust there is no problem in carrying out scratch tests. For convenience sake, the commercial

houses now prepare extracts of the dusts. These are a little simpler to handle, probably less troublesome and expensive, and are equally good. The only difference in technique is that the extract is rubbed into the scratch in the skin rather than the dry dust. A positive reaction, of course, means only that the skin or dermal cells are sensitized. Fortunately, in inhalant allergy this indicates, in the vast majority of cases, that the nasal and bronchial mucosa are also sensitive. However, false reactions may occur. That is, the patient may suffer from animal dander sensitivity and yet his skin may not react to it. On the other hand positive skin tests may occur without clinical manifestations. Of course, the only test which is really acceptible is a direct test. If the patient has hay fever it should be possible to reproduce the hay fever by planting the suspected pollen on the nasal mucosa. If no reaction occurs the suspicion is obviously ill-founded. Similar tests are done on the conjunctiva or by inhaling the dust in the form of an aerosol directly into the lung. Obviously such tests are usually impractical because of their inconvenience and because most patients would refuse to submit to them. Luckily, the skin test is more convenient but must not be accepted blindly and only with a knowledge of its limitations.

In the light of my preceding remarks it would obviously be of no importance to find that a patient in Vancouver reacted to ragweed if, as I suspect, there is no ragweed in Vancouver. Of course, it might be important to warn him not to visit Winnipeg in August. In fact, he should remain west of the Rockies in the ragweed season. Negative skin tests do not mean that the patient is not allergic. They simply mean that his skin cells are not sensitive to the agents tested. His respiratory mucosal cells might still be sensitive. Nothing is more tragic than to tell a mother that her boy does not react to dog dander by skin and therefore that he may keep the dog when the dog might well be causing much of his trouble.

Another form of skin test often used is the intradermal or intracutaneous test. This is carried out by injecting an extract of the suspected dust into the dermal layers of the skin and the subsequent reaction is similar to that produced by a scratch test. This test is more delicate but it is also more dangerous and false reactions are more apt to occur. In the hands of the experienced man who is doing a great deal of this class of work the intradermal test is valuable but there can be little or no excuse for it when it is used occasioually and is apt to do more harm than good. Skin tests are only useful as an aid to diagnosis and are not a diagnosis in themselves. A patient should not be given a list of skin reactions to carry around with him any more than a list of his blood sugars, blood urea nitrogens or other laboratory tests. He cannot interpret them and he nearly always gets into trouble with them. A careful history and a knowledge of the patient's environment are the most important factors in diagnosis. Skin tests serve to supplement these diagnostic measures and are not diagnostic in themselves. The misuse of skin tests has probably done more to put clinical allergy into disrepute than any other factor.

I have discussed diagnosis and inhalant sensitivity at some length because the management of inhalant sensitivity is predicated on an accurate diagnosis and a thorough understanding of the problem. It is obvious that once a diagnosis has been accurately made, the proper treatment is to attempt to separate the patient from the offending agent if this is possible. For example, it is obvious that the ragweed patient cannot be separated from his ragweed pollen during August and September unless he goes to some such salubrious place as Vancouver where ragweed does not exist. This is obviously impractical in most instances. However, if the patient is sensitive to cat dander it is perfectly clear that it would be much better for him to part with his cat and clean the house out thoroughly than to undergo desensitization for the rest of his life or at least, for the rest of the life of the cat. In general, it is possible and practical to separate the patient from his offending agent when that agent arises from animals, birds, cosmetics, tobacco, insecticides, etc. Sometimes, of course, the patient's livelihood depends on him remaining in his unfavourable environment. The average farmer is not able to leave his farm, particularly in the harvest season. Such a patient must have other protection. The engineer who has spent his whole professional life in a hydro-

electric plant obviously is unable readily to move to another and strange job. The operator of a grain elevator may have no other training and needs to stay with his job at all costs. Similarly with the furrier, the hairdresser or the fish worker, or the miller. All these are highly specialized trades and it is rare that one can separate the victim from his trouble. In all instances where it is impossible to separate the patient from his allergens, and I repeat, this is your primary duty when it is possible, the method of treatment is to offer him desensitization, or more correctly, hyposensitization.

Briefly, this is carried out by making an extract of the offending material with physiological saline, and injecting tiny amounts of this subcutaneously into the patient. These amounts are gradually increased as the patient is able to tolerate them and in many instances a remarkably effective immunity results. Generally speaking, desensitization to animal dander is sometimes effective. Often the treatment carries an element of danger and it should only be used when no other method is available. Feathers are seldom of use in desensitization and avoidance is the only solution. Obviously house dust itself cannot be avoided, although it can be mitigated. Desensitization to house rust is highly effective. Substances such as pyrethrum are better not used for desensitization. Desensitization to grain dust is very effective. Fish dust and glue dust is much too dangerous to use. Flour and other cereal dust cannot effectively be made into suitable solutions for desensitizing. The vegetable gums are also unsuitable and the hairdresser had best find another occupation. As I have said desensitization is an effective procedure in selected cases. Unfortunately it is not permanent but has to be continued for many years. It must be done carefully because if too large a dose is given a very grave general reaction, and even a fatality may occur. If too small amounts are given protection is poor. A conscientious doctor who carried out a desensitization program very carefully, will often be rewarded with good protection for his patient. Ingenuity, of course, will suggest the use of a rubber pillow and other protective devices to help the patient. Grain elevator operators, even with desensitization, find they must wear a mask when the dust density is great. A pollen sensitive patient should not go to the country at the height of his pollen season. The housewife will learn new methods to keep dust down, perhaps she will use a vacuum cleaner with a water bath dust collector. Suitable cosmetics are available for allergic women. Bath powder left in the family bathroom cupboard should not be permitted. The bird fancier must deny himself the luxury of pets in his home.

Inhalant allergy is common. Diagnosis must be specific. With an accurate etiological diagnosis treatment will readily suggest itself and will be most satisfactory to both the doctor and the patient. Diagnosis is the essence of good management.

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News and Notes

Dr. J. C. Kovach, of Vancouver, has begun a year of surgical studies in New York.

Dr. C. G. Campbell, of Vancouver, has begun a practice of internal medicine in new offices.

Dr. J. A. CcCaffrey is now practising urology in a new location in Vancouver.

Dr. J. A. Ganshorn, of Vancouver, has been elected a director of M.S.A. The other medical representative on the board is *Dr. E. C. McCoy.*

Dr. William G. Trapp, of Tranquille, has been awarded a bursary to continue surgical studies at the Vancouver General Hospital.

Dr. Adam Waldie has taken over the offices of *Dr. J. C. Shillabeer* in Vancouver. We wish *Dr. Shillabeer* a pleasant retirement.

The Bulletin is interested in publishing items of interest to all B.C. doctors. Please send in regional notes.

Dr. Warren Bell, of Vancouver, is continuing his studies in internal medicine this year in Philadelphia.

Dr. John Nelson will return from the Eastern U.S. this month to become director of V.D. Control when *Dr. Charles Hunt* returns to private practice.

Dr. F. J. Buller has closed his city office in Vancouver and plans to carry on a limited practice before full retirement.

Drs. J. D. Stenstrom, J. G. Patterson and *J. E. Dalton,* of Victoria, attended the 5th Congress of the Pan-American Surgical Association in Honolulu in November. *Dr. Stenstrom* presented a paper on "Carcinoma of the Lung."

Dr. Neil Stewart, of Victoria, is taking a Residency in Internal Medicine at the Research and Education Hospital of Chicago.

The Annual Dinner of the Victoria Medical Society was held on December 1, and the Guest Speaker was *Dr. John M. Ewing,* of Victoria, Principal of Victoria College.

Dr. E. A. Boxall, of Vancouver, has received his certificate in internal medicine.

Dr. A. Crossland has begun practice in Vancouver.

Dr. J. M. Hershey, formerly of Victoria, is now with the office of medical defence for New York State.

Dr. A. W. Brown, of Kelowna, has been granted a certification of ophthalmology. by the Council of the Royal College of Physicians and Surgeons.

Dr. J. H. Kope is now practising at Enderby.

Dr. W. D. Panton is now practising in Powell River.

Dr. H. M. Shimokura is now practising in Vancouver.

Drs. Estelle and *Arnot Stevens* are now practising in Campbell River.

Dr. S. C. Peterson, of Vancouver, has retired.

Dr. W. A. Wickett is now practising in Penticton.

Births

To *Dr.* and *Mrs. A. E. Gillespie,* of Victoria, a daughter.
To *Dr.* and *Mrs. Sid Segal,* of Vancouver, a son.
To *Dr.* and *Mrs. James Minnes,* of Vancouver, a daughter.
To *Dr.* and *Mrs. Bruce Cates,* of Vancouver, a son.