THE

BULLETIN

Published By

The Vancouver Medical Association

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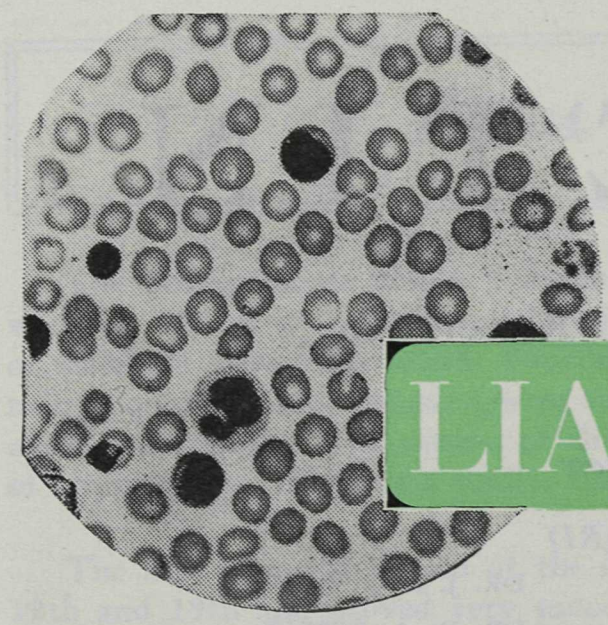

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Programme for Fiftieth Annual Session

(Spring Session)

February 17th CLINICAL MEETING—St. Paul's Hospital, Nurses' Auditorium.

March 5th (Friday) OSLER DINNER AND LECTURE—Hotel Vancouver, Banquet Room.
Osler Lecturer—Dr. Murray Blair.

March 16th CLINICAL MEETING—Children's Hospital.

April 6th GENERAL MEETING—Auditorium, Medical-Dental Building.
Speaker—to be announced.

April 20th CLINICAL MEETING—Place of meeting to be announced.

May 4th ANNUAL MEETING—Auditorium, Medical-Dental Building.

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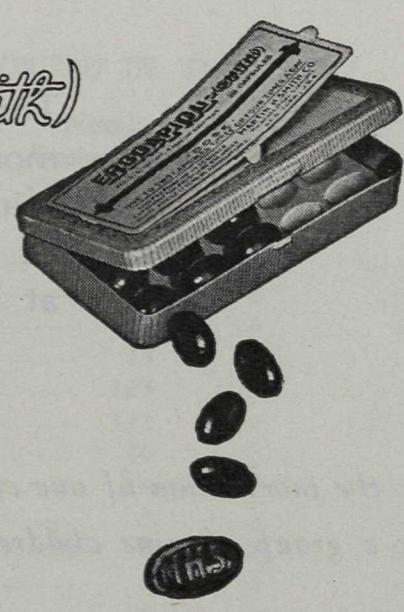

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VANCOUVER HEALTH DEPARTMENT

CASES OF COMMUNICABLE DISEASE REPORTED IN THE CITY

STATISTICS—JANUARY, 1948

Total Population—Estimated	354,045
Chinese Population—Estimated	7,979
Hindu Population—Estimated	275

	Number	*Rate Per 1,000 Population*
Total deaths	389	13.0
Chinese deaths	13	19.2
Deaths, residents only	362	12.1
BIRTH REGISTRATIONS:		
Male	425	
Female	408	
	833	27.8
INFANT MORTALITY:		
Deaths under 1 year of age	20	14
Death rate per 1000 live births	31.5	18.8
Stillbirths (not included above)	8	6

CASES OF COMMUNICABLE DISEASE REPORTED IN THE CITY

	Number		Rate Per 1,000 Population	
	December, 1947		January, 1948	
	Cases	Deaths	Cases	Deaths
	February, 1948		January, 1948	
Scarlet Fever	12	0	18	0
Diphtheria	7	0	4	1
Diphtheria Carrier	15	0	1	0
Chicken Pox	125	0	71	0
Measles	331	0	157	0
Rubella	10	0	7	0
Mumps	14	0	30	0
Whooping Cough	2	0	10	0
Typhoid Fever	0	0	0	0
Undulant Fever	1	0	0	0
Poliomyelitis	0	0	0	0
Tuberculosis	40	0	33	8
Erysipelas	1	0	1	0
Meningococcus (Meningitis)	1	0	2	0
Infectious Jaundice	0	0	0	0
Salmonellosis	1	0	3	0
Salmonellosis (Carrier)	0	0	0	0
Dysentery	0	0	0	0
Dysentery (Carriers)	0	0	0	0
Tetanus	0	0	0	0
Syphilis (not available)	0	0	63	3
Gonorrhœa (not available)	0	0	257	0
Cancer (Reportable)—	69	0	92	0
Resident	13	0	18	0
Non-Resident				

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The Editor's Page

It was with great satisfaction that we heard of the recent decision of the B. C. Medical Association to go ahead with the building of the Academy of Medicine that has been in contemplation for two years or more. Dr. H. H. Milburn, Chairman of the Committee on Economics of the B.C.M.A., made this announcement at the quarterly meeting of the Board of Directors. The Council of the B. C. College of Physicians and Surgeons has set aside a considerable sum towards this building, which will provide a permanent and a very much needed home for all the medical organizational activities of the Province.

The building will, of course, house the Library of the V.M.A.—and this institution, so essential to our medical life, and so long "cabined, cribb'd and confined" in quarters hopelessly too small for it, will at last have room to grow and perform its functions. It will provide ample room for meeting rooms, board rooms and for all the three organizations whose activities centre so largely in Vancouver, on account of its size and location. The College of Physicians and Surgeons, the B. C. Medical Association, as well as the Vancouver body, will be given quarters adequate to their needs and importance. We are promised that the Bulletin will have its own office and quarters—and this will become increasingly necessary to the proper working of the journal.

An auditorium is also planned for—and we consider that this is a *sine qua non.* We feel that it should be a large auditorium, and that our planners should set their sights high. This city has only begun to grow—and there can be no doubt that in the years to come, our own membership, and the numbers that are attracted to our Summer School and other meetings, will need a large auditorium to accommodate them. A good sized auditorium too, will be an important source of revenue to the Academy. A small one will not pay, and will be only an annoyance.

The medical profession has been, or will be, asked to support this project, and that not only by moral support, but by active financial participation. Just what form this should take is not yet decided, but we shall be told before long. Meanwhile, we urge every medical man in the province to hold himself ready to subscribe to the best of his ability. We should be able, as a profession, to put this building up completely paid for.

It may be asked, indeed it has been asked, "Of what value will this be to men outside Vancouver? Why should they be asked to contribute to a Vancouver building?"

The answer to that question, *more Socratico,* is another: "Of what value is the College of Physicians and Surgeons to a man practising in Kelowna or Victoria? What does the B. C. Medical Association, and its Committee on Economics do for him?" Forget the Library for a minute—though it can be readily shown that since any medical man in B. C. can for a five dollar Associate Membership fee, obtain any book he wants as often as he needs it, with no other cost to him, the Library is of value to the whole Province, and the better we make it, the more this value to every B. C. medical practitioner.

But consider the other activities. How can they do their best work when they have no room to work? During the next few years an enormous amount of work is going to fall on the B. C. Medical Association—the hospitalization scheme, with all the negotiation that is going to be necessary—the extension of the social assistance medical aid plans, which will require a staff—the almost certainty of a spread of social medicine—the welfare of every doctor in British Columbia is going to hang on what is done by the B.C.M.A. There has got to be a central building somewhere—and Vancouver is

the only practical place to put it. We are sure that all medical men will agree as to the need and importance of an Academy of Medicine. Let us all get behind it, and give it our entire and ungrudging support.

LIBRARY NOTES

HOURS:

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

RECENT ACCESSIONS TO LIBRARY—

Surgical Clinics of North America, Symposium on Minor Surgery, Chicago Number, February, 1948.

Curare, Its History, Nature and Clinical Use, 1947, by A. R. McIntyre.

Human Genetics, 2 vols., 1946, by Reginald R. Gates.

Libido and Delusion, 2nd ed., 1945, by Louis E. London. (Gift of Publisher.)

Professional Anecdotes, 1825, A Vignette of the Royal College of Surgeons. (Gift of Dr. W. W. Francis, Librarian, Osler Library, McGill University.)

Modern Drug Encyclopedia, 3rd ed., 1947, by Alexander B. Gutman.

Textbook of Gynecology, 3rd ed., 1948, by Emil Novak.

Medical Clinics of North America, Symposium on Diseases of the Digestive System, Nationwide Number, March, 1948.

Recent Advances in Medicine, 12th ed., 1947, by Beaumont, G. E., and Dodds, E. C.

Textbook of Pathology, 5th ed., 1947, by William Boyd.

Sir William Arbuthnot Lane, His Life and Work, 2nd ed., 1948, by W. E. Tanner. (Nicholson Fund.)

Rare Diseases and Some Debatable Subjects, 2nd ed., 1947, by F. Parkes Weber. (Ultra-Scientific Fund.)

BOOK REVIEW

DISEASES OF CHILDREN—VOLUME I—Garrod, Batten & Thursfield, edited by Paterson and Moncrief.

This is a new edition of a time-honoured classic of British Paediatrics, last edited in 1934. For the new edition, this work has been put into two volumes, of which the first volume only has so far been published. Twenty-nine contributors have written this volume, of whom three are Americans.

The book is nicely bound and is easily read, on good paper, fairly well illustrated and well printed. The index is good. Numerous references are provided at the end of each section. The reviewer discovered only one mistake in spelling the book ("plural for "pleural" on Page 596). Altogether the authors and publishers are to be congratulated on the excellence of this volume, especially considering the extreme difficulty in achieving this under the conditions that exist in Britain today.

The opening chapter on Heredity will not do much to clarify this subject in the mind of the average reader, for a very large amount of information is presented in a too-condensed fashion. There is little of practical value in Chapter 2 for North American readers. The chapter on Water and Electrolyte Control and Acid-base Regulations by Scott is very good, and gives a clear picture of present-day knowledge. Unfortunately, most of the infant milk and food preparations referred to in this book are those used in Britain, and are not used or familiar on this side of the Atlantic. One wonders that no mention is made of penicillin in the section on Infections of the Newborn, although an excellent discussion of the drug is found in an earlier chapter.

This reviewer regrets the prominence given to Thymic Hypertrophy in Chapter XIV, and notes that the references given to this section are dated from 1917 to 1927, when this diagnosis was more popular than now.

Chapter XVIII by James Crooks on Diseases of the Nose, Pharynx, Larynx and Ears is superior to comparative sections in other paediatric texts.

The excellent diagrams and x-ray reproductions in the chapter on Respiratory Diseases deserve special mention. The reviewer is not familiar with the concept that "hypochlorhydria" is an etiological factor in asthma. It would seem pointless to retain the term acute heorrhagic pneumonia of infants when referring to the non-inflammatory hemorrhagic condition founds in the lungs of the newborn, which is almost certainly due to hypoprothrombinemia and/or trauma.

Finally, the reviewer cannot condone the use of oily preparations in the infant nose, even for a "day or two", as advised on Page 611.

This volume should be in every Paediatrician's library, and can be recommended to the General Practitioner as a practical guide to the management of the diseases of children. G. F. H.

CORRESPONDENCE

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

31st March, 1948.

Dr. F. L. Whitehead,
Executive Secretary,
British Columbia Medical Association,
925 West Georgia,
Vancouver, B.C.

Dear Dr. Whitehead:

The Executive Committee of the Registered Nurses' Association has asked me to consult with you regarding difficulties private duty nurses are encountering in collecting fees. In some instances, the reluctance of patients to pay their nursing bills is apparently due to the fact that either they were not told that private duty nurses were being called or were not told how much such nursing would cost them.

I am sure you realize that when a private duty nurse is not paid for her services, it means that her entire income is cut off for the period the case lasts. This sometimes represents a loss of several weeks' income.

Is there some way by which, through your office, this problem can be brought to the attention of doctors? We feel that it is becoming increasingly serious.

Yours sincerely,

ALICE L. WRIGHT, R.N., *Executive Secretary.*

We would warmly endorse this appeal for the registered nurses of B. C. Nobody earns his or her money more thoroughly, or at a greater cost of energy and hard work, than the nurse, and we, who owe so much to her help, should do everything we can to assist them in getting their just dues.—EDITOR.

C.M.A. ANNUAL MEETING

1948—TORONTO, WEEK OF JUNE 21st

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VANCOUVER MEDICAL ASSOCIATION

SUMMER SCHOOL

JUNE 1st to 5th, 1948, Inclusive

HOTEL VANCOUVER

* * *

SPEAKERS:

DR. SAMUEL AYERS, JR., *Professor of Dermatology and Syphilology,* College of Medical Evangelists and College of Dentists, University of Southern California, Los Angeles, Calif.

DR. DOUGLAS G. CAMPBELL, *Asst. Clin. Professor of Psychiatry,* University of California Medical School, San Francisco, Calif.

DR. LAURENCE S. FALLIS, *Surgeon-in-Charge,* Division of General Surgery, Henry Ford Hospital, Detroit, Mich.

SIR WILLIAM FLETCHER SHAW, formerly *Professor of Clinical Obstetrics and Gynæcology,* Victoria University of Manchester, England.

DR. JAMES J. WARING, *Professor of Medicine,* University of Colorado, School of Medicine and Hospitals, Denver, Colorado.

PROGRAMME

Tuesday, June 1st

9:00 a.m.—Registration and Film.
10:00 a.m.—Sir Wm. Fletcher Shaw: "Ectopic Pregnancy."
11:00 a.m.—Dr. J. J. Waring: "The Physical Examination; Helps and Hindrances."
12:30 p.m.—LUNCHEON—Salon A, Hotel Vancouver.
2:30 p.m.—Surgical Clinic—St. Paul's Hospital, Dr. Laurence Fallis.
8:00 p.m.—Dr. Samuel Ayres: "Diagnosis of Drug Eruptions."
9:00 p.m.—Dr. Douglas Campbell: "Clinical Examples of Psychosomatic Conditions."
10:00 p.m.—Dr. Waring's Film on "Poliomyelitis in Colorado."

Wednesday, June 2nd

9:00 a.m.—Dr. Samuel Ayres: "Superficial Mycoses."
10:00 a.m.—Dr. Douglas Campbell: "Emotional and Physiological Mechanisms."
11:00 a.m.—Dr. Lawrence S. Fallis: "Experience with Vagotomy in the Treatment of Peptic Ulcer."
2:00 p.m.—Medical Clinic, Shaughnessy Hospital, Dr. J. J. Waring.
8:00 p.m.—Sir Wm. Fletcher Shaw: "Genital Prolapse."
9:00 p.m.—Dr. J. J. Waring: "The Chronic Pulmonary Invalid after Poliomyelitis."
10:00 p.m.—Film.

Thursday, June 3rd

9:00 a.m.—Dr. Laurence S. Fallis: "Acute Pancreatitis."

10:00 a.m.—Sir Wm. Fletcher Shaw: "Functional Bleeding."

11:00 a.m.—Dr. Samuel Ayres: "Contact Dermatitis."

2:00 p.m.—GOLF TOURNAMENT.

Friday, June 4th

9:00 a.m.—Dr. J. J. Waring: "Spontaneous Pneumothorax: Etiology, Diagnosis and Treatment."

10:00 a.m.—Dr. Samuel Ayres: "Cutaneous Manifestations of Internal Disease."

11:00 a.m.—Dr. Douglas Campbell: "Diagnostic and Therapeutic Methods in Psychopathology Available to the General Practitioner," Part I.

2:00 p.m.—Gynaecological Clinic, Vancouver General Hospital, Sir Wr. Fletcher Shaw.

8:00 p.m.—Dr. Douglas Campbell: "Diagnostic and Therapeutic Methods in Psychopathology Available to the General Practitioner," Part II.

9:00 p.m.—Dr. Lawrence S. Fallis: "Diagnosis and Treatment of Common Ano-Rectal Complaints."

10:00 p.m.—Film.

Saturday, June 5th

9:00 a.m.—Sir Wm. Fletcher Shaw: "Urinary Symptoms in Gynaecology."

10:00 a.m.—Dr. Laurence S. Fallis: "Diverticulitis of the Colon."

11:00 a.m.—Dr. J. J. Waring: "Pleural Effusions: Diagnosis, Prognosis and Treatment."

PROGRAMME SPEAKERS

The Summer School Committee takes pleasure in presenting the names of the five visiting lecturers. Each is an outstanding authority in his own field.

Sir William Fletcher Shaw was for many years Professor of Clinical Obstetrics and Gynæcology at the Victoria University of Manchester and is a past president of the Royal College of Obstetricians and Gynæcologists. The Committee feel they are fortunate in having been able to persuade Sir William to come to Vancouver to speak at the Summer School, while on a visit to Canada.

Dr. James J. Waring, Professor of Medicine at the Colorado University of Medicine, is a well known internist and is an authority on chest conditions in particular. Many of our members will recall his papers which were given at the Annual Meeting of the American College of Physicians in Chicago last year and later published in the *Annals of Internal Medicine*. Dr. Waring, who is a Fellow of the American College of Physicians, is also a member of the Association of American Physicians.

Dr. Laurence S. Fallis, Surgeon-in-Charge, Division of Surgery of the Henry Ford Hospital, is also well known for his extensive writings in surgical journals. Dr. Fallis is a member of the American Board of Surgery.

Dr. Douglas G. Campbell, a Canadian, is now associated with the staff of the California Medical School and the Langley Porter Clinic in San Francisco. He is a fluent speaker and well able to discuss psychosomatic problems with the general practitioner.

Dr. Samuel Ayres, Jr., a well known dermatologist of Los Angeles, is much in demand as a speaker at dermatological meetings. He is a member of the American Dermatological Association and a Fellow of the Academy of Dermatology and Syphilology.

FEES

The Committee has found it necessary to increase the fee this year to $10.00 in order to cover the expenses of the Summer School.

HOSPITAL INTERNES

Internes at the various city hospitals are invited to attend Summer School as usual, without charge. They will be provided with special complimentary tickets, which may be obtained at the Registration Desk.

REGISTRATION

The first hour from 9:00 to 10:00 A.M. of the opening day of the School will be devoted to registering doctors attending the School. A film will be shown simultaneously. so that those who register early may use this time to advantage. Holders of tickets will be asked to show them at each session.

HOTEL ACCOMMODATION

A block of fifty double rooms has been reserved at the Hotel Vancouver for doctors attending the School from out-of-town. It is requested that doctors will make their own arrangements with the Hotel at the earliest possible date.

PHONE SERVICE

A private telephone will be installed at the Registration Desk and calls which are received during lectures will be projected onto a special screen.

GOLF

A golf tournament and dinner will be held on Thursday afternoon, June 3rd. As usual there will be an interesting assortment of prizes.

NOTICE

The Bulletin has previously announced, at the request of Chief Constable Mulligan, of the Vancouver Police Department, that a card would be prepared which could be given by medical men to patients who suffer from an ailment which might at any time result in collapse, on the street, in public places, etc. The following is a facsimile of this card, which is now ready.

Copies of this card may be obtained at the Library, and some have been placed at the Vancouver General Hospital and St. Paul's Hospital.

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City.....

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Dr......

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This card is endorsed by the Vancouver Police Department.

Date issued .....

NOTICE OF SALE

The War Assets Corporation, Branch Office, Sea Island, B. C., now has a considerable quantity of Medical supplies, Surgical instruments and Drugs available for sale. Some of the items are new and the used equipment is in excellent condition.

All items are offered on a bid basis.

Telephone Richmond 1500 or by letter to T. A. Ball, P.O. Box 429, Vancouver, B.C.

Vancouver Medical Association

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Vice-President ..... Dr. Gordon C. Johnstone
Honorary Treasurer ..... Dr. Gordon Burke
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Editor ..... Dr. J. H. MacDermot

ANNUAL REPORT
EYE, EAR, NOSE AND THROAT SECTION
of the
VANCOUVER MEDICAL ASSOCIATION
1947 — 1948

Regular monthly meetings of this Section were held October to April inclusive and scientific papers were presented by both members of the Section and visiting speakers from other specialties, giving interesting papers by Dr. Donald H. Williams, Dr. Peter Lehman and Dr. Don S. Munroe. We were very fortunate in having Dr. E. Washington, Professor of Oto-Laryngology at Manitoba University, at the B. C. Medical Association meetings, and Dr. Alfred Elliott, Professor of Ophthalmology of University of Toronto, at the summer school. Both of them gave very fine lectures at the sessions and at luncheon meetings. The Section was also fortunate in having Dr. J. A. Sullivan of Toronto speak at the January meeting, presenting some outstanding work in the field of Fenestration operations for Oto-sclerosis.

The meetings have all been exceptionally well attended, and I wish to take this opportunity of expressing my appreciation of the fine work done by the newly-formed Programme Committee in giving us a year of outstanding speakers and instilling, I feel, new life into the Section.

The foregoing report is respectfully submitted.

GORDON C. LARGE, *Chairman.*

REPORT OF THE HONORARY SECRETARY
1947 — 1948

Mr. President and Members:

Nine general meetings and eleven executive meetings were held during the year. One of the former was a special meeting, called to discuss problems on medical economics was appointed, the chairman to be an active member of the Committee on Medical Economics of British Columbia.

There was evidence of an increased interest in the general meetings, as reflected in a rise in the average attendance to 100, as compared with 73 the previous year. The members were given the opportunity of hearing three well-known visiting speakers—Dr. A. H. Gordon of Montreal, Dr. Laurence Selling of Portland, Oregon, and Dr. Ray Farquharson of Toronto.

The Osler Dinner was held as usual in March, and a lecture of outstanding interest was delivered by the Osler Lecturer for 1948—Dr. Murray Blair. P.G.F. Degrees were bestowed on the same night to Doctors Harry Pitts and G. F. Strong.

The Annual Dinner, which was held late in November, was an even greater success than usual.

The resolution transferring the entire Sickness and Benevolent Fund of the Vancouver Medical Association to the Benevolent Fund of the B.C.M.A., was found to be

unconstitutional, and legal advice was sought to amend the Constitution so that this transfer could be made. The motion was finally passed at the General Meeting of January 6th, 1948.

A new Section of Radiology was organized during the past year and is now functioning as a unit of the Association.

The Association's present membership stands at 471, in the following classifications:

Active Members	376
Associate Members	74
Privileged Members	4
Life Members	17

We regret to report that the following members were lost by death during the year: Dr. Bertie Blackwood, Dr. Cameron MacEwen, Dr. R. C. Novack, Dr. T. F. Saunders.

Respectfully submitted,

W. J. DORRANCE, M.D., *Honorary Secretary.*

REPORT OF THE HONORARY TREASURER
VANCOUVER MEDICAL ASSOCIATION
1947 — 1948

Mr. President and Members:

I beg to submit herewith the following financial report of your Association for the year 1947-48, which has been duly audited by Plommer, Whiting & Co., Chartered Accountants, under date of March 31st, 1948:

RECEIPTS AND EXPENDITURES

Receipts

Income from members' annual dues		$6,898.00	
Interest on invested funds		441.15	
Relief administration, management allowance		550.00	
Profit on Association Bulletin		508.48	
			$8,397.63

Expenditures

Salaries		$3,298.53		
Rent	$2,270.70			
Credit by payment from C. P. & S.	756.89			
		1,513.81		
			$4,812.34	
Other expenses (including charges for office alterations		$ 163.85		
And moving library books		63.20		
			$1,385.75	
				$6,198.09
The Association also expended on the library		$1,828.65		
Excess of Income over Expenditures				$2,199.54
Depreciation:				
Library		$1,428.45		
Furniture and Equipment		101.84		
			1,530.29	
Net Transfer to Surplus Account				$ 669.25

GENERAL FUND BONDS AND SAVINGS ACCOUNTS

As at March 31, 1948

Present value (Bonds at cost)	$14,342.91
Cash on hand and in Bank	3,240.27
TOTAL	$17,583.18

ASSETS

Investments:		
Historical and Ultra Scientific Fund:		
Bank savings account	$ 424.94	
Bonds at cost	2,475.00	
		$2,899.94
Stephen Memorial Fund:		
Bank savings account	$ 16.91	
Bonds at cost	100.00	
		116.91
Benevolent Endowment Fund:		
Bonds at cost	$ 734.00	
Coupons on hand	15.74	
		749.74
John Mawer Pearson Lecture Fund:		
Bank savings account	$1,055.95	
Bonds at cost	2,981.25	
		4,037.20
TOTAL		$7,803.79

The annual income from members' dues shows a substantial increase for the first time in several years, and amounts to approximately $2,000.00. This is accounted for in part by an increase in new members and partly by the fact that all members returning from Military Service are again paying full dues.

Profit on the Bulletin, based on excess of receipts over disbursements for the period from April 1st, 1947, to March 31st, 1948, is $508.41. The Summer School on the other hand shows a small deficit of $164.41.

Disbursements are up in all branches, salaries, rent and library expenditures.

It is expected, however, that receipts from members' dues will be even greater in the coming year, and that the Bulletin will continue to show a profit.

Respectfully submitted,

GORDON BURKE, M.D., *Honorary Treasurer.*

ANNUAL REPORT—BOARD OF TRUSTEES

May 4th, 1948.

Mr. President and Members:

Your Association at the present time is in good standing financially, having a surplus in the General Fund of $14,342.91 in investments, as well as some $3,240.00 in cash on hand and in the bank. There is also $7,803.79 in the Special Funds, making a total of some $27,386.00.

In February of this year, the entire Sickness and Benevolent Fund amounting to $6,997.62 was signed over to the Benevolent Fund Committee of the British Columbia Medical Association.

The Historical and Ultra-Scientific Fund amounts to almost $3,000.00 and the earnings from this fund are used by the Library Committee for the purchase of special books and journals which fall within this classification.

The total in the Stephen Memorial Fund, including invested funds and savings, is

$116.00. Your Trustees would like to recommend that this fund be amalgamated with either the Pearson Memorial Lecture Fund or the Ultra-Scientific Fund.

The Benevolent Endowment Fund amounting to approximately $750.00 is composed of a number of donations from members of the Association, made during their lifetime though no specific instructions were given as to the purpose for which they were intended. Heretofore the earnings have been transferred to the Sickness and Benevolent Fund, but now that this Fund has been turned over to the B. C. Medical Association, it is suggested that the Benevolent Endowment Fund might be combined with either the Pearson Memorial or the Ultra-Scientific Fund.

The John Mawer Pearson Memorial Lecture Fund now stands at slightly more than $4,000.00. It was founded in 1936 to commemorate the founder of the Vancouver Medical Association. The purpose was to honour Dr. Pearson's memory by having a lecture every third year, the lecturer to be chosen by the Executive of the Vancouver Medical Association. This includes over $1,000 in interest, which could be invested.

There is also over $2,000.00 in the General Savings Account which your Board of Trustees will ask permission to invest. In this connection we would recommend that investment counsel be sought before investing the amounts mentioned above, and re-investing those bonds which will mature shortly and those which have been called in.

In closing I wish to give notice of a motion which I shall introduce at the next regular General Meeting, when I shall move:

"THAT the Stephen Memorial Fund, the Benevolent Endowment Fund, and the Pearson Memorial Lecture Fund, shall be amalgamated."

Respectfully submitted,

G. H. CLEMENT, M.D., *Chairman, Board of Trustees.*

LIBRARY COMMITTEE—ANNUAL REPORT

BOOKS ADDED TO LIBRARY—

General Collection—

63	new books added at a cost of	$ 476.10
62	gifts	
4	from Nicholson Fund at a cost of	31.00
Total 129	books added at a cost of	$ 507.10

NICHOLSON FUND—

4 books purchased at a cost of $31.00, leaving a balance of $237.38 in this fund.

MEDICAL JOURNALS—

80	journals subscribed to at a cost of	$ 809.61
41	journals received as gifts.	
37	journals received in exchange.	
158	journals received in Library	
146	volumes bound at a cost of	327.45

OTHER EXPENSES—

Dues to Library Associations	29.99
Messenger Service	37.60
Miscellaneous	116.90
TOTAL	$1,828.65

New Statistics—

Books and journals loaned—

Borrowed direct from Library 2373

Borrowed by messenger service (10 months)	170	
Borrowed by mail	146	
		2689
Inter-Library Loans—Out	34	
In	5	
		39
Books returned by messenger	189	
Visits to Library—		
Members	2495	
Others	459	
During evening hours (9 months)—		
Members	138	
Others	60	
		3152
Bibliographies prepared		265

Seven meetings were held during the year.

Comparing this year's report with that of last year, it will be apparent that there has been an increase of more than 50 per cent in library expenditures over last year's figures. A large portion of this can be accounted for by the increased number of books purchased, as it was the opinion of your Library Committee that the various sections were in acute need of replacements and additions as a result of the retrenchment programme which was in effect during the war and the immediate post-war years. A number of books were purchased on the recommendation of special Sections or specialized groups. The Committee appreciates the interest and advice of these groups, and will always be glad to consider similar requests from any of the Sections or individual members. Also several new journals have been added to the shelves and the cost price of many of the subscriptions already received has increased by 10 per cent or more. A greater number of journals were bound during the year, also, some of these being back issues which had been held up owing to lock of funds, or because of incomplete files.

Statistics on circulation and library visits have been kept for the first time during the past year, as it was felt that there should be a record of the volume of work carried out in the Library, and that statistics would be helpful as an index of the growth of the Library in the future.

The messenger service for Vancouver doctors whose offices are not in the Medical-Dental Building, was commenced last June, and has been used by many of the members. It is expected to increase in volume as more members become aware that this service is available.

The Library has been kept open three nights a week during the year, with the exception of three months, from June 15th to September 15th, and although the average use has been only about two visitors an evening, it is felt by your Committee that the service is worth while.

Two moving operations of some magnitude were carried out during the year. All the books in the storeroom were checked and those which were not considered to be of practical value, e.g., out of date books or old editions, were discarded or moved to new storage space in the basement. Later in the year all books in the stack room were rearranged, the texts being placed on the front shelves, and the bound journals arranged alphabetically by title in the back.

New lamps were installed in the reading room and a special type of flood lamp is being tried out in the stack room.

Because of an increased demand for certain standard texts, your Library Committee decided to limit the loan period for a selected list of books to 24 hours. This list was published in the Bulletin recently. It is hoped that this ruling will allow access to a greater number of books by a greater number of members.

The Committee wishes to express its appreciation to all those who have made donations of books and journals to the Library. Individual acknowledgment has been made during the year.

In concluding this report the Committee wishes to draw attention to the resignation of the librarian, Mrs. Craig. This is a matter of keen regret, not only to the Committee, but I am sure to every member of the Association. During Mrs. Craig's eight years of service, she has carried out her duties cheerfully and efficiently. Mrs. Craig is resigning because of her husband's appointment to a position in Victoria, and I am sure she will take with her the best wishes of this Association.

All of which is respectfully submitted.

J. E. WALKER, M.D., *Chairman Library Committee.*

ANNUAL REPORT OF THE SECTION OF NEUROLOGY and PSYCHIATRY
1947 — 1948

Regular monthly meetings were held this year, three with clinical cases, at Shaughnessy, Vancouver General and Essondale Hospitals. Correspondence relating to the problem of six delinquents was referred to the section.

This problem was discussed in co-operation with several interested lay people and certain recommendations were sent to the central committee in reply to their letter.

The usual subscriptions to the Journal of Nervous and Mental Diseases was donated to the Library by the Section and new books were reviewed by various members.

Respectfully submitted,

J. C. THOMAS,

Chairman, Section of Neurology and Psychiatry.

REPORT OF THE HISTORICAL COMMITTEE
1947 — 1948

I beg to submit the annual report of the Historical Committee of the Vancouver Medical Association.

Illness has prevented the completion of the "History of the Vancouver Medical Association" as had been planned.

I suggest that a new Chairman be elected, and the history might be completed with myself as a member of his Committee.

Respectfully submitted,

G. E. KIDD, M.D., *Chairman, Historical Committee.*

SUMMER SCHOOL COMMITTEE—INTERIM REPORT

Mr. President and Members:

Arrangements have been made to hold the 1948 Summer School from June 1st to 5th, inclusive, at the Hotel Vancouver.

Five visiting speakers, all authorities in their various fields, will appear on the programme.

A complete report will be given at the October Meeting.

Respectfully submitted,

A. B. MANSON, M.D., *Chairman, Summer School Committee.*

REPORT OF THE RELIEF ADMINISTRATION COMMITTEE FOR THE YEAR ENDING MARCH 31st, 1948

The past year has seen a further increase in the number of patients who are receiving medical care under the Social Assistance scheme as well as the number of doctors rendering this service. In March, 1947, 1541 patients received medical attention, while in 1948 there were 1903. In March, 1947, 221 doctors rendered accounts and in March, 1948, there were 253. The gross amount of accounts in 1947 was $90,297.00 and in 1948 $115,867. The amount paid to the medical men was $51,612.60.

In October last the amount received from the City and the Province for the payment of doctors' accounts was increased from $4,000.00 to $5,000.00 a month but the Committee feels that this amount is still insufficient.

Dr. D. F. Busteed, who has served on the Relief Administration Committee since September, 1937, and as Chairman since 1945, handed in his resignation in October and it was with an unanimous expression of regret that it was accepted.

The Committee on Medical Economics of British Columbia has met with representatives of the Provincial Government regarding a proposed Province-wide scheme for the medical care of all Social Assistance cases. The various medical societies in the Province have been circularized and a meeting will be held in Vancouver for the purpose of studying the proposed scheme.

We are pleased to report that Doctor J. W. Shier has recently joined the Committee. Other members serving are as follows: Dr. Gordon Burke, Chairman, and Doctors Roy Mustard, F. Day-Smith, Neil McNeill, T. A. Johnston and J. C. Grimson.

All of which is respectfully submithted.

J. C. GRIMSON, M.D.,
Secretary, Relief Administration Committee.

REPORT OF THE CLINICAL SECTION VANCOUVER MEDICAL ASSOCIATION, 1947-48

Mr. President, Members of the Vancouver Medical Association:

The activities of the Clinical Section during the year 1947-48 are reported as follows:

Seven monthly meetings were held, three at the Vancouver General, two at St. Paul's and one each at Shaughnessy and the Children's Hospital. Two guest speakers, one from Victoria and one from Ottawa, addressed the Section. The programmes covered a wide field of clinical material of high calibre.

This year marked the first time the Clinical Section has been invited to the Children's Hospital. The meeting took the form of a "Clinical Open House," whereby all phases of the hospital's activities were demonstrated. It is suggested that in future more diversity would be obtained if meetings were held at other hospitals such as Grace or the Cancer Institute.

All of which is respectfully submitted.

REG. A. WILSON, M.D., *Chairman, Clinical Section.*

REPORT OF PAEDIATRIC SECTION—VANCOUVER MEDICAL

Mr. Chairman, Ladies and Gentlemen:

The past year has been a busy one for the Pædiatric Section. Seven well attended meetings were held, as well as two dinner metings honoring Dr. Clement Smith, of Harvard University, one of the speakers at the last Summer School, and Dr. Alton Goldbloom, Professor of Pædiatrics at McGill University.

Much of the time of our regular meetings was taken up with discussions of plans for the establishment of a new Children's Hospital in Vancouver.

Definite steps have now been taken and with money supplied by various persons and agnecies and in a building loaned by the Vancouver General Hospital, the first unit, an out-patient department, will be opened for the care of poor children, in the next few weeks.

Each and every member of this section will assist by attendance and work in this department.

Future development of this scheme has been taken on by a committee of prominent business men, with this Section acting in a medical advisory capacity.

We expect this much needed expansion will continue.

Respectfully submitted,

J. H. B. GRANT, M.D., *Chairman.*

REPORT OF REPRESENTATIVE TO THE BRITISH COLUMBIA MEDICAL ASSOCIATION

As the official representative of the Vancouver Medical Association I attended four meetings of the British Columbia Medical Association during the past year.

One of the most important matters discussed was that of the Academy Building to be erected on Tenth Avenue. I would urge the Vancouver Medical Association to give its full support and encouragement to this project, in view of the serious shortage of space now existing in the Library.

H. A. DesBrisay.

REPORT OF PUBLICATIONS BOARD

During the past year the Bulletin has maintained its position, and in fact added to it, as far as circulation and size of the journal are concerned.

As regards circulation: In March, 1947, our circulation was 1500, while our present circulation is over 1800. This increase is mainly due, of course, to the increase in the number of medical men practising in B. C., each of whom receives a copy. In addition, we have a considerable system of exchanges with other libraries, universities and so on, and with other medical journals. We constantly receive requests for these, and wherever it seems advisable, we institute the exchange.

As rgards the size of the journal, Mr. W. G. MacDonald, our publisher, tells us that there has been approximately 25 per cent increase in the size of the journal during the past year. This, of course, has made the cost of each issue higher.

We have absorbed the cost of publishing 1100 reprints of varying sizes. This has meant a cost of something over $100—but in most cases the reprints were for men who had come here to speak at the Summer School, or at the B. C. Medical Association meeting—and we felt that this was a courtesy we should extend to men who had been very generous to us.

As you will have noticed, we have altered the cover of the Bulletin, using new and better stock, and a more cheerful design and colour. The white stock from which the cover is made gives a much better background for printing, and we hope our members will agree with us that this is an improvement.

Our balance sheet shows a profit of some $500. This would have undoubtedly been larger, but for the increases in costs, of which some items have been given above. The average cost of a printing runs over six hundred dollars, six hundred and twenty-eight, to be more exact. And as we all know, costs of printing and publishing have gone up *pari passu* with all other costs.

It has been rather a struggle at times to get the journal out on time. Printers only work five days a week, and publishers have their troubles, too. We have held our meetings of the Publications Board regularly once a month on the first Wednesday and every attempt has been made to speed things up but not always with entire success.

I have again to thank all those who have worked with me on the Publications Board. Dr. Grant as Secretary, has been a devoted worker, while Dr. Cleveland has done particularly good work in connection with the staff papers of the Vancouver General Hospital—collecting and editing them, so that they are in perfect shape for publication. More and more good material is coming from this source. Dr. H. A. DesBrisay, who has recently joined the Board, has been a most welcome addition. Mrs. Craig, our Librarian, has been indispensable. She covers most of our sins of omission, at least of mine, by her careful attention to detail, and constant care.

Lastly, Mr. W. E. G. MacDonald, our Publisher, has been untiring in his help and in his efforts to make the Bulletin a success. He has attended practically all our meetings, and we find that this saves a great deal of time, and avoids errors. He has been our business manager and is very largely responsible for the present financial condition of the Bulletin.

All of which is respectfully submitted.

J. H. MacDERMOT, *Editor.*

BRONCHIECTASIS

D. S. Munroe, M.D.

Read at Symposium on Chronic Non-Tuberculosis Chest Disease, Vancouver General Hospital Staff Meeting, November, 1947.

Bronchiectasis may be defined as dilatation of one or more bronchi with the formation of a cavity. The lung parenchyma is usually excavated in addition.

The importance of this disease has been greatly increased in recent years for several reasons:

(1) Its greatly increased frequency or at least its greatly increased recognition.

(2) The recognition of the causes and pathogenics which lead to a substantial effort at prevention by early and adequate bronchoscopic therapy.

(3) The tremendous improvement in surgical and anaesthetic procedures which offer the only hope of cure to the victim with established disease.

(4) The great morbidity, economic loss and mortality of the disease. It is now stated to rank next in frequency to tuberculosis as a cause of chronic chest disease. Two-thirds of the cases arise in the first two decades of life and the prognosis in general is not good because the disease is progressive.

Scarlett[1] in 1946 summarized his review of the literature on prognosis as follows:

(1) The mortality is 30-50% in a fifteen-year period after onset of symptoms.

(2) "Patients who develop bronchiectasis under ten are unlikely to live beyond forty."

(3) "The vast majority of patients with the disease will ultimately die of the disease or its complications"—recurrent pneumonitis, brain abscess, cor pulmonale, empyema, etc.

(4) The morbidity of the disease from both physical and psychological viewpoints is devastating. Many of these patients are semi-invalids.

The etiology and pathogenesis of bronchiectasis have now been pretty well worked out and in broad general terms the three great factors are bronchial obstruction, atelectasis and infection. It is quite possible that even these three factors may boil down to one; namely, atelectasis, and indeed one chest man in England with whom I had a short association went so far as to say that atelectasis, whatever its cause in an individual case may be, is always the forerunner of bronchiectasis.

The sequence of events in the development of bronchiectasis is about as follows:

(1) Poor pulmonary ventilation due to infections or a lesion within the bronchus.

(2) Retention and stagnation of viscid secretions in the smaller bronchi.

(3) Destruction of bronchial musculature and elastic tissue with weakening of the bronchial wall.

(4) Bronchial stenosis from fibrosis.

(5) Greater or lesser degrees of atelectasis.

(6) Traction and dilatation of the bronchi by the high negative intra-thoracic pressure. Subsequent fibrosis makes this dilatation permanent.

The actual disease entities which commonly result in bronchiectasis may be listed as follows:

(1) *Pulmonary infections*: These form the most important group not only because it is the commonest cause but because these are the causes at work in children. Included here are the pneumonias which may be primary or a complication of one of the exanthemata, notably pertussis. In pneumonia it has been shown that collapse is a very common event due to retained viscid secretions and of course heavy infection is always present. Here also are included the cases of bronchial stenosis from traction of healed tuberculous lymph nodes in children, and the bronchiectasis which may be seen in cases of old fibroid tuberculosis in adults.

(2) *Bronchial Obstruction*: Foreign bodies are not to be forgotten in children especially, and in older patients the problem of new growths whether benign or malignant. The development of bronchiectasis in a middle aged or older person should always cause one to think of bronchogenic carcinoma.

The prevention of bronchiectasis is a subject of considerable importance for two main reasons.

(1) It is preventable in many instances.

(2) The disease once established is irreversible, and correctable by nothing less than obliterative surgery.

Prophylaxis is possible and is likely to be most successful in those cases caused by pulmonary infections. In the first place, active immunization of children against such respiratory infections as pertussis is important. Furthermore, a child having developed a respiratory disease such as pertussis or morbilli should be treated with the respect which the complications of these diseases demand.

Secondly, the course of respiratory infection and in particular pneumonia should be carefully watched clinically and radiographically for evidence of collapse of a lobe or segment thereof. If this event should occur, the bronchoscopist should be called. Failure of a pneumonia to resolve completely in a reasonable period of time should raise one's suspicions that there is inadequate bronchial drainage, and bronchoscopic suction or dilatation, once or more, may entirely correct the situation. Most authors on the subject of bronchiectasis are insistent that the term "unresolved pneumonia," being merely a misnomer for atelectasis or bronchiectasis, should be dropped entirely from medical literature and thought.

It is, of course, unnecessary to emphasize the prophylactic value of removal of a foreign body in a bronchus.

DIAGNOSIS

It seems unnecessary to point out the signs and symptoms of bronchiectasis because they are very well known to everyone. A few clinical facts in this regard may, however, be stated.

(1) Neither fetid sputum nor clubbing of the digits, nor emaciation is necessary before considering bronchiectasis.

(2) Bronchiectasis is a common cause of haemoptysis. Haemoptysis is the presence of a negative x-ray and in the absence of heart failure should always awaken suspicion of bronchiectasis, or bronchogenic carcinoma, or both. The absence of chronic cough and expectoration do not invalidate this argument.

(3) A history of recurrent or unresolved pneumonia should always make one consider bronchiectasis. This applies even if the clinical and radiographic findings of an attack are compatible with pneumonia. Pneumonitis surrounding an area of bronchiectasis is common.

(4) Persistent dullness and/or rales in one lower lobe with a negative x-ray is a common objective dissociation in bronchiectasis.

(5) Extensive bronchiectasis may be present with a normal x-ray.

In conclusion, I think it a fair statement that one will miss few cases of bronchiectasis if these points are remembered, and adequate investigation instituted, and one will be the agent in preventing the disease if he refers to the bronchoscopist any case of pulmonary infection that is not doing well.

It is rightly the problem of the thoracic surgeon and radiologist to confirm or correct the suspicions of bronchiectasis which arise in our minds. It is, however, the responsibility of those of us who see the patient in the first instance to suspect the development of bronchiectasis in, for example, a case of pneumonia and refer him to a specialized prophylactic treatment. It is also our responsibility to suspect the condition in a developed case and to have it investigated with particular reference to surgical removal of a lobe, etc. I have tried to point out some of the clues which will lead us to these ends.

REFERENCES

(1) Scarlett, E. P.—Can. Med. Assn. J. 54: 275, 1946.

SURGICAL ASPECTS OF BRONCHIECTASIS

G. D. Saxton, M.D.

Read at Staff Clinical Meeting, Vancouver General Hospital, November 25, 1947

The surgical treatment of bronchiectasis is now well established. Under favourable conditions the offending portion of the lung is removed and the patient returned to a relatively normal state. Lung resection should not be regarded as heroic surgery and a last resort; it should be considered the treatment of choice. Any patient between the ages of 4 and 40 with reasonably well localized bronchiectasis, and unless very definite contraindications exist, should definitely be regarded as a candidate for surgery. Children tolerate operation well; in addition there is a true hyperplasia of the remaining lung tissue to replace the area lost. This is in contrast to the compensatory emphysema which occurs in adults.

An accurate mapping of the tracheo-bronchial tree by lipiodol instillation, essential in diagnosis, is a fundamental requirement before surgery. The precise extent of disease must be known. The left lower lobe is involved in about 40% of cases, the right lower in about 27%, and both lower lobes in about 28%. An isolated involvement of an upper lobe as well as complete involvement of one lung does occur. Involvement of the lingula division of the left upper lobe not infrequently accompanies left lower lobe disease. If this is not removed at resection of the lower lobe the disease will obviously not be completely cured. Resection of both lower lobes at separate sittings, or of a whole lung is frequently practised.

In the investigation of a case of bronchiectasis to decide the feasibility of operation certain information is required:

Age: Under 40, age in itself should have no bearing. Over 40 it must be considered with other factors.

Respiratory Reserve: Will there be sufficient lung left after resection to carry on respiration?

Myocardial Function: Will the heart stand a major surgical procedure?

Systemic Diseases: Diabetes, nephritis, etc.

Secondary Infection: Nasopharyngeal, including sinusitis, teeth, pneumonitis. These should be controlled before operation.

R.B.C. and Haemoglobin Level.

General Nutrition: Does the patient require extra feeding, vitamins, etc., and can he be brought into a state fit for surgery by these means?

When surgery is decided upon the preparation of the patient is important. As mentioned above, any respiratory infection, including pneumonitis, should be controlled. An attempt is made to sterilize, or reduce infection in, the bronchiectatic cavities. This is done by postural drainage, and/or bronchoscopic suction and the use of antibiotics. Penicillin by intramuscular injection of aerosol inhalation frequently produces this temporary result. Recently some surgeons have combined penicillin with streptomycin in an aerosol spray with the hope of destroying the gram negative organisms as well. A bronchoscopic aspiration immediately before operation may still be necessary if secretion is excessive.

Modern anæsthesia has made thoracic surgery possible. At operation an intratraheal tube is inserted and a closed system established between the patient's lungs and the anaesthetic machine. Pressures in this system can be varied as necessary by the anaesthetist. More recently the anaesthetist has further minimized the surgeon's problems by the use of controlled respirations. The patient is deliberately put into a state of apnoea by curare or other means and the anaesthetist aerates the lungs by rhythmic compression of the bag of his gas machine. This does away with movement of the diaphragm and the chest wall and makes surgical technique less of a catch-as-catch-can procedure. Through the intratracheal tube, a catheter can be inserted for suction if necessary.

The actual operative procedure need be touched on only briefly. Exposure is obtained by the subperiosteal resection of an appropriate rib, usually the seventh for a lower lobe. If this is insufficient the posterior ends of the ribs above and below can be divided. The individual ligation technique is now generally used. The branch or branches of the pulmonary artery to that lobe are located in the hilum. They are dissected free of surrounding tissue, doubly ligated, transfixed and divided. The inferior pulmonary vein drains th elower lobe of the corresponding side. It can be easily located in the pulmonary ligament as the lowest structure in the main hilum. On the right side it is very short, coming from the pericardium to enter the lung directly and may present some difficulty because of this shortness. Uncontrollable haemorrhage during operation usually has its origin from a ligature which has slipped on a vein. Once the vessels are controlled the bronchus is isolated and divided between clamps. Except for some minor strands of tissue the lobe can now be removed. The technique of bronchial closure has been progressively simplified. The older more elaborate procedures with their many failures have been replaced by a simple series of vertical interrupted silk or fine wire sutures which do nothing more than approximate in a line the open bronchus. By this method the bronchial artery is undisturbed and the blood supply of the stump is retained. The cut end of the bronchial artery has frequently to be ligated as a separate structure. If the interlobar fissure was not well defined and, in order to reach the hilum, dissection between lobes was necessary, there will be air leaks in the remaining lobe and these must be closed. Airtight closure of the bronchus and the raw area of the adjoining lobe can be tested for by filling the thoracic cavity with saline and watching for air bubbles just as the garage mechanic tests his leaking inner tube. The collapsed remaining lobe or lobes can be re-expanded in one of two ways. The anaesthetist can exert pressure in his anaesthetic system to forcibly expand the lobe to occupy the thoracic cavity. The wound is then closed with or without intercostal catheter drainage to which later suction can be applied. Or alternatively, and to my mind a better way, an intercostal catheter, or catheters, is inserted and immediately the wound is closed suction is applied to exhaust the free air. This permits a more gradual expansion with less danger of rupture of pulmonary alveoli. There is usually considerable pleural effusion in the immediate post-operative period. If no drainage is used it must be removed by thoracentesis. If a catheter was employed it can usually be removed in 48 hours.

A new refinement in technique is segmental resection. If the bronchiectasis is confined to one segment of a lobe, that segment can be removed and the remainder of the healthy lobe preserved. The bronchus to the segment is isolated and clamped, the

remainder of the lobe is expanded by pressure and a line of demarcation between segments becomes evident. The vessels follow the bronchus and can be found with it.

Along with modern anaesthesia, the free use of blood transfusions and of the antibiotics have markedly reduced mortality and morbidity. Operative shock and haemorrhage can be controlled by blood; post-operative infection and empyaema can be almost eliminated. The mortality for lobectomy has been reduced to something between two and five percent which compares very favourably with other major surgical procedures. In picked cases, notably in service personnel, a series have been reported with well over a hundred cases without a single death. But in the poor risk cases, of course, there will be deaths. Pneumectomy for whatever the reason carries a higher risk than lobectomy.

Post-operatively apart from haemorrhage, air leak with tension pneumothorax, pleural effusion or empyæma, atelectasis is the most frequent complication. Bronchoscopic aspiration is done routinely at the end of operation. This removes secretion formed during operation but not infrequently, especially in bilateral cases at the first stage, blocking of a major bronchus with atelectasis beyond can have a fatal outcome unless recognized. A rising pulse rate, rising temperature and shallow respirations in the patient who has passed his first few post-operative hours without concern strongly suggest atelectasis. Dramatic improvement follows aspiration of the obstructing secretions.

Palliative treatment, if surgery is contraindicated or refused, gives at the best only symptomatic relief. General supportive treatment, improvement in nutrition, and drainage of the tracheo-bronchial tree are all that can be offered. Postural drainage carried out systematically will remove some of the often foul smelling sputum. Bronchoscopic aspiration with instillation of penicillin into the bronchiectatic cavities may temporarly reduce the degree of infection in the cavity walls. Aerosol inhalation of penicillin alone or combined with streptomycin for a period of several days may produce a similar result. But for the recurring peribronchial pnuemonia ærosol is inadequate and parenteral treatment is necessary.

I would like to stress the importance of the possibility of preventing bronchiectasis.

If we accept the etiology of bronchiectasis as being the late end result of bronchial obstruction, infection and atelectasis, then we must conclude that there is a prebronchiectatic state when these factors have not produced irreversible dilation, fibrosis and bronchial wall infection. By keeping in mind, in the presence of respiratory infection, foreign body inhalation, enlarged lymph nodes, stricture, etc., the possibility of bronchial obstruction; by looking for it, and by treating it bronchoscopically the incidence of bronchiectasis should be markedly reduced.

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COMMON DISORDERS OF MENSTRUATION

By DR. D. N. HENDERSON, University of Toronto

During recent years great advances have been made in our understanding of the physiology of menstruation and its functional disturbances. We have seen at least a partial shattering of the dictum of Colombat that, "the mystery of menstruation will be forever covered by a veil that cannot be completely removed." Each few years since 1863, when Pflueger first ascribed menstruation to the ovaries, have seen important facts established that have led to a more complete understanding of the phenomena of menstruation. Ludwig Frankael in 1903 established the endocrine importance of the corpus luteum which previous to that date had been considered functionless. Five years later Hitschmann and Adler described the cyclic histological changes that occur in the endometrium during the menstrual cycle. This made it possible to correlate endometrial change with follicular and corpus luteum development in the ovary. Up until 1923 the advances in our knowledge of the physiology of menstruation had been largely due to the work of gynæcologists and obstetricians. In 1923, however, Allen and Doisy demonstrated that the chronology of sex changes could be studied from smears of vaginal secretion and turned what up until that time had been a clinical problem into a laboratory one. This led to important discoveries in rapid succession. Following the discovery by Zondek in 1929 that the urine contained large quantities of estrogenic hormone, estrogen was soon isolated and its chemical formula constructed. In the same year Corner and Allen established the presence of a hormone principle in the corpus luteum which in turn was soon followed by its isolation in crystalline form. The isolation of these two ovarian hormones and the establishment of the relationship of the pituitary gland to the ovaries, by Aschheim and Zondek in Germany, and Smith and Engle in America, led to a most intensive laboratory and clinical investigation of both ovarian and pituitary hormones. Laboratory research far outstripped clinical study. Conclusions based on animal experiments were applied without justification to human physiology, and claims were made for the therapeutic value of ovarian and pituitary hormones based on inaccurate, uncontrolled and unscientific clinical trials. The conflicting opinions of the value of, and indications for, hormone therapy that have resulted, were inevitable and until many gaps in our knowledge of the physiology of menstruation are filled, and until chemically pure pituitary sex hormones are available for use, such confusion will persist. Nevertheless, sex hormones are extensively used in the treatment of the common disorders of menstruation. It is appropriate, therefore, to discuss briefly some general aspects of hormone therapy before proceding to the discussion of their use in specific disorders of the menstrual function.

Successful hormone therapy depends on accurate diagnosis of the hormone deficiency and a potent hormone for therapeutic use. In thyroid deficiency these requisites are ideally met. Myxoedema presents a clear clinical picture leading to accurate diagnosis, a potent hormone is available for therapeutic use, and the results of treatments are highly satisfactory. In disorders of the reproductive endocrine system, however, the diagnosis of hormone deficiency in most instances is difficult, depending on complicated chemical analysis of large quantities of urine, and difficult biological tests on experimental animals. This difficulty in diagnosis of hormone deficiency and its effect on treatment is well exemplified in abortion. There is ample evidence that an absence or deficiency of the corpus luteum hormone, progesterone, will cause abortion. The diagnosis of progesterone deficiency is made by determining the amount of pregnandiol excreted in the urine. This nescessitates the collection of all urine passed each 24 hours, preferrably for several days. The chemical analysis is not simple and by the time the results are obtained, abortion may have occurred. It is therefore not difficult to understand the variable results obtained by progesterone therapy, when it must be administered to all threatened abortions in order to treat the few that are due to a deficiency of this ovarian hormone. To complicate the diagnosis of sex hormone deficiency further it is frequently impossible to determine which gland is at fault. The ovaries, the thyroid, the pituitary and the adrenals are

all concerned with normal menstruation and a disturbance in any one may profoundly affect the others and result in a variety of menstrual disturbances.

Despite these difficulties of diagnosis, organotherapy plays an important role in the treatment of functional gynaecological disorders. In many instances the therapy is largely empirical. Best results will be obtained by the physician who has acquired a reasonable amount of knowledge of the endocrinology of the human menstrual cycle and who restricts the use of sex hormones to potent hormones of known physiological action in the human.

The Sex Hormones

The ovarian hormones, estrogen and progesterone, have been isolated, their chemical structure is known, and a great deal is known also of their physiological action. Commercial preparations are numerous and of unquestioned potency. The estrogens are available as estrone, estriol, and estradiol. In general it may be said that estriol preparations are less potent when administered hypodermically but more potent when given orally than estrone and estradiol. Estrone and estradiol are therefore generally used for hypodermic injection. Estradiol is usually combined with some organic salt, mostly benzoate or dipropionate. The standardization of estrogenic preparations is extremely confusing, with rat units, international units and day-oral units all being employed. These units apply to the estrones, estriols and estradiols, and are not comparable in physiological effect. Dosage is largely empirical. For the busy practitioner a knowledge of these details of standardization is not necessary. A suitable estrogen should be selected for oral use and one for hypodermic administration. Dosage recommended by the manufacturer may be safely followed without necessarily accepting the manufacturers' indications for the use of the hormone or their estimation of its therapeutic value.

Also available for estrogen therapy are certain non-hormonal substances not chemically related to the estrogens but having a potent estrogenic effect. The most commonly used of these is stilbestrol. These substances are relatively cheap compared to the natural estrogens and have the advantage of being extremely potent when given orally. There are some disadvantages in their use: They occasionally cause nausea and vomiting, and owing to their strong estrogenic effect they frequently cause uterine bleeding, which is particularly undesirable during menopausal and post-menopausal years. The average oral dose is from ¼ to ½ mgm and except for unusual indications, the dose should rarely exceed 1 mgm per day.

In general it may be said that estrogen therapy should rarely be continued over long periods without interruption. For example, in the treatment of menopausal symptoms, treatment should be discontinued for one week out of every four and as time goes on the week without treatment should be gradually extended, a few days at a time, until therapy is permanently discontinued. Large initial doses of the natural estrogens may be administered with safety but the maintenance dose should be the minimum amount necessary to control symptoms.

Owing to the close chemical relationship between the natural estrogens and certain carcinogenic compounds, it has been suggested that estrogens, used therapeutically, may be carcinogenic. In experimental animals cancer-like lesions may be caused by the prolonged and excessive administration of estrogens and if a strain of animals susceptible to malignancy is used, an increase in the normal incidence of malignancy results. Dosage required, however, is far in excess of the therapeutic dose used in clinical practice. There is little if any evidence that the rational therapeutic use of estrogens increases the incidence of cancer in the human. Nevertheless, long continued estrogen therapy should be avoided and if the patient has been treated for malignancy, it would seem reasonable not to employ such therapy.

The second ovarian hormone, progesterone, is commercially available in pure potent form. One mgm represents one international unit. It is potent when given orally but the dose required is ten to fifteen times that necessary when the hypodermic method is used. Recommended dosage has gradually increased as the cost of the hormone has decreased, but this unfortunately has not been accompanied by a corresponding increase in satis-

factory therapeutic results. It has been recommended in the treatment of abortion, some cases of dysmenorrhea, functional uterine bleeding and premenstrual tension.

The male sex hormone, testosterone is now recommended for use in functional gynaecological disorders due to an excess of the estrogenic hormone. The rationale for its use is its known inhibiting effect on follicular maturation, which results in a lessening of estrogen secretion. Testosterone may be administered hypodermically as the propionate, or orally as methyl testosterone. As the hormone is quite potent orally in 10 mgm doses this is the preferable method of administration. The possibility of causing masculinization, the signs of which do not always regress upon withdrawal of the hormone, is a real hazard in the use of testosterone in the female patient. Sot more than 125 mgm of methyl testosterone should be administered in a month and therapy should not be continued for longer than three months. When such a plan is followed, masculinization is unlikely to occur. Nevertheles, male sex hormone should be used with great caution in the female patient and if facial hirsutism or deepening of the voice is even suspected, therapy should be promptly stopped.

The pituitary sex hormones require only passing mention. They have not been isolated in fure form and commercial preparations contain a mixture of pituitary hormone principles, as well as protein material. They have been of little value in the treatment of functional gynaecological disorders, and their use for the present at least should be restricted to experimental clinical investigation by those specially qualified for such work. The chorionic hormones, which is pituitary-like in action and is commonly known as anterior pituitary-like hormone or A.P.L. is widely used in the treatment of functional uterine bleeding. In some cases it is of undoubted value, and recent clinical investigation has shown that this hormone prolongs the life of the corpus luteum and may delay the onset of menstruation for as long as ten to fourteen days. A discussion of hormone therapy for functional gynaecological disorders would indeed be incomplete if thyroid were not mentioned. Its method of action is obscure and its use empirical, but nevertheless it is widely used and exerts a beneficial effect in a great variety of functional disorders such as sterility, amenorrhea and habitual abortion.

The common disorders of menstruation assume varying degrees of importance depending on the age of the patient at the time of their occurrence. It is therefore of value to discuss these disturbances in relationship to the years of puberty and adolescence, sexual maturity and the menopause.

Puberty and Adolescence

The onset of menstruation at puberty is usually preceded by the development of the secondary sex characteristics. Menstruation as a rule begins between thirteen and fourteen years, but a much wider variation may be considered to be within normal limits. It may occur as early as nine years and as late as eighteen without being considered pathologic. The onset of menstruation and the development of the secondary sex characteristics before the ninth year, however, must be considered as precocious, and a complete investigation and study should be underatken to determine the cause of the precocity. In some cases, despite a most complete investigation, no cause will be found nor will it eventually become evident with the passage of years. These cases comprise the group of so-called "constitutional type of precocity." Such children, as Novak has so aptly stated, pass from infancy to adolescence, skipping their childhood. They obviously require special maternal care and observation to protect them from sexual violation which might result in pregnancy.

Precocious puberty may be due to a granulosa cell tumour of the ovary. The tumour secretes estrogen, which is responsible for the uterine bleeding as well as the breast development and growth of public and axilliary hair. Ovulation does not occur in precocious puberty due to granulosa cell tumour and pregnancy cannot occur. Following the removal of the ovarian neoplasm, the secondary sex characteristics regress and uterine bleeding ceases.

Hyperplasia or tumour of the adrenal cortex produces a syndrome which may be easily confused with precocious puberty. These children characteristically exhibit growth

of pubic and axillary hair, enlargement of the external genitalia, particularly the clitoris, increased weight and excessive muscular development. Uterine bleeding is rare and breast hypertrophy does not occur, but the deposition of fat over the pectoral muscles may suggest its presence. When the syndrome is due to a cortico-adrenal tumour, surgical removal may be successful in restoring the child to normal.

Late onset of menstruation is more common than its early occurrence. The failure of menses to occur at the expected time 13 to 14 years frequently causes considerable maternal worry. In the majority of instances reassurance is all the therapy that is required, and no specific treatment is indicated, as in the majority of cases menstruation will eventually occur. General physical examination, haemoglobin estimation and an inquiry into the patient's diet, hours of rest and social life will often reveal serious faults and give the physician the opportunity to correct these hygienic factors which are so important during the emotional and physical adjustment of puberty. In addition to the general physical examination, inspection of the external genitalia combined with rectal and abdominal examination of the pelvis will give weight to the physician's assurance that everything is normal or may reveal an organic cause for the amenorrhoea, such as an imperforate hymen or congenital absence of the vagina or uterus.

Irregularities of flow during puberty

Menstruation during early puberty is normally characterized by irregularity of cycle and variation in amount of flow. Menstruation without ovulation occurs frequently and accounts for the relative sterility of this period as well as the irregularities of flow and cycle. Prolonged and excessive bleeding beyond the limits of normal variation are, however, common at this age and may be considered as a failure of co-ordination of the menstrual endocrine system. In the absence of severe bleeding, general supporting measures, such as adequate diet, rest and the administration of iron for anaemia is usually all that is required. Occasionally bleeding is very severe and in such instances curettage of the endometrium is almost uniformly successful in arresting it. Frequently curettage results in amenorrhoea of several months' duration which is followed by a return of menstruation that is regular and of normal flow. Every effort should be made to temporize and to employ only general measures in the management of menstrual irregularities during puberty. Hormone therapy may only interfere with the noraml adjustment of the complex endocrine system. Such a "laissez-faire" form of treatment will be rewarded in the majority of cases by the establishment of a normal menstrual cycle.

Dysmenorrhoea

Primary or essential dysmenorrhoea usually begins during the early years of adolescence. The pain is probably due to ischaemia and spasms of uterine muscle, but the cause of this remains obscure. There is little, if any, evidence that ovarian hormone imbalance deficiency or excess are of etiological importance. On the contrary fertility is unimpaired, menstruation is usually regular and the endometrium is normal, all of which is evidence of normal ovarian function. Congenital anomalies, such as uterine hypoplasia, small cervix and retroversion are of doubtful etiological significance. The general health, diet, emotional and psychic state of the patient all exert a profound influence on the occurrence and severity of menstrual pain and appear to be factors of major etiological importance. It is often a difficult problem to assess the importance of this complaint and estimate its severity. Not infrequently the over-solicitous mother has created an unfortunate mental attitude in the minde of her daughter towards menstruation. Such terms as "the curse" and "unwell" imply that discomfort and pain are to be expected and that activities should be curtailed, with the result that menstruation is considered as a convenient excuse for missing a disagreeable day at school in exchange for the comforts of a hot water bottle and a day's rest at home. A quiet talk with the young patient, explaining in simple words the physiology of menstruation, the normal discomforte that is to be expected, and emphasizing at the same time the importance of carrying on normal activities during the period, is an important part of the therapeutic

management of these young patients. Such advice, combined with efforts to improve the general health by diet, rest, posture and exercise, is often all the therapy that is required.

Hormone therapy, however, is extensively employed in the treatment of dysmenorrhoea. Estrogen, progesterone and testosterone have all been rather widely used. That good results are claimed for all of them only emphasizes the psychic value of any form of therapy in a functional disturbance. Estrogens are usually employed in one of two ways. One consists in the oral administration of small doses of natural estrogens throughout the cycle, for the purpose of increasing uterine circulation. The second method consists of large doses of estrogen given hypodemically during the post-menstrual period, for the purpose of inhibiting ovulation. The rationale of this therapy is based on the known fact that in the absence of ovulation, dysmenorrhea is rare. Of all forms of hormone therapy employed in the treatment of dysmenorrhoea, the small doses of estrogen continued throughout the cycle can be most recommended. Endocrine therapy has proved most disappointing in the treatment of this complaint, is expensive and may disturb both the menstrual cycle and flow. Sex hormones have not replaced aspirin, codeine and anti-spasmodics in the treatment of dysmenorrhoea.

Surgical treatment is largely limited to dysmenorrhoea of the secondary type which may be due to a variety of local pelvic causes such as endometriosis, inflammatory and neoplastic disease and occasionally retroversion with prolapse. In a few intractable cases of primary dysmenorrhoea, wide dilatation of the cervix followed by tight packing of the uterus and cervical canal for five to seven days will prove to be a successful procedure. The cases in which this treatment is most likely to be successful are those in which the cervix is small, the external os pin-point, and the uterus hypoplastic. Surgical correction of congenital retroversion is probably the most unsuccessful of all operative procedures employed in the treatment of dysmenorrhoea.

There is no single treatment, medical, surgical or endocrine, for dysmenorrhœa. Each case must be individually studied and all etiological factors considered. The physician who ignores this and places reliance on a single form of therapy will have disappointing results.

Irregularities of flow during menopause

Irregular, prolonged or excessive menstruation which occurs during the reproductive period or menopausal years should not be considered endocrine in origin until adequate investigation has excluded systemic or pelvic disease. Bimanual examination under anaesthetic, inspection of the cervix and biopsy of any unhealthy areas, combined with dilatation and curettage are necessary diagnostic procedures to exclude pelvic disease. If such examination is not carried out, the opportunity to diagnose early cervical or endometrial carcinoma will be lost, and such causes of bleeding as endometrial polypi, tuberculous endometritis and sumucous fibroids may remain unrecognized.

It is the unfortunate and tragic experience of all who work in large hospital clinics to repeatedly encounter patients with well established carcinoma of cervix or uterus who have been treated for months for bleeding, by various drugs, without having had even a bimanual examination for diagnosis. Curettage in cases of suspected functional bleeding should be performed a few days before the onset of bleeding or during the first 24 hours of bleeding. When such a time is chosen, a maximum amount of endometrium is obtained for study, the diagnosis of menstrual phase is facilitated and endometrial hyperplasia readily recognized. On the other hand, if curettage is performed during the later bleeding period or post-menstrual week, scant tissue obtained for study, the occurrence of ovulation cannot be determined and nothing is learned about the functional capacity of the corpus luteum. Curettage is not only of diagnostic value in excluding malignant and other disease of the endometrium, but frequently is of therapeutic value as well. The curettage temporarily arrests the bleeding and is occasionally followed by a return of normal menstruation.

The essential principle in the management of excessive or irregular uterine bleeding during menopausal years is a diagnosis which excludes malignant disease of cervix or uterus. This can only be accomplished by dilatation and curettage. The treatment will de-

pend on the degree of blood loss. If it is not excessive, treatment other than general measures may not be necessary, as the physiological cessation of menses may occur at any time. On the other hand, if the general health and strength of the patient is impaired by the blood loss, then there is no excuse for delay and radical methods of treatment are justified. Roentgenotherapy, either X-ray or radium, is almost uniformly successful in establishing an artificial menopause. As many of these patients, however, are parous, and have some degree of relaxation of the vaginal walls and cervical disease, total hysterectomy and vaginal repair is often the treatment of choice. For the younger woman during child-bearing years such radical treatment is rarely justified. If curettage does not result in a return of normal menstruation, hormone therapy combined with general therapeutic measures such as diet, iron for anaemia and increase in rest will frequently prove successful. Anteriorpituitary-like hormone, progesterone, either alone or combined with estrogen and testosterone, are all worthy of a trial. The use of anterior-pituitary-like hormone should be restricted to those pathients who are ovulating. This, as previously mentioned, will have been determined by the microscopic examination of the endometrium. 500 to 1,000 units of the hormone should be administered hypodermically daily or every other day for fourteen days before the expected date of the next menstruation. This should be repeated for three menstrual cycles before a final decision in regard to its effect is made. The treatment is harmless and there is suggestive evidence that larger doses might increase the number of satisfactory therapeutic results.

For those patients who are not ovulating, chorionic or anterior-pituitary-like hormone is without value. These patients usually have completely irregular cycles with period of amenorrhoea of six weeks or longer. The bleeding also shows marked variation in amount and duration from one period to the next. Progesterone administered intramuscularly in five mgm doses every other day for six days may be followed by bleeding which is not excessive and of short duration. If such a result is obtained, therapy may be repeated at monthly intervals for several months. If bleeding does not occur after discontinuing progesterone at the sixth dose, preliminary administration of estrogenic hormone before giving progesterone may result in menstrual-like bleeding. This form of therapy however, is purely substitutional, and does not promote ovulation. It may be considered a temporizing measure, employed in the hope that with the passage of time, the functional disturbance will undergo spontaneous cure. Testosterone, owing to its inhibiting effect on estrogen secretion, has been used in anovulatory bleeding. Methyl testosterone in 10 mgm doses given orally for ten days may be tried if other methods of treatment have failed. It may be administered before or during the bleeding period. The potential danger of masculinization resulting from the use of testosterone must be remembered, and treatment should not be continued for longer than three months with a total dosage of not more than 125 mgm in any single month.

Slight vaginal spotting at the time of ovulation and during the few days preceding the onset of menstruation is a relatively common complaint. Such spotting is probably due to variations in estrogen production and can be often relieved by the administration of small doses of natural estrogen given throughout the cycle for one to three months.

Pre-menstrual tension

The term "pre-menstrual tension" is one that has recently been used to include such symptoms as nervousness, a feeling of anxiety, apprehension and a general sense of depression, occurring during the immediate premenstrual period. A disturbance in the metabolism of estrogen and progesterone affecting the autonomic nervous system in some obscure manner has been suggested at the cause of these distressing symptoms. The condition in many ways seems related to menstrual oedema and migraine and treatment is varied and on the whole rather unsatisfactory. Estrogen, progesterone and testosterone have all been tried with unsatisfactory results. On the assumption that water retention plays a part, a low salt intake and the administration of 0.6 gms of ammonium chloride three times daily during the premenstrual period may be tried. Such therapy, combined with small doses of phenobarbital is harmless, inexpensive and certainly worthy of a trial.

Amenorrhoea

Amenorrhoea is probably the most common disturbance of menstruation. It is perhaps trite to point out that the most frequent causes are physiological: pregnancy, lactation and the menopause. In common with other menstrual disorders, amenorrhoea of a temporary character may result from a great variety of causes such as poor general nutritional state and anæmia, emotional stress, fear of pregnancy and a change of occupation and environment. The high incidence of ameorrhoea that has been reported in the underfed women of the belligerent countries in Europe is evidence that the ovary is sensitive to dietary deficiency, a fact long known to be true in experimental animals. Amenorrhoea of one year's duration or more, occurring in a woman in whom such etiological factors are not evident, is usually due to serious disturbance of the endocrine system. The ovaries, the pituitary, the thyroid and the adrenals are all correlated to maintain normal menstruation and a functional disturbance of any one may result in amenorrhoea.

Amenorrhoea due to ovarian failure in a young woman is similar in many respects to the normal menopause of later life. Estrogen secretion is low, anterior pituitary gonadotropic hormone appears in the urine, occasionally in sufficient quantities to give a falsely positive Aschheim-Zondek test for pregnancy. Hot flushes, emotional instability and gain in weight may accompany the amenorrhoea. In many cases, however, amenorrhoea is the only symptom, the ovary continuing to secrete estrogen in sufficient quantities to prevent the occurrence of the secondary manifestations of the climacteric, but not in sufficient quantities to cause uterine bleeding. In the absence of symptoms other than amenorrhoea no treatment is required other than reassurance that the failure to menstruate will not adversely affect the general health. In some cases, however, treatment is indicated because of associated sterility, mental depression over the failure to menstruate or the association of obesity with the amenorrhoea. All these patients can be made to bleed either by the administration of estrogen alone or by estrogen combined with progesterone. Such therapy, however, is purely substitutional, has no effect on the ovary and in the majority of cases must be repeated each month. Thyroid extract, even in the absence of any signs of hypothyroidism, is generally accepted as a most valuable therapeutic agent in these cases and should be administered either alone or along with the ovarian hormones. If obesity is present a low-calory diet is an important therapeutic adjunct. Amenorrhoea due to ovarian failure, in common with other disturbances of menstruation, is very liable to spontaneous remission, which makes it difficult to evaluate the effect of any form of therapy. In general, it may be said that the longer the duration of amenorrhoea, the less is the likelihood that any form of therapy will be followed by a return of normal menstruation.

Amenorrhoea due to pituitary dysfunction is probably more frequently encountered than the ovarian variety. The classical example of pituitary dysfunction and amenorrhoea known as Frohlich's disease was first described in 1903 as adiposo-genital dystrophy. Weight gain is excessive with the fat being deposited over shoulder and pelvic girdle. Amenorrhoea or very scanty or irregular menses with uterine hypoplasia is usual. In these cases pituitary hormone therapy is without real value. Estrogen and progesterone will in the majority of cases cause bleeding but the therapy is purely substitutional, and except for its psychological values, serves no useful purpose.

A word should be added about the rare types of amenorrhoea associated with signs of masculinization. The most striking type is that seen with pituitary basophilic adenoma and adenoma or hyperplasia of the adrenal cortex. These unfortunate young women exhibit a most striking change in physical appearance due to increase in weight, muscular development and facial and body hirsutism. Except for the rare case in which a benign adenoma of adrenal is surgically removable, therapy is of no value. A somewhat similar clinical picture may be caused by the arrhenoblastoma or masculinizing tumour of the ovary. In these cases removal of the tumour arrests further masculinization and is usually followed by a return to nromal of both menstruation and physical appearance.

In conclusion it may be said that a great variety of factors may be of etiological importance in many of the common disorders of menstruation. The nutritional state of

the patient, blood disorders and systemic infection, along with emotional and psychic disturbances, are important factors that affect the inter-relationship between the endocrine glands concerned with menstruation. To all these must be added organic disease of the reproductive organs themselves. The family physician who appreciates the wide field of investigation that is necessary for correct diagnosis, has an equally wide choice of therapeutic measures to employ, and will be rewarded by a high incidence of satisfactory therapeutic results.

A LARGE PAROTID TUMOR CAUSING PHARYNGEAL OBSTRUCTION

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The following case report is that of a woman suffering from a parotid tumour so large and so situated that it caused almost complete pharyngeal obstruction. The anatomical pathway that the tumour followed to encroach on the pharynx is also of interest as well as the response of the chronically anoxic respiratory centre to an injection of morphine and atropine.

Mrs. J. M., a married white female, aged 53 years, presented herself at the Clinic, suffering from a recently fractured right radius and ulna as a result of an accident. She did not mention it but it was noted that she had a large nodular tumour in the right parotid region, that she talked as though she had an obstruction in her throat, and that she was short of breath on slight exertion. All inquiries about the tumour met with reticence on the part of the patient to discuss the matter further. However, it was learned that the tumour had been present for about ten years and had been growing slowly and causing increasing difficulty in swallowing and breathing. Aside from these complaints, she insisted she was very well.

Examination of the arm confirmed the presence of a fracture of the upper end of the right radius and ulna.

Examination of the tumour revealed it to be large, nodular, moderately firm in consistency, and to extend inferiorly well below the angle of the mandible and posteriorly beneath the lobe of the ear, displacing that structure laterally and posteriorly. Medially the tumour could be seen pushing the right tonsil towards the midline and slightly forward. The soft palate was markedly distended by a lobule of the tumour mass and the uvula pushed well over to the left. There was very little actual air passage visible in the oropharynx. Physical examination was otherwise essentially negative. No cardiac enlargement was noted.

The patient was admitted to hospital for care of her fractured arm. Morphine sulphate grains 1/6 and atropine grains 1/150 was given subcutaneously and reduction and immobilization of the fracture completed satisfactorily. General anæsthesia was not employed because of the nasopharyngeal obstruction. The patient was then taken to the X-ray Department for check rœntgenograms of the reduced fracture. The rœntgenograms were taken and while the patient was lying on the stretcher preparatory to being returned to the ward she stopped breathing. Artificial respiration was instituted but failed to get adequate air past the point of obstruction. A metal airway could not be passed because of the tumour. A small, soft, rubber catheter was passed beyond the tumour and oxygen administered while a tracheotomy was done and the patient revived.

Ten days after the insertion of the tracheotomy tube, with the tube still in place, the parotid tumour was removed.

Report of Operation: A vertical incision was made anterior to the right ear and extending well down into the neck. A horizontal incision was made extending anteriorly from the mid portion of the first incision and along the inferior border of the ramus of the mandible. The skin flaps were reflected and the tumour exposed. The anatomical landmarks were difficult to define owing to the size of the tumour, and the

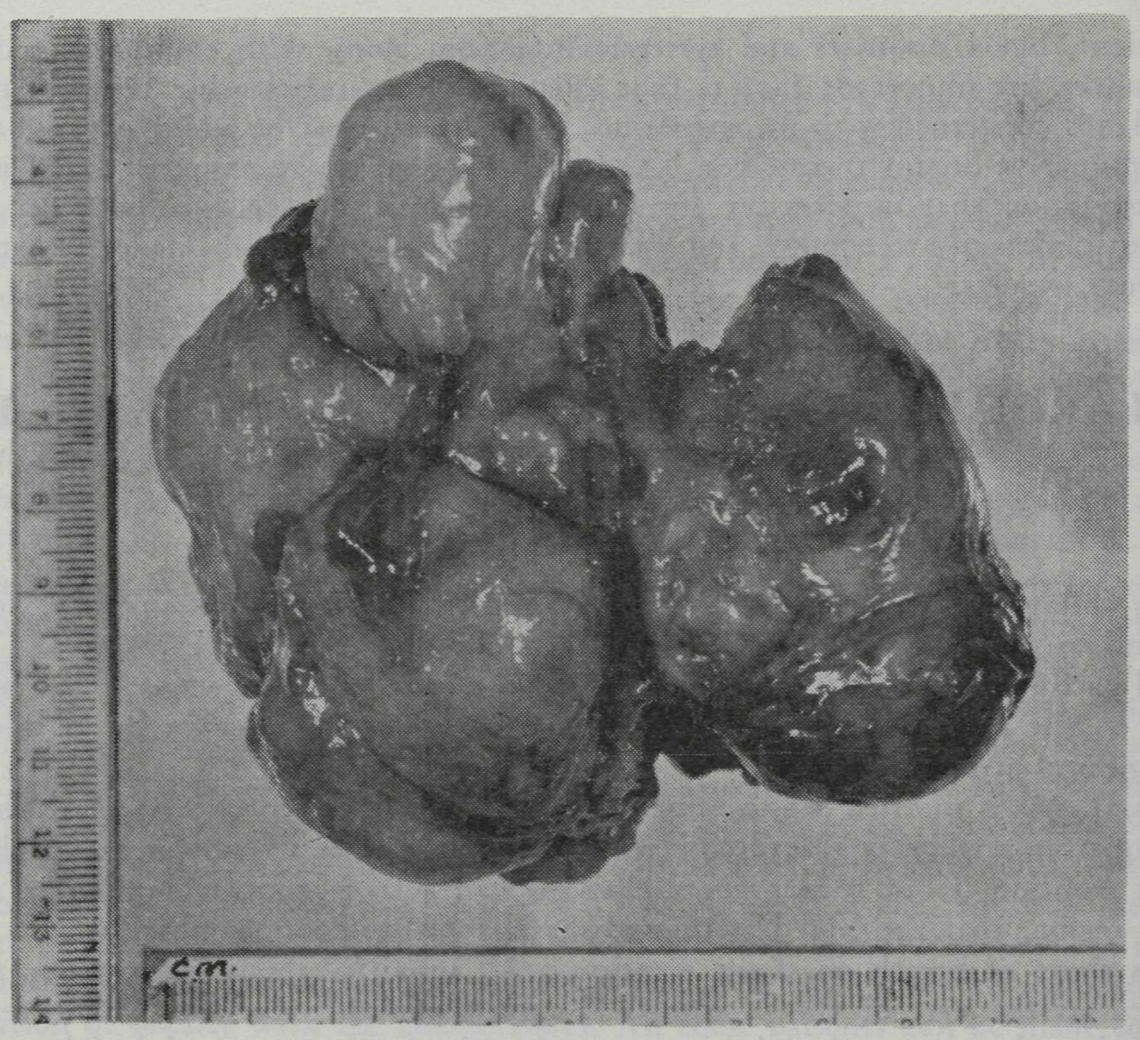

Fig. 1—Showing size and Sobulation of the Parotid Tumour

fact that structures were displaced from their normal positions. The tumour, along with the adjacent inferior portion of the parotid gland, was removed by blunt and sharp dissection. The tumour was found to pass medially through a triangular hiatus bounded inferiorly by the inferior border of the ramus of the mandible, anteriorly by the anterior belly of the digastric muscle and posteriorly by the styloid muscles and the posterior belly of the digastric muscle. The mylohyoid muscle was pushed medially against the side of the tongue and when the tumour was removed the lateral side of the base of the tongue was exposed. The styloid process of the temporal bone was exposed almost its entire length and the facial nerve was searched for but never actually seen. It was assumed that the facial nerve was displaced upwards and flattened against the skull immediately after leaving the stylomastoid foramen. The nerve developed a temporary paralysis after the operation but recovery of the face was eventually complete except for weakness of the small muscles at the angle of the mouth on that side due to interruption of the small infra-mandibular branch of the seventh cranial nerve.

Pathological examination revealed a tumour weighing 206 grams (Fig. 1) and showing a varied type of cell structure typical of the so-called mixed tumour of salivary glands. No evidence of malignancy was noted.

Comment

It is unusual in this tumour-conscious age to see a tumour of this size, because the public, as well as the physicians, is becoming educated to have all tumours removed while they are small. This women was an exception, and did not come for treatment early because of her fear of doctors. She had been entreated by her family to have the tumour attended to by a physician but she had refused all entreaties, and eventually, to silence their urgings, had forced her husband to swear with his hand on a Bible that he would never mention the tumour again in her presence. Thus, the tumour had been allowed to reach its huge size.

The tumour was of the mixed tumour type and it was realized that some tumours of this type tend to recur[1] and it is often wise to remove all of the parotid gland along with the tumour. However, because of the size and situation of the tumour, the removal of the growth as it was done was the operation of choice.

The path of entry traversed by the tumour extending from the sub fascial area of the parotid region to the submucosal region of the pharynx is noteworthy.

The cause of the sudden cessation of respiration without complete occlusion of the respiratory tract. King[2] has given an explanation in reference to a similar happening in chronic incomplete laryngeal obstruction, secondary to bilateral recurrent laryngeal nerve paralysis. The explanation might well apply in this case. The patient, he believes, is in a constant state of mild oxygen deficiency because o fthe difficulty in breathing. The carbon dioxide level in the blood is constantly higher than normal and the respiratory centre becomes depressed and less sensitive to changes in the carbonic acid blood level. The administration of a sedative that is ordinarily a well-tolerated respiratory centre depressant may in these cases depress the already depressed respiratory centre still further to the point where respiration ceases. Artificial respiration does not maintain adequate oxygenation owing to the obstructing factor preventing a proper intake of air and an immediate tracheotomy is necessary to save life. He adds that because of this risk he believes that no patient with chronic incomplete respiratory obstruction should be given sedatives for fear of complete respiratory centre paralysis.

This patient is now well and shows no evidence of ill effects from her operation other than a slight weakness of the muscles at the corner of her mouth.

REFERENCES

1. Quattlebaum, Frank W.; Docherty, Malcolm B.; Mayo, Charles W.: AAdenacarcinoma, Cylindroma type of the Parotid Gland: A Clinical and Pathological Study of 21 Cases. Surgery, Gynecology & Obstetrics: 82:342-347, March, 1946.
2. King, Brien T., Seattle, Washington. Verbal Communication.

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IMPORTANT NOTICE

The serologic tests for syphilis are procedures for determining the presence of a specific antibody known as reagin, which is produced by the human body as a result of infection with *Treponema pallidum*, the causative micro-organism of syphilis. This reagin is produced in much the same way, e.g., typhoid antibodies are produced during infection by *Eberthella typhosa*, the micro-organism causing typhoid fever. The presence of this syphilitic antibody (reagin) in the blood stream or cerebro-spinal fluid can be detected by means of the artificially prepared antigens which are employed in serologic tests.

I nrecent years, a demand has developed for *quantitative* estimations of the amounts of circulating reagin in the serologic tests for syphilis. This demand will justifiably increase as recently developed methods of treatment are more generally used. Quantitative serologic tests are primarily necessary in the control of treatment of syphilis with penicillin, since they may serve as one of the principal guides for determination of treatment adequacy, or of reinfection.

The terminology used for reporting quantitative findings has hitherto not been satisfactorily standardized, and a difficult extra burden of interpretation has thus been placed on the clinician. Appreciating this fact, recent meetings in Ottawa of Directors of Provincial Laboratories and Directors of V.D. Control across Canada recommended that quantitative serologic reactions be reported in terms of the greatest dilution in which the tested specimens produces a positive reaction. Thus, a report of "Positive to dlution 1:16" for a quantitative serologic test for syphilis, will indicate that the tested specimen produced positive reactions in dilutions up to and including, but not greater than, 1:16. A specimen found to react positively only in the undiluted state would be reported as "Positive to dilution 1:1." The previous system of reporting quantitative Kahn results, and the new system, are compared in the following examples:

Example 1: *Kahn Test*—Actual laboratory readings on *blood* specimens . . . Positive in dilutions 1:2, 1:4, and 1:8; partial in dilution 1:16; negative in higher dilutions.

Reports: Previous system: "32 Kahn units."
New system: "Positive to dilution 1:8."

Example 2: *Kolmer (Complement-fixation) Test* — Actual laboratory readings on *cerebro-spinal fluid* specimens . . . Positive in dilutions 1:2, 1:4, 1:8, 1:16, 1:32; partial in dilution 1:64; negative in higher dilutions.

Reports: Previous system: "128 Kolmer units."
New system: "Positive to dilution 1:32."

The new system of reporting quantitative serologic tests for syphilis will go into effect in the immediate future.

For further information if desired, write Division of V.D. Control, 2700 Laurel Street, or phone FAirmont 8411.

Visiting doctors are cordially invited by the B. C. Division of the Canadian Anæsthetists' Society to observe and discuss modern methods of anæsthesia at the Vancouver General Hospital, Shaughnessy Hospital, St. Paul's Hospital, St. Vincent's Hospital.

Daily schedules commence at 8 a.m.

ROSTER OF SPEAKERS FOR LAY AUDIENCES

There have been a number of requests, during the past few months, for medical men to address lay groups such as Rotary, Kiwanis, Y.M.C.A., etc.

Would any doctors who would be willing to participate in meetings of this sort please communicate with the Executive Secretary, at their earliest convenience, stating if possible the subject upon which they would be prepared to speak. A list will then be prepared from which suitable speakers can be chosen to meet any future requests.

NEWS AND NOTES

Dr. L. H. Appleby, well known Vancouver surgeon, is attending the biannual assembly of the International College of Surgeons where he will present a paper on gastric surgery. The assembly this year is being held in Rome and Turin.

Dr. J. G. McKay has recently retired from active practice. He has been Medical Superintendent of the Hollywood Sanatorium for a number of years. Dr. Ernest A. Campbell has taken over the institution.

We regret to record the death of Dr. J. S. Rivers, a resident of Vancouver since 1937. Dr. Rivers graduated from the University of Toronto medical college in 1896, and practised medicine in Ontario and Alberta before coming to British Columbia. Sincere sympathy is extended to Mrs. Rivers and family.

We regret to record the passing of Dr. R. H. McCutcheon, who has been in this province since 1926. Dr. McCutcheon graduated from the University of Toronto in 1907 and lived in Saskatchewan for some time before coming to British Columbia. Our sincere sympathy is extended to his family.

We regret to record the sudden passing of Dr. W. R. Sutherland Groves at the age of 49. Dr. Groves graduated from Toronto University in 1935 and has practised in British Columbia since 1936. Deepest sympathy is extended to Mrs. Groves and family.

Dr. A. N. Beattie, formerly of Kelowna, is now with the Central Vancouver Island Health Unit at Nanaimo.

Dr. Katherine C. Lewis has left Vancouver to take up residence in Los Angeles, California.

Dr. E. Lewison is at present taking a post graduate course in New York, N.Y.

Dr. A. C. Vey has left Victoria to take up practise in Honeymoon Bay.

Deepest sympathy is extended to Dr. and Mrs. J. H. Clement on the death of their son, Earl Herbert, which occurred suddenly at his home on April 13th, 1948. He had been a medical student at the University of Manitoba.

Sympathy is extended to Dr. and Mrs. J. C. Poole on the death of Dr. G. F. Stephens of Montreal. Dr. Stephens was Mrs. Poole's father and his death occurred at their home in Vancouver.

Dr. H. L. Ormsby has left Vancouver to make his home in Vernon.

Dr. Dorothy Miller, formerly of Parksville, has taken up practice at Sooke, Vancouver Island.

Sincere wishes for a speedy recovery are extended to Dr. H. F. Tyerman of Ashcroft, who is at present indisposed. Dr. F. E. Maxwell is substituting for Dr. Tyerman during the latter's illness.

Dr. F. H. G. Mills has recently come to Smithers and is associated with Dr. L. M. Greene.

Congratulations are extended to the following doctors and their wives on their recent good fortune:

Dr. and Mrs. C. E. Battle—a daughter.
Dr. and Mrs. J. C. Becher—a daughter.
Dr. and Mrs. E. C. McCoy—a son.
Dr. and Mrs. J. S. Monteith—a son.
Dr. and Mrs. C. G. Pow—a daughter.
Dr. and Mrs. H. E. St.-Louis—a daughter.
Dr. and Mrs. W. D. Smaill—a daughter.
Dr. and Mrs. D. H. Stanwood—a daughter.
Dr. and Mrs. W. N. Toone—a daughter.
Dr. and Mrs. G. R. Wilson—a daughter.

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