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The BULLETIN

of the

VANCOUVER MEDICAL ASSOCIATION

Vol. XVII OCTOBER, 1940 No. 1

With Which Is Incorporated
Transactions of the

Victoria Medical Society

the

Vancouver General Hospital

and

St. Paul's Hospital

In This Issue:

	Page
NEWS AND NOTES	6
B. C. MEDICAL ASSOCIATION ANNUAL MEETING	9
MEDICAL SERVICES ASSOCIATION	15
DYSMENORRHOEA FROM AN ENDOCRINE STANDPOINT— By J. H. Willard, M.A.	17
NOMENCLATURE OF DISEASES	29

NOTICE

Certain mutual benefit associations which have been organized within the Province of British Columbia are now approaching the doctors, trying to obtain a reduction in the minimum fees. As we have never been approached, as a Council or otherwise, we would ask the doctors to restrain from granting such a reduction in fees to any of these associations.

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

Published Monthly under the Auspices of the Vancouver Medical Association in the interests of the Medical Profession.

Offices: 203 Medical-Dental Building, Georgia Street, Vancouver, B. C.

EDITORIAL BOARD:

DR. J. H. MACDERMOT

DR. G. A. DAVIDSON DR. D. E. H. CLEVELAND

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VOL. XVII OCTOBER, 1940 No. 1

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F. Hendrych and K. Klimesch, Arch. Exptl. Path. Pharmakol 178, 178-88, 1935, regard ferrous chloride as the physiological form of iron. They find that it does not cause chronic poisoning when administered orally, but that ferrous carbonate and ferric citrate cause characteristic liver damage.

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VANCOUVER MEDICAL ASSOCIATION

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GENERAL MEETINGS will be held on the first Tuesday of the month at 8 p.m.

CLINICAL MEETINGS will be held on the third Tuesday of the month at 8:00 p.m. Place of meeting will appear on the Agenda.

General meetings will conform to the following order:
8:00 p.m.—Business as per Agenda.
9:00 p.m.—Paper of the evening.

Programme of the 43rd Annual Session (Fall Session)

1940

October 1—GENERAL MEETING.
Dr. Hamish McIntosh: "Some commonplace variations in the spine."

October 15—CLINICAL MEETING.

November 5—GENERAL MEETING.
Dr. E. R. Hall: "The obstructing prostate—Recognition and treatment."

November 19—CLINICAL MEETING.

December 3—GENERAL MEETING.
Speaker to be announced.

December 17—CLINICAL MEETING.

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—AUGUST, 1940

Total Population—estimated	269,454
Japanese Population—estimated	9,094
Chinese Population—estimated	8,467
Hindu Population—estimated	339

	Number	Rate per 1,000 Population
Total deaths	239	10.5
Japanese deaths	8	10.4
Chinese deaths	11	15.3
Deaths—residents only	202	8.8
BIRTH REGISTRATIONS:		
Male, 261; Female, 260	521	22.8

INFANTILE MORTALITY—	August, 1940	August, 1939
Deaths under one year of age	7	10
Death rate—per 1,000 births	13.4	29.3
Stillbirths (not included in above)	7	8

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	July, 1940		August, 1940		Sept.1-16, 1940	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	4	0	11	0	2	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	17	0	13	0	10	0
Measles	45	0	14	0	6	0
Rubella	0	0	1	0	1	0
Mumps	1	0	1	0	3	0
Whooping Cough	4	0	8	0	3	0
Typhoid Fever	0	0	1	0	1*	0
Undulant Fever	0	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	24	18	28	20	15	–
Erysipelas	2	0	6	0	1	0
Meningococcus Meningitis	0	0	0	0	0	0
Paratyphoid Fever	1	0	0	0	0	0

* Carrier.

V. D. CASES REPORTED TO PROVINCIAL BOARD OF HEALTH, DIVISION OF VENEREAL DISEASE CONTROL.

	Burnaby	West Vancr.	Richmond	North Vancr.	Vancr. Clinic	Hospitals, Private Drs.	Totals
Syphilis	0	0	2	0	28	31	61
Gonorrhœa	0	1	0	0	73	29	103

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THE EDITOR'S PAGE

Elsewhere in the BULLETIN we publish, at the request of Dr. A. J.McLachlan, the Registrar of the College of Physicians and Surgeons of B. C., a warning to medical men against certain schemes, or shall we say rackets, that are being set on foot, to induce doctors to take on medical contracts, which will provide medical service at reduced rates to groups of persons who may be persuaded by hope of cheap medical attention to buy such contracts. We are asked by the College to have nothing to do with such contracts. The BULLETIN thoroughly endorses this request, and urges its readers to report all such attempts to the College, either through Dr. McLachlan, or through Dr. Thomas, the Secretary of the College.

These contracts are pernicious things. There is nothing new about them. In one form or another, they have swindled both doctors and patients ever since we can remember. They are bad for various reasons—but the outstanding objection to them is that they exist for one purpose only—the profit to be made out of them by those who organise them. It has long been a cardinal principle of any form of health insurance which can deserve the support of the medical profession that there must be no opportunity for profit in it for any third person. Any surpluses made must be used for the advantage of the members, in the form of additional or better service, or the reduction of cost of membership.

When the element of profit enters in, it invariably leads to deterioration and cheapening of service, especially of medical service: no reputable physician will engage in this work for any length of time—and sooner or later, the whole thing crashes—and the beneficiaries, so-called, are left with nothing but disillusionment and disappointment. These schemes are dishonest in their inception, not always intentionally so, we must admit, but in the long run they all go the same way.

The College of Physicians and Surgeons of British Columbia has an Economic Committee, which will carefully scrutinise and survey all suggested schemes. Its criteria are few and simple: the scheme must be actuarially sound; it must maintain the standards of service we have set up, must pay fair fees, and give fair return to the beneficiaries. All the schemes at present endorsed by the College fulfil these requirements. Do not let yourself be persuaded to accept any scheme that has not received the endorsation and approval of the College. You injure yourself—you injure your fellows—you injure the public.

* * * *

The Medical Services Association has begun operations, and we wish them luck. This scheme fulfils all the requirements of the College of Physicians and Surgeons, and should, we believe, be very successful. It gives to people of low income the opportunity to get the best medical service at a price they can afford, through co-operation. It gives to medical men the right to keep their own patients, and to obtain fair remuneration for the work they do. It is calculated to give the best of medical service. It is actuarially sound, and will not be wrecked on the rock of financial unsoundness. It is not designed to make any profit—but if there is a surplus, this will be used for the benefit of its members. It is not a scheme of the medical profession. It is being run by a board of laymen with some medical representation; the members of the Board are chosen from those interested in its operation.

We bespeak for this organization the support of all medical men. Its operation will, at first, be limited to the Lower Mainland—but it will, as it develops, and is found to be a success, spread further, and be applied to other parts of the Province.

NEWS AND NOTES

At the Annual Meeting of the North Shore Medical Society, held on September 11th, the following officers were elected: President: Dr. E. Therrien of West Vancouver; Vice-President: Dr. W. G. Saunders of North Vancouver; Secretary-Treasurer: Dr. G. A. McLaughlin of North Vancouver.

* * * *

We extend our sincere sympathy to Dr. T. W. Walker of Victoria, Superintendent of the Jubilee Hospital, in the recent sad loss of his wife.

* * * *

We regret to report the loss of a member of the Victoria Medical Society in the passing of Lt. Col. J. A. Murray, R.C.A.M.C. Lt. Col. Murray was District Medical Officer in Victoria until his retirement a short time ago on account of ill health.

* * * *

Several members of the Victoria Medical Society, including Doctors Lucas and Elkington, have returned from two weeks' training at Nanaimo, while Doctors Roxburgh, Buffam and Alcorn and others are undergoing their training at the present time.

* * * *

We offer congratulations to Dr. B. L. Dunham of Nelson on his marriage on September 15th to Miss Ferguson of Procter, formerly a nurse at the Kootenay Lake General Hospital.

* * * *

Dr. and Mrs. L. E Borden of Nelson have left for a visit in Nova Scotia, Dr. Borden's old home.

* * * *

Dr. and Mrs. G. F. Young of Salmo were holidaying in Vancouver.

* * * *

Dr. W. J. Endicott of Trail is visiting in Winnipeg.

* * * *

The profession extends congratulations to Dr. George R. F. Elliott on his marriage to Miss Elizabeth Kathleen Bourne on September 17th.

* * * *

Dr. J. D. Galbraith of Bella Coola called at the office while in Vancouver recently.

* * * *

Dr. W. C. Mooney, who has been doing post graduate study in Toronto leading to the Diploma in Public Health, has returned to Vancouver and is now associated with the Department of Venereal Disease Control.

* * * *

Dr. and Mrs. W. C. Mooney are receiving congratulations on the birth of a son.

* * * *

Dr. and Mrs. L. S. Chipperfield of Port Coquitlam are receiving congratulations on the birth on September 17th of a daughter.

* * * *

Dr. and Mrs. David A. Steele of Vancouver are receiving congratulations on the birth on September 9th of a daughter.

* * * *

Dr. and Mrs. C. H. Gundry of Vancouver are receiving congratulations on the birth of a daughter on September 1st.

* * * *

Dr. and Mrs. J. S. Henderson of Kelowna are on a holiday trip around the Big Bend Highway to Banff.

Dr. A. J. Wright is now associated with Doctors J. E. Harvey and Osborne Morris in the practice at Vernon. Dr. Wright formerly practised in the Peace River District of Alberta and for the past year has been doing post graduate work in Radiology.

* * * *

Congratulations are extended to Dr. and Mrs. R. J. Macdonald of Pouce Coupe on the birth on September 22nd of a daughter.

* * * *

Dr. and Mrs. H. V. Gale of Copper Mountain are away on two weeks' holiday.

* * * *

Dr. W. H. White and Mrs. R. B. White of Penticton motored to Banff and back via the Big Bend Highway, after attending the Annual Meeting of the British Columbia Medical Association at Nelson.

* * * *

Dr. and Mrs. H. McGregor of Penticton attended the Annual Meeting of the British Columbia Medical Association in Nelson. Dr. McGregor was re-elected president of District No. 4 Medical Association and Dr. R. J. Parmley was re-elected Honorary Secretary. Dr. H. L. Burris of Kamloops is the representative on the Board of Directors of the British Columbia Medical Association. The next meeting of District No. 4 Medical Association will be held in Penticton, the home of the president.

* * * *

Lieut. W. Roy Walker of Penticton has been at camp in Vernon.

* * * *

Dr. and Mrs. Osborne Morris of Vernon attended the Meeting in Nelson. His many friends were glad to realize that Dr. Morris had recovered from his recent illness.

* * * *

The friends of Dr. Thom and Dr. Coghlin of Trail, who missed them at the recent Meeting of the British Columbia Medical Association, will be glad to hear that Dr. Thom's condition is improved and Dr. Coghlin is back at work.

* * *

Dr. Arnold Francis of New Denver is having a vacation at the coast and is going to Cowichan Bay to take some Cohoe on the Bucktail fly.

* * * *

Dr. E. J. Lyon of Prince George was in Vancouver on the occasion of his daughter's wedding early in September.

* * * *

Dr. Ross Stone of Vanderhoof was at the coast in September.

* * * *

Dr. Frederick Chu has opened an office on Hastings Street in Vancouver.

* * * *

Dr. Noel Bathurst Hall of Campbell River spent a few days in Vancouver and Victoria after his return from Nelson.

* * * *

Dr. J. G. Robertson, who has just returned from post-graduate study, is opening an office in New Westminster and confining his practice to the specialty Eye, Ear, Nose and Throat.

* * * *

Dr. C. M. Henry, formerly of Regina, has taken an office in the Campbell Building, 1029 Douglas Street, Victoria, and will confine his practice to Radiology.

* * * *

Dr. K. A. Bibby is the new Radiologist at St. Joseph's Hospital, Victoria.

* * * *

Dr. G. S. Rothwell has been at Port Alberni assisting Dr. N. H. Jones during the absence of Dr. R. W. Garner on vacation.

* * * *

Dr. W. A. McTavish has been at Duncan on Vancouver Island carrying on in the absence of Dr. G. W. C. Bissett.

Dr. R. S. Woodsworth is assisting Dr. D. W. Davis at Kimberley.

* * * *

Dr. J. H. Kope has taken over the practice at Enderby. Dr. J. L. Coltart, who was formerly there, is now associated with Dr. R. W. Irving at Kamloops.

* * * *

On his return journey from Nelson, Dr. Thomas visited Dr. Kope and also called upon Dr. W. Scratchard at Chase. Dr. Scratchard was bearing up bravely in the face of his recent bereavement, Mrs. Scratchard having passed away in August.

* * * *

Dr. R. W. Irving of Kamloops has returned after a long vacation spent in company with Dr. Dave Smith, an old classmate. They had a wonderful six weeks together.

* * * *

The East Kootenay Medical Association held a short meeting at Nelson and elected Dr. W. O. Green as President and Dr. M. J. Swartz as Honorary Secretary-Treasurer. This will permit of the East Kootenay Medical Association carrying on from a fresh start. The Association was unfortunate in losing both Dr. G. E. L. McKinnon as President on his retirement from practice, he having been elected to Dominion Parliament, and Lt.-Col. J. F. Haszard as Secretary when he left to take command of No. 8 Field Ambulance being mobilized at Calgary.

* * * *

The West Kootenay Medical Association held its Annual Meeting at Nelson and returned to the various offices those members who were elected last year—Dr. J. S. Daly as President, and Dr. W. Laishley as Secretary-Treasurer. The 1941 Annual Meeting of the West Kootenay Medical Association will be held in Trail.

SPECIAL LIBRARY NOTICE

Following is a list of books which have been taken from the Library, and for which the Librarian has no Doctors' signatures:

Index of Differential Diagnosis, 5th ed. Edited by Herbert French, (Reading Room Copy.)

Alcohol (36-Z-4), Strecker & Chambers.

American Journal of Obstetrics and Gynæcology, v. 37, 1939.

American Journal of Surgery, v. 44, April to June, 1939.

Annals of Internal Medicine, v. 12, Jan. to June, 1939.

Journal of Infectious Diseases, Nov.-Dec. number, 1939.

Lancet, Jan. 6th, 1940.

As these books have been out for some length of time, varying from a month to a year, it is requested that they be returned to the Library at once.

BOOK REVIEW

OTOSCLEROSIS

By Louis K. Guggenheim, M.D., F.A.C.S.

Assistant Professor of Clinical Oto-Laryngology, Washington University School of Medicine

"Otosclerosis is not a disease in the ordinary sense; it is not just a familial affliction which could result from either intra or extra—uterine environmental factors, but it is an hereditary affliction—a gene produced condition and it is obviously related to the morphology of the recently acquired structures, oval window, round window and cochlea."

The author presents an excellent technical treatise to substantiate the theory of Regression in the etiology of Otosclerosis.

—J. A. McL.

(See August Issue of Bulletin for names)

British Columbia Medical Association

(Canadian Medical Association, British Columbia Division)

President ..... Dr. Murray Blair, Vancouver
First Vice-President ..... Dr. C. H. Hankinson, Prince Rupert
Second Vice-President ..... Dr. A. H. Spohn, Vancouver
Honorary Secretary-Treasurer ..... Dr. Walter M. Paton, Vancouver
Immediate Past President ..... Dr. F. M. Auld, Nelson
Executive Secretary ..... Dr. M. W. Thomas, Vancouver

ANNUAL MEETING

The Annual business session of the British Columbia Medical Association was held on Tuesday evening, September 10th, in the Silver Room of the Hume Hotel.

Doctor F. M. Auld presided.

The financial report was presented by the Honorary Secretary-Treasurer, Doctor A. H. Spohn, and the report of the Auditor, Dr. A. J. MacLachlan, was read. On motion this report was approved.

The reports of Chairmen of Standing Committees covering the year's transactions were presented in writing.

The report of the Nominating Committee was presented to the meeting by Doctor H. H. Milburn, who acted as Chairman. On motion, nominations were closed. It was then moved, seconded and carried that the Secretary be instructed to cast the ballot for the following offices: President: Dr. Murray Blair, Vancouver; First Vice-President: Dr. C. H. Hankinson, Prince Rupert; Second Vice-President: Dr. A. H. Spohn, Vancouver; Honorary Secretary-Treasurer: Dr. W. M. Paton, Vancouver.

The election of five Directors-at-Large placed the following on the Board of Directors: Doctors G. F. Amyot and P. A. C. Cousland of Victoria, Dr. P. S. McCaffrey of Agassiz, Dr. H. McGregor of Penticton and Dr. Wallace Wilson of Vancouver.

Doctor A. J. MacLachlan was re-appointed Auditor.

It was announced that the 1941 Meeting of the British Columbia Medical Association would be held in Vancouver.

The suggestion that the Canadian Medical Association Meeting might be held at Jasper in 1942 was discussed and on motion the principle of a Joint Meeting of the Canadian Medical Association, the Alberta Division and the British Columbia Division was approved by the Meeting.

Doctor Auld conducted Doctor Blair to the Chair and Doctor Blair in accepting the office of President referred to the excellent work which Doctor Auld had done on behalf of the Association.

1940 Annual Meeting

Registration

Dr. J. A. Alton, Lamont, Alberta.
Dr. G. F. Amyot, Victoria.
Dr. G. H. Anderson, Spokane, Washington.
Dr. L. H. Appleby, Vancouver.
Dr. F. M. Auld, Nelson.
Dr. M. R. Basted, Trail.
Dr. Murray Blair, Vancouver.
Dr. L. E. Borden, Nelson.
Dr. H. H. Boucher, Vancouver.
Dr. F. W. Brydone-Jack, Vancouver.
Dr. J. M. Burnett, Greenwood.
Dr. H. L. Burris, Kamloops
Dr. Harold H. Caple, Vancouver.
Dr. H. R. Christie, Rossland.
Dr. W. A. Clarke, New Westminster.
Dr. D. E. H. Cleveland, Vancouver.
Dr. M. G. Cody, Calgary, Alberta.
Dr. J. H. Couch, Toronto, Ontario.
Dr. F. E. Coy, Invermere.
Dr. P. A. C. Cousland, Victoria.
Dr. D. J. M. Crawford, Trail.
Dr. J. Stuart Daly, Trail.
Dr. W. A. Drummond, Salmon Arm.
Dr. B. L. Dunham, Nelson.

Dr. H. W. Epp, Sardis.
Dr. A. Francis, New Denver.
Dr. E. H. Funk, Vancouver.
Dr. V. Goresky, Castlegar.
Dr. H. F. P. Crafton, Kamloops.
Dr. R. F. M. Glasgow, Michel.
Dr. Duncan Graham, Toronto.
Dr. F. W. Green, Cranbrook.
Dr. A. B. Greenberg, Vancouver.
Dr. N. Bathurst Hall, Campbell River.
Dr. S. W. Harrington, Rochester, Minnesota.
Dr. David Hartin, Spokane, Washington.
Dr. E. S. Hoare, Trail.
Dr. R. H. Irish, Tranquille.
Dr. George R. Johnson, Calgary, Alberta.
Dr. G F. Kincade, Vancouver.
Dr. D. M. King, Bralorne.
Dr. C. M. Kingston, Grand Forks.
Dr. W. J. Knox, Kelowna
Dr. M. E. Krause, Trail.
Dr. W Laishley, Nelson.
Dr. R. G. Large, Prince Rupert.
Major F. W. Lees, Vancouver.
Dr. J. W. Lennox, Victoria.
Dr. W. T. Lockhart, Vancouver.
Dr. J. W. Lynch, Spokane, Washington.
Dr. P. S. McCaffery, Agassiz.
Dr. J. H. MacDermot, Vancouver.
Dr. S. A. McFetridge, Vancouver.
Dr. H. McGregor, Penticton.
Dr. H. H. MacKenzie, Nelson.
Dr. N. D. C. MacKinnon, Trail.
Dr. A. J. MacLachlan, Vancouver.
Dr. Thomas McPherson, Victoria.
Dr. A. H. Mcneely, Nanaimo.
Dr. H. H. Milburn, Vancouver.
Dr. Osborne Morris, Vernon.
Dr. N. E. Morrison, Nelson.
Dr. J. S. Murray, Calgary, Alberta.
Dr R. A. Palmer, Vancouver.
Dr. W. M. Paton, Vancouver.
Dr. H. H. Planche, Vancouver.
Dr. J. C. Poole, Revelstoke
Dr. T. C. Routley, Toronto 2, Ontario
Dr. G. E. Seldon, Vancouver.
Dr. W. W. Simpson, Vancouver.
Dr. L. F. Stephens, Revelstoke.
Dr. G. F. Strong, Vancouver.
Dr. Walter de M. Scriver, Montreal, Quebec.
Dr. R. B. Shaw, Nelson.
Dr. Albert M. Snell, Rochester, Minnesota.
Dr. F. P. Sparks, Nelson.
Dr. Howard Spohn, Vancouver.
Dr. M. J. Swartz, Cranbrook.
Dr. Kingsley Terry, Nelson.
Dr. J. C. Thomas, Vancouver.
Dr. M. W. Thomas, Vancouver.
Dr. W. M. Toone, Nelson.
Dr. E. E. Topliff, Rossland.
Dr. Ethlyn Trapp, Vancouver.
Dr. W. A. Trenholm, Imperial, Saskatchewan.
Dr. H. F. Tyerman, Nakusp.
Dr W. H. White, Penticton.
Dr. F. L. Wilson, Trail.
Dr. G. T. Wilson, New Westminster
Dr. Wallace Wilson, Vancouver.
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Dr. Morley A. R. Young, Lamont, Alberta.

DIARY OF THE NELSON MEETING OF THE B. C. MEDICAL ASSOCIATION

This is in the nature of a despatch from the front, being started on the train *en route* from Vancouver to Nelson.

Everything has contributed so far to making this meeting a complete success. The weather is the best B. C. fall weather (early fall) and there is no better. As we bucket along through the Kettle Valley (and it is a bumpy road in places, but very beautiful from a scenic point of view) we are enjoying the trip immensely, being in the very best of company. Vancouver and Victoria, New Westminster, Penticton, Grand Forks—men are coming on the train all the way up, many of them accompanied by their wives: and we cannot remember having seen so many doctors on one train before; it is a very happy, congenial crowd, and we practically own the train. An excellent programme has been arranged for lady visitors—and the omens for a really big and successful meeting are very favourable. This is the first time this Annual Meeting has been held away from the bigger centres on the Coast, and so we are specially glad that things are going so well.

Many men, too, have motored up—amongst them Drs. Wallace Wilson, G. F. Strong, R. A. Palmer, H. H. Boucher, and others. The Canadian Pacific Railway has, as usual, done things in generous fashion, and has given us a special car and special rates.

Among those from Vancouver taking the trip are Dr. Ethlyn Trapp, Dr. and Mrs. F. W. Brydone-Jack, Dr. and Mrs. D. E. H. Cleveland, Dr. and Mrs. J. H. MacDermot, Drs. H. H. Milburn, A. H. Spohn, A. J. McLachlan, T. Lockhart, Dr. and Mrs. W. A. Wilson, Drs. A. F. Strong, H. A. Plante, H. H. Boucher, and many others.

From Victoria are Drs. P. C. Cousland, J. Lennox, T. McPherson, and others, while Dr. G. F. Amyot, Medical Health Officer for B. C., represents the Provincial Health Department.

Dr. P. McCaffrey of Agassiz, Dr. W. A. Clarke and others of New Westminster joined the train *en route*.

After a delightful day on the train, where the interior of the air-conditioned cars was far cooler and fresher than the rear platform of the observation car(temp. 100°), we were all glad to reach Nelson at 8.45 p.m.

Here we were met by many of the medical men of Nelson, who drove us to our respective hotels, and made us very welcome and feeling very much at home. Dr. and Mrs. F. M. Auld (Dr. Auld is president of the B. C. Medical Association), received us informally but very graciously. At the front door of the Hume Hotel was the ubiquitous Dr. C. T. Routley, Executive Secretary of the Canadian Medical Association, and we have no doubt he was also present in person at the front door of the other hotels to which doctors went—since no one hotel could hold all the visitors. The latter are unanimous in their praise of the hotels of Nelson. Comfortable beds, good meals, a very warm welcome, and courteous service, are to be found in them all, and we are very grateful.

The morning of Monday, Sept. 9, opened with registration of members of the ladies of the party. Mrs. Bender, of whom we have so often had occasion to speak, as an indispensable part of all medical meetings in B. C., was on hand to register us, take our money for luncheons, dinners, etc., while the ladies had their own registration desk.

The Silver Room of the Hume Hotel is the main meeting-place of the Association, and to reach it one goes through an ante-room where several excellent displays have been put on by various pharmaceutical firms, including an especially popular one, where several doctors were to be seen at various times all day, increasing their vitamin B intake, by the inhibition of one of its more palatable forms. From this anteroom (carefully avoiding a stairway which Dr. Thomas McPherson of Victoria informed your Editor led to what he described as "Licensed Premises") we went down into the Silver Room. Here for some three hours we listened to excellent papers on subjects of the keenest interest to us all.

Dr. Frank Couch of Toronto spoke on Recent Advances in Fractures; Dr. Walter Scrive of McGill on Nephritis and Its Management, while Dr. Wookey reported some 12 cases of operation on one of the most difficult types of cancer to reach and to treat surgically, that involving the pharynx and œsophagus in its upper third or half. A reduction of mortality from 100% treated by any other method, to less than 50% by surgery, is in the nature of a revolution.

Dr. Albert Snell of Rochester aroused our interest and opened up new vistas of diagnosis and treatment by his talk on Deficiency States—especially as regards vitamins.

The scene shifted then to the Canadian Legion Building, where we had a luncheon at which Mayor Stibbs of Nelson formally gave us a most gracious welcome to Nelson. He gave us an interesting account of the city and its very happy financial and economic condition, and said several very nice things about our profession.

He was followed by Dr. Duncan Graham of Toronto, President of the Canadian Medical Association, who reviewed the work of the national body and filled us with pride as he pointed to its accomplishments, and to the fact that the Canadian Medical Association has attained a position where it is consulted by the Canadian Government in all matters appertaining to public health. Notable examples of this are with regard to medical service both for war purposes and for civilian purposes; the work on dietetics, of national importance; the work on cancer, and so on.

Dr. T. C. Routley, General Secretary of the C.M.A., well known to us all, then addressed us briefly but in a most interesting manner. He told us of the growth in prosperity and membership of the C.M.A. and of further steps to be taken by provincial and Dominion medical bodies to ensure closer unity and to serve better and more fully the national weal. He reminded us that some twenty years ago the Canadian Medical Association was dying of inanition and in a bankrupt state. It had debts of $18,000 or more, a membership of a few hundred, a Journal hardly worth the printing, and a thor-

oughly discouraged Executive Council: which considered very carefully a resolution for disbandment and dissolution of the Association. More courageous counsel prevailed, Dr. J. C. McEachern being one of the leaders in this, and reorganization was done. Today the C.M.A. has funds of over $140,000, a membership of 5000, and a Journal the equal of any. He stressed the need and the urgency of organization, and showed that it was bound to succeed.

The afternoon was given up to a symposium on Lead Poisoning, a most vital consideration in these parts. A few unregenerate souls ,and some whose growing waistline indicates regular exercise, especially as a corrective to any possibly "detrimental" after-effects of the generous hospitality of our Nelson hosts, decided to take a run-out powder, and headed for the golf course. Here, high in the hills, Nelson has a most delightful little nine-hole course, every hole a real pleasure and test of golfing ability. The view from the course, of hills and valley and lake, is gorgeous—and all cares and anxieties just fell away from us, like Christian's bundle. Amongst the golfers we noticed were Drs. T. Lockhart, Geo. Seldon complete with cigarette, and many others.

Back to the centre of town in the gloaming, slipping down the long winding hills of Nelson, past its pleasant well-ordered homes and gardens, to dinner. After this, the programme included a Public Meeting at the Capitol Theatre, where a packed audience listened to Drs. Duncan Graham, Walter Scriver, Stuart W. Harrington and H. W. Wookey, tell of Recent Advances in Medicine, Surgery, and the knowledge of the Diagnosis and Treatment of Cancer.

A large meeting was also held at Trail, where Drs. Couch, Snell and Routley spoke.

On Monday, the Ladies' programme was a varied and very full one. It began with a scenic drive round Nelson, and led up to a luncheon at the Nelson Golf Club, after which many remained to play Bridge or Golf, while others went to see the lovely gardens of Mr. and Mrs. S. G. Blaylock, near the city. These are now at their very best, and are one of the beauty spots of the Kootenays.

Tuesday opened, like Monday, with addresses and lectures for the men; while the Ladies' Entertainment Committee had again provided bounteously for their guests, who visited the homes of Mrs. F. M. Auld, wife of the President of the B.C.M.A., and Mrs. H. H. Pitts, whose son, Dr. H. H. Pitts, is well known as the Pathologist-in-Chief of the Vancouver General Hospital. These two gracious hostesses provided a very delightful morning for their visitors.

The lectures referred to were again of a very high order. Dr. Scriver spoke of "Diabetes as a Quantitative Disease." Dr. J. Harold Couch gave a most interesting and practical talk on the "Injection Treatment of Hæmorrhoids and Varicose Veins," liberally illustrated with slides. He was followed by Dr. Duncan Graham, who summed up in admirably concise manner from the present-day knowledge and practice with regard to Sulphanilamide and Related Compounds in the treatment of infections.

Dr. Stuart W. Harrington spoke on the Diagnosis and Results of Radical Mastectomy for Carcinoma of the Breast in 5000 Cases.

In the afternoon, we all got into cars, dozens of them, and took a long drive along the easterly border of Kootenay Lake, to a point where we boarded a simply gigantic ferry, which took us for a long sail up the Lake. The weather was superb, the water like a mill-pond, and the company congenial, and all enjoyed themselves immensely. Our speakers and guests came with us, and we saw Drs. Duncan Graham of Toronto, or rather we should now say, of Canada, Dr. Albert Snell of Rochester, Dr. Anderson of Spokane, Dr. Lynch of the same city, all evidently enjoying the trip. Dr. T. C. Routley, too, had a short interval of peace, which is a rare visitor to his crowded life. As we came back, fish were jumping in the lake, canoes were out looking for the fish—and the beauty of the lake, and the real happiness of the whole event, will remain with us a long, long time.

After dinner the business part of the programme began, with the Annual Meeting of the College of Physicians and Surgeons of British Columbia. Dr. L. H. Appleby,

Chairman of the Council, presided, and Dr. A. J. McLachlan reviewed the year's work briefly. Dr. W. A. Clarke, Chairman of the Committee on Economics, presented a report, showing the work done on the plan suggested last year for the provision of complete medical service to groups of employees and their families, and to people generally in lower income groups. The formation of the Medical Services Association goes a long way to supplying these services. Dr. Clarke told the members that after a year's work of organization, the M-S-A was now ready to begin operations. Twelve hundred firms on the Lower Mainland have been canvassed; a fairly large proportion of these are willing to enter such a plan, and it is certain, Dr. Clarke felt, that once the scheme is in operation, many more will join.

Its operation will at first be confined to the Lower Mainland, for reasons of administrative facility and compactness and workability—but will be extended as rapidly as canbe done.

The report was adopted by the members of the College.

The reports of the various Committees of the Association have been published in the BULLETIN, and reflect a great deal of hard work during the past year.

Elections were then in order, and the following were elected by acclamation, on the recommendation of the Nominating Committee: President, Dr. Murray Blair, Vancouver; First Vice-President, Dr. C. H. Hankinson, Prince Rupert; Second Vice-President, Dr. A. H. Spohn, Vancouver; Honorary Secretary-Treasurer, Dr. W. M. Paton, Vancouver.

Wednesday, the final day of the meeting, was, like its predecessors, full to the brim. The scientific programme in the morning was excellent. Dr. Geo. H. Anderson, of Spokane, discussed the "Hyper-Ventilation Syndrome" and the diagnosis and treatment of this much overlooked clinical entity. Some most interesting slides were shown.

Dr. Snell, following up his previous paper on Deficiency States, dealt with the Jaundiced Patient and His Problems. He was followed by Dr. J. W. Lynch of Spokane, who dealt with Headaches, Their Diagnosis and Treatment, from an entirely new angle, the neuro-vascular. It is hoped that we shall be able to publish an abstract at least of this address, which was most stimulating and original.

Dr. Stuart W. Harrington of Rochester then gave an address on the Differential Diagnosis and Treatment of Diaphragmatic Hernia. He showed a series of X-rays dealing with this condition, which was a complete monograph in itself. His work is monumental, and, of course, authoritative. He ended with a motion-picture of the operation by the abdominal approach. Every step could be clearly seen, and one was amazed at the improvement in technique shown by those who take these very difficult pictures.

After lunch, we all adjourned to the Nelson Golf Course for what to certain fellows of the baser sort was undoubtedly the chief *raison d'être* for the meeting. We mention no names, but one of them, in our own foursome, won four brand new balls (most of us lost at least that many) because of a pure fluke.

There was a tournament on, and the weather was delightful, and the course in beautiful shape. At one hole, liquid refreshment was provided, and it did no good to our putting touch, or the security of our stances. But it was a good idea, all the same.

Then we came back to dress for the Annual Dinner. Gathering at the hospitable home of Dr. and Mrs. Wilfrid Laishley, we had cocktails before proceeding to the Canadian Legion Building. Here the sexes separated, the ladies, as was only proper, going up into an upper room, while the men congregated below.

A delightful dinner was had, and the highlight of the meeting was a witty and friendly address by the Ven. Archdeacon T. H. Graham, well-known in the Interior of B. C. He was thanked by Dr. Murray Blair, our new president, who then distributed the golf prizes.

Next day, Thursday, we began the trek homeward, having had a most enjoyable and profitable time. We pity sincerely all who were unable to come. It was a good meeting from a numerical standpoint—but it was a marvellously successful meeting from

every other standpoint, and we think will do much to strengthen the bonds of unity in our B. C. profession. It taught us another thing: that we of the Coast have much to learn from our brethren in the other parts of B. C. along the lines of hospitality and friendly cordiality. Without fuss, and in the truest spirit of a good host, the profession of Nelson made us completely at home in their midst. They were unfeignedly glad to have us, and we were given a royal time.

How the sick and afflicted burghers of Nelson fared during these days, we cannot tell, but we do know that the doctors of Nelson were on the job at the meeting all the time. Perhaps there was a moratorium of some kind—in any case, we would like the men of the Interior to know that we have an intense appreciation of their kindness and hospitality, and we congratulate them heartily on having put on one of the very best meetings ever held in British Columbia.

Nor was it only the doctors of Nelson that put themselves out to welcome us and give us a royal time of it. His Worship Mayor Stibbs we have already mentioned—and except for a brief mention that Nelson had a Chief of Police, and that the latter knew we were in town, and had taken all suitable precautions, there was no jarring note at all in his remarks, which were cordial and friendly to a degree. He threw open the gates of the city to us, and extended all its privileges, which are many, and include a unique and marvellous Community Centre, and the Golf Course of which we spoke.

And especial thanks are due to the Nelson Board of Trade. Six busy members of this organization, business men of the city, gave up their afternoon, left their places of business, and drove their cars down to the hotels to help transport our members to various drives, water trips, etc. This act of courtesy and generosity will stay long in our memories, as well as the action of the Rotary and Kiwanis Clubs, which cancelled their meetings for the week, in order that the Canadian Legion Hall might be available for our Luncheons.

Take it all together, one realizes that when Nelson sees fit to welcome anyone, she does it better than any other place we ever heard of, and with no ostentation or fuss.

We have left to the last our mention of the man who did the most, and worked the hardest, to make this meeting the great success it was: we refer, of course, to Dr. M. W. Thomas, Executive Secretary of the B. C. Medical Association. While he would be the first to deprecate any praise of himself and would say he was simply doing his job, we feel that it is not enough to dismiss the matter as simply as that. For months he has worked on this project, has sponsored publicity, written and telephoned and made arrangements, and at the last, from 6 a.m. to 2 a.m. (perhaps later, but we were sleeping the sleep of the just after that) he was constantly on the job. And at times it must have tried even his patient soul. But it must be very gratifying to him to know that it is all over, to reflect upon the smoothness and ease with which everything went.

We are sure that we are only speaking for everyone that was there, when we congratulate him most sincerely, and thank him cordially, for having done his job so well, and given to the British Columbia Medical Association one of the best meetings it has ever had.

NOTICE

A request has been received from the Eva Webely Club for samples of medical supplies, to be used by convalescent soldiers.

Doctors are therefore asked to put aside such samples as they are willing or deem advisable to contribute to this cause. They will be called for at regular intervals by representatives of the Club.

College of Physicians and Surgeons

President ..... Dr. L. H. Appleby, Vancouver

Vice-President ..... Dr. W. A. Clarke, New Westminster

Treasurer ..... Dr. W. E. Ainley

Members of the Council—Dr. J. Bain Thom, Trail; Dr. Thomas McPherson, Victoria; Dr. Gordon C. Kenning, Victoria; Dr. Osborne Morris, Vernon.

Registrar ..... Dr. A. J. McLachlan

Executive Secretary ..... Dr. M W. Thomas

MEDICAL ECONOMICS

M-S-A OPENS OFFICE

The Medical Services Association is now located in office No. 217 in the Medical-Dental Building. (This office is on the same floor and close to the Medical Library and Executive Offices of the College.)

This announcement should be of interest to every member of the practising profession in that all doctors are eligible for service to the employee contributors and their dependants.

Enrolment of members now proceeds. Services will commence on November 1st.

Every doctor should enroll,—he will thus be known to the office when reports and accounts are submitted by him.

Enrolment as a Professional member involves no financial outlay or obligation.

Application forms will be distributed by the Office of the College and members will be asked to sign and return these cards promptly to the office, 203 Medical-Dental Building, Vancouver.

The Committee on Economics, acting on behalf of the profession, has supervised the preparation of all forms and literature. The report forms have been made very simple,—elaborate detail being avoided. This Plan under which the M-S-A will provide services to these lower-income groups has been sponsored by the profession. Every member is asked to support the M-S-A. It meets a need and at the same time recognizes those fundamentals in Medical Practice which produce:

Contentment in practice;

Normal patient-physician relationships;

Free choice of doctor;

Remuneration on the basis of the Schedule of Fees.

The M-S-A does not disturb normal conditions in practice. The M-S-A is not operated for profit. Monies are all expended in providing Medical Services.

The M-S-A thus deserves the support of the profession.

Members of the profession are asked to introduce this Plan to their patients and friends who would be helped to offset those mental worries which debts bring into the homes and lives of low-income groups. Doctors will be provided with literature which will aid them to present this Plan to all who should be interested,—whether employees, dependants or employers. How often a sizeable bill from the doctor is liable to produce the terror and destruction of a modern bomb. Doctors often hesitate to send such accounts. Under this Plan these bills will go to the office of the M-S-A and will be paid by it.

The patient is happy, the doctor is happy, and there is nothing to impede the patient's recovery.

Members practising throughout the Province and outside of what may be called the Greater Vancouver and New Westminster area are being asked to sign the applica-

tion card for Professional Membership. This is requested because any enrolled member may require medical services while outside of his own area and would seek service from any doctor.

Travelling salesmen, employees in branch establishments, and others would thus be assured service.

As the M-S-A develops it will extend its activities throughout the Province. As it spreads to other areas, all doctors will of necessity expect to very actively participate.

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NATIONAL DEFENCE TAX

Extracts from pamphlet issued by Dominion Income Tax Division.

NOTE: This information is set forth here that you may provide for the required taxes payable by you on or before April 30th, 1941.

Particulars are also given of deductions which must be made from salaries of office assistants, such monies to be transmitted by employer to Department of National Revenue.

Where wages paid including Board, etc., to Domestic help are sufficient in amount to be taxable, deductions must be likewise made.

Form N.D.T.1 must be completed by employee. Please apply for forms and read instructions on reverse side re deduction of 2% or 3% depending on income and status of employee.

Offences and Penalties: (14) Every person failing to deduct or remit or to deduct and remit the tax due pursuant to the provisions of this section at the time prescribed therefor shall be liable to a penalty equal to the amount of tax which should have been deducted and remitted, but the penalty shall not exceed five hundred dollars.

APPENDIX "D"

GENERAL INCOME TAX LIABILITY

Which Is In Addition to the National Defence Tax

The tax payment to be made on or before the 30th April next year and each year thereafter will be so heavy that it may come as a surprise to those who have to pay it and have not provided for it.

You are earnestly requested in your own interest to observe the weekly and monthly savings that must be made out of weekly or monthly earnings in order to have the money on hand to pay the tax, the indicative total of which at the end of the year should also be noted.

All employers will please draw the attention of their employees to the table given below, so that each individual may be well informed.

The table is made up for a married person, without dependents. The reduction of tax for a dependent, having regard to the general weight of liability, is not brought into consideration because, relatively, it is small. Therefore, the table as a savings guide is substantially correct for all persons.

TABLE

Married Person, No Dependents

Income (Before Exemption)	Tax Payable	Weekly Saving	Monthly Saving
$ 1,500	$ —	$ —	$ —
2,000	35.00	0.67	2.92
3,000	135.00	2.60	11.25
4,000	275.00	5.29	22.92
5,000	455.00	8.75	37.92
6,000	695,00	13.37	57.92

7,000	970.00	18.65	80.83
8,000	1,275.00	24.52	106.25
9,000	1,610.00	30.96	134.17
10,000	1,970.00	37.88	164.17
11,000	2,360.00	45.38	196.67
12,000	2,770.00	53.27	230.83
13,000	3,190.00	61.35	265.83
14,000	3,610.00	69.42	300.83
15,000	4,030.00	77.50	335.83
16,000	4,450.00	85.58	370.83
17,000	4,870.00	93.65	405.83
18,000	5,290.00	101.73	440.83
19,000	5,710.00	109.81	475.83
20,000	6,130.00	117.88	510.83

The Inspectors of Income Tax will be glad to receive advance payments at any time.

DYSMENORRHŒA FROM AN ENDOCRINE STANDPOINT

J. H. Willard, M.A.

(The following is a thesis written by Mr. J. H. Willard, for his Master's Degree in Science at a well-known University to the South of us. We feel that it is an excellent summary of modern knowledge on this subject, and as such is well worth publishing in the Bulletin.—Ed.)

* * *

The following is a presentation of dysmenorrhœa from an endocrine standpoint. Experimental reports indicate it to be associated with ovarian and uterine disfunction as affected by a hormone imbalance. We may look towards an understanding and control of these factors for therapeutic measures.

An appreciation of dysmenorrhœa from an endocrine point of view first necessitates a picture of the problem as a whole. Experimental reports are both conflicting and corroborating.

By the word dysmenorrhœa we refer to the cramps, general distress, and premenstrual tension just preceding, or in many cases experienced during the first day or two of menses by approximately 40 per cent of women who are apparently otherwise normal and in good health.

We hear of primary, secondary, ovarian, extrinsic, spasmodic, and congestive dysmenorrhœa. Secondary dysmenorrhœa is associated with pathological conditions in the pelvis such as uterine fibroids, endometriosis, and inflammations. Primary or functional dyhmenorrhœa is not associated with any demonstrable abnormality in the pelvis. The endocrine relations are concerned mostly with the primary type. Ovarian dysmenorrhœa according to O. Browne is a definite clinical entity with characteristic symptoms and signs which allow an accurate diagnosis. It is present alone in about 11.9 cases of dysmennorhœa, but may be associated with dysmenorrhœa of uterine origin, thus constituting "mixed dysmenorrhœa."

Classification of any clinical advantage has been hindered by ignorance of the ætiology back of the symptom, and until more progress is made in this direction therapy will be inefficient. The most recent and intelligent contribution towards classification to date has been made by Dr. E. V. Schute, who suggests the following grouping, after a study of 130 cases of which 44 were married women:

(a) Endocrine dysmenorrhœa (entailing excess or deficiency of œstrogen) (35 cases);

(b) Inflammatory dysmenorrhœa (entailing parimental cellulitis and tubovarian inflammation) (6 cases);

(c) Mechanical dysmenorrhœa (16 cases):
   1. Fibromyomata of the uterus,
   2. Endometriosis,
   3. Ovarian cysts;

(d) Mixed types (51 cases);

(e) Unclassified membranous (22 cases).

An effective therapy necessitates an appreciation of the causal factor or factors promoting dysmenorrhœa. The ætiolegy of the colicky pain, premenstrual tension, and occasional nausea is far from clear; however, several theories have been advanced, the more important of which are along the following lines:

1. Psychological;
2. Obstruction;
3. (a) Passage of clots; (b) Breaking away of unduly large flakes;
4. Hypoplastic condition of the uterus;
5. Neurogenic theory;
6. Organ and tissue œdema;
7. Hormonal or endocrine imbalance. (That this could be concerned in any of the others is not only possible but probable.)

It is the purpose of this paper to consider the hormonal or endocrine imbalance as a causal factor. The following are certain well founded reasons for ascribing a hormonal ætiology to certain types of dysmenorrhœa, namely, functional.

(1) The normal changes of the endometrium during the menstrual cycle are dependent primarily on the influence of œstrone, and in the second half of the intermenstrual interval upon the superimposition of the corpus luteum hormone, progesterone. When normally prepared by these hormonal influences the endometrium, if not receiving the embryo, disintegrates and is expelled along with the effused blood. Now, the disintegration of the endometrium could be due to a deprivation of both œstrone and progesterone, as experiments indicate menses can be delayed and endometrium maintained by injections of either œstrone or progesterone. An excess of progesterone, on the other hand, might produce a thickened endometrium which would disintegrate less readily and require more vigorous contractions for its expulsion. In view of this it is possible that a hormonal imbalance with progesterone in excess or a relative deficiency of œstrin may cause the pain through:

(a) The difficulty with which the endometrium becomes disintegrated;

(b) The passage or loosening of largish flakes of endometrium, the sloughing of which may irritate or expose the nerve endings close to the surface;

(c) By the uterine motility being affected by a disproportionately small amount of œstrin.

(2) Dysmenorrhœa when believed to be due to hypo-uterine development has been alleviated by œstrone administration resulting in the growth of the uterus to the normal size.

(3) According to reports by Kennedy and Blotvegolt, the cells in the pelvic plexus undergo degenerative changes after castration, and they can be restored by injections of œstrin. In view of the role these plexuses play in relation to the distribution of the total nerve supply of the uterus, this observation provides another possible clue to the importance of œstrin in connection with dysmenorrhœa and links the whole question of the sex hormones with the neurogenic theory prementioned.

Dysmenorrhœa is closely associated with the menstrual cycle, and since this cycle is so definitely affected by hormonal ratio and concentration variations it is possible that a hormonal imbalance may be the cause of functional dysmenorrhœa, in which case intelligent hormone therapy may alleviate at least temporarily the distress. Some success has been reported along these lines and in view of this a better understanding of the menstrual cycle with its effects on the endometrium, myometrium, and corpus luteum, is desirable.

According to Goldzieher, the cyclic phenomena of menstruation would be something as follows: Follicular development, maturation of ovum and ovulation, as well as œstrogen production, are under control of the gonadotropic hormone of the pituitary. Transformation of the ruptured follicle into a lutein body depends upon the luteinizing gonadotropic factor of the pituitary. Any increase in œstrogen, either by ovary secretion or by injection, decreases the potency of the gonadotropic factor from the anterior pituitary. Hence, inhibition of gonadotropic activity of the pituitary causes decrease of œstrogen production and degeneration of corpus luteum, as a consequence of which menstruation and involution of endometrium sets in. The pituitary, now released from ovarian inhibiting influence, resumes secretion of the follicle stimulating hormone and starts a new cycle.

Menstruation and the Endometrium.

Since menstruation is attended with the disintegration of the endometrium, an insight into the cyclic variation which this lining undergoes would be in order. As previously stated, the flow probably occurs as a result of degenerative changes in the endometrium following regression of the corpus luteum. In the normal ovulatory cycle the secretory endometrium is cast off more or less completely the first day or two of the flow. Since endometrial biopsies with the suction curette and vaginal smear examination vary throughout the menstrual cycle, the nature of the variation should be given at this time. During the early half of the intermenstrual cycle the endometrium is undergoing a proliferative phase. After ovulation, about the thirteenth day of the intermenstrual cycle, progestin production increases with the activity of the corpus luteum and the secretory type of lining appears in preparation to receive the fertilized ovum. The recognition of this suggests a functioning corpus luteum and nomal progestin stimulation. Atrophy will present an abnormal endometrial picture and suggest an endocrine imbalance. Wilson and Kurzrok have repeatedly pointed out the inadequacy of the œstrogen and progesterone withdrawal theory and believe it necessary to include some additional factor beside the two ovarian hormones in mechanism back of menstrual bleeding. Several authors have designated this unknown the "bleeding factor," and it has been suggested by B. Zondek to be the third ovarian hormone. There is little substantial evidence for this, however. Smith, Tyndal, and Engle demonstrated conclusively that the pituitary was not essential for menstrual bleeding. Now menstruation, despite its dependence on ovarian secretion, is primarily a vascular phenomena. G. H. Daron has shown that the arterioles and capillaries of the endometrium undergo certain functional and morphological changes during the menstrual cycle. This recently discussed bleeding factor could well be the potentially variable reaction of the vascular components to the ovarian hormone. In this case menstrual bleeding depends not only on the stimulus supplied by the ovary, but also on the reaction of the endometrial vessels to this stimulus.

Pursuant with this line of reasoning Oscar Hechter has reported an interesting experiment indicating the existence of a uterine factor which has an important influence on shortening the life span of the corpus luteum either directly or through the pituitary gland. This is quite possible, as the corpora of hysterectomized guinea pigs, rabbits, and rats persist for a time interval approximately equivalent to their normal gestation period. The chance, then, of the uterus playing an endocrine role or exerting a governing influence is of interest and importance. Since functional corpora inhibit ovulation and vaginal œstrus, then the appearance of a fully cornified œstrus smear can be taken to represent the time of regression of function of the corpora. More will be said later regarding this uterine corpus luteum antagonistic in discussion of experiments by Hechter *et al.*

Uterine Motility

Whatever the ætiology of functional dysmenorrhœa may be, many believe that the pain is caused by contractions of the uterus. An appreciation of the relative merits of this statement must be preceded by a vision of the normal myometrium motility throughout the cycle. Leo Wilson and Ralph Kurzrok have studied the uterine motility by the intra-uterine balloon method technique. They find that during the middle two weeks

of the normal twenty-eight-day cycle the uterine contractions are characterized by small amplitude short duration, short interval between contractions, and high tonus. In the week preceding menses the contractions gradually increase in amplitude and duration and decrease in frequency and tonus. The maximum amplitude is generally reached at the onset of menstruation. That these should appear precisely when dysmenorrhœa occurs adds considerable support to the concept above mentioned. During the ensuing week there is a gradual return to the small type of contraction. The latter have been shown by Wilson and Kurzrok to be an œstrogen effect, while the large contractions are produced by the corpus luteum hormone acting in conjunction with the œstrogenic hormone. There is probably no ætiological relation between the menstrual flow itself and the pain, as there is an absence of dysmenorrhœa in an ovulatory bleeding. Here we have a profuse and prolonged flow accompanied by the passage of clots. The failure of ovulation prevents the formation of corpus luteum, consequently the large luteal phase contractions fail to appear as does pain. In view of this, Wilson *et al* believe that only women who have a corpus luteum can have dysmenorrhœa. H. S. Sturges has done considerable work along these lines and is in agreement with Wilson and Kurzrok. However, they are not sure if ovulation is necessary for cramps because the endometrium is made secretory in type or because the luteal hormone itself has a direct action on the myometrium. Venning has recently shown that all demonstrable progesterone is apparently eliminated about two days before the menses. This would suggest that cramps must be due to some result of progesterone action such as secretory endometrium rather than to its presence itself in the system.

In an attempt to find a hormonal common denominator, Sturgis and Albright made a study of twenty-five cases of fairly severe dysmenorrhœa. Care regarding case histories, physical examination, sexual development, and a discard of cases of probable organic pathology was observed and treatment tried on consecutive cases with no attempt to select from any one group or type. They used estradiol benzoate at a strength of 1.7 mg. per cc. (10,000 r.u.). Treatment was by intramuscular injection once every third day. A series of injections consisted of from three to fourteen, depending upon the severity of the cramps. They found that injections had to be commenced by the end of the first week after the onset of menses if the next period was to be free from uterine cramps. It was additionally observed that although a complete cramp-free period followed a course of treatment, if started early enough in the cycle, yet the next menses which had been preceded by no œstrin course was as painful as ever. They point out an "all or none effect." The dependence of the results upon the timing of the injections in relation to the cycle suggest the effect might be related to the action of the injected hormone on ovulation. By observing biopsies for three consecutive months they concluded that œstrin treatment one month did not inhibit or repress the recurrence of ovulation the next month. It was found that in patients receiving two consecutive treatments the pain returned on the second month in spite of the repetition of the injection treatment. In view of this, the œstrin injections were given only on alternate months, therefore only alternate menstrual periods could be cramp-free. They claim cramp-free periods in ninety-five per cent of courses. In an additional experiment they found with a few patients who had repeated responded to œstrone in the past, and where the optimum number of œstrin injections were followed by daily injections of 5 mg. of progesterone (prolutan) for five days, that although previously free from cramps, due to œstrone treatments, the progesterone brought cramps in two out of three cases. Observations from endometrial biopsy would thus indicate ovulation is probably necessary for essential dysmenorrhœa. It is possible that œstrone, due to an antagonistic action on the follicle stimulating hormone of the anterior pituitary prevents maturation of a Graafian follicle. This antagonistic action possibly must take place before the follicle has received an adequate growth stimulus by the follicle stimulating hormone from the pituitary.

Testosterone propionate is receiving considerable attention in the therapy of dysmenorrhœa. It is now synthetically produced from cholesterol and has been found by L.

F. Fieser to be closely related to progesteron chemically. L. G. Bowman has found some of the androgens to have progesterone-like effect. In view of this Rubinstein and Abarbanel studied its effect on twenty-six patients with dysmenorrhœa. Their treatment consisted of two injections of testosterone propionate (Perandrene, Ciba) in 5 mg. doses administered subcutaneously on the twentieth and twenty-third days of the menstrual cycle. Menses began on the twenty-fifth day in this typical case and was practically free from discomfort. During the next cycle the treatment was repeated with similar results. Of the twenty-six patients, sixteen obtained complete relief; of these fifteen had a functional disorder, and one had a chronic salpingitis. Four patients were partially relieved; of these two had infantile uteri and two had retroverted uteri. Four cases failed to respond to the therapy. Of these, two were functional, one had an infantile uterus, and one had a chronic salpingitis. Two patients experienced an aggravation of symptoms; of these one was functional and one had an infantile uterus. They concluded it relieved most cases of essential dysmenorrhœa.

U. J. Salmon, S. H. Geist and R. I. Walter have carefully studied the effect of testosterone propionate in dysmenorrhœa. They report on thirty cases treated. Their report is of interest as they used very high doses of hormone and are one of the first group of workers to avoid the administered hormone. In order to obtain presence or absence of normal progesterone activity and also to follow the effect of their treatment, they made extensive endometrial biopsies and vaginal smear studies according to the technique of U. J. Salmon. The hormone was injected intramuscularly in the gluteal region three times a week in individual doses of 10-15 mg. per cc. of sesame oil. In some of the cases injections were given throughout the entire month, in several only during the first week of the cycle, and in others treatment was started on the fifteenth or sixteenth day of the cycle and continued up to the onset of the following menstrual period. Most patients were treated during three successive cycles. There were fourteen of the twenty-five cases followed up that were symptom-free from 3-24 months after; twenty-two cases had complete relief; four cases were improved; four cases experiencd no improvement. In nine cases, one or two menstrual periods were suppressed during the treatment; in ten patients there was a slight decrease in the amount of bleeding which occurred; in two cases during the course of treatment menses occurred 5-10 days early.

Insulin has been found by E. W. Schrick and A. Altschul to be effective against dysmenorrhœa in some cases. The latter, in using *insulin* for its metabolic stimulating effect in malnutrition, found in such patients with dysmenorrhœa, an absence of painful menses. With this observation in mind he tried the direct result of insulin on patients having an attack of painful menses and noticed relief in 10 of 12 cases. E. W. Schrick found in a study of 10 cases that 5 units of insulin daily before lunch for 3-5 days before menses for 2 or 3 months "cured" or brought about painless menses in 8 of the cases. He also reported marked success in a case with 5-7 units of Squibbs regular insulin given during an attack of dysmenorrhœa. The injection was accompanied by a supply of carbohydrate to counteract the effect of the insulin on blood sugar.

Altschul, *et al*, have suggested that insulin may work through its hypoglycæmic effect. However, efforts to control the antidiabetogenic effect of insulin and a few blood sugar studies would seem to discredit this hypothesis. Tedstrom and Wilson believe hypoglycæmia is a cause for dysmenorrhœa and not a cure, moreover the nausea, vomiting, and faint feelings associated with dysmenorrhœa suggest the hypoglycæmic condition. Fasting blood sugar studies showed no uniform variation in fasting blood sugar levels at menstruation as compared with mid-menstrual level. Eighty per cent of a group of dysmenorrhœa patients of Tedstrom and Wilson showed a lower blood sugar (below 80 mg. per 100 cc. of blood). These patients were relieved by high carbohydrate feedings and intravenous glucose immediately.

Discussion.

Functional dysmenorrhœa may be regarded, then, as a disorder in which normal uterine contractions during the phase of maximum amplitude reach consciousness. The

exact explanation for the reduction of the pain threshold is as yet unknown. The existence of a psychic factor in dysmenorrhœa has been recognized by many medical men. Novak and Harnik believe that the psychic trauma associated with menses is responsible for the initial attack of dysmenorrhœa and that the fear of repeated attacks in subsequent periods perpetuates the condition. The relief of dysmenorrhœa by a wide variety of therapeutic measures, some rational and others purely suggestive, adds support to this psychogenic concept. Because of the successful results reported to follow pre-sacral sympathectomy, the role of the pelvic autonomic nervous system in functional dysmenorrhœa warrants consideration. It is conceivable that this pathway might permit nervous impulses arising from the myometrium to reach the sensorium. The absence of dysmenorrhœa in anovulatory bleeding might be attributed to the absence of the large luteal phase contractions. The reason administration of large doses of œstrogen and such gonadal hormones abolishes or diminishes the pain of the subsequent period may be attributed to a reduction of the uterine motility (via the hypophysis and ovary) when menses occurs prematurely. When menses occurs at the normal time or is prolonged, the contractions are of the usual large amplitude, at least there may be no demonstrable difference. In these cases, too, the pains are frequently absent. Lockner, Krohn and Soskin have found that pain has been relieved and no apparent diminution in size of contractions, in others large contractions and no pain, and others, of course, when decreased pain on œstrin therapy was accompanied by decreased contractions. This seems to point to either an undemonstrable but effective diminution in contractions or an elevation of the pain threshold.

Carl G. Heller has shown that œstrone is increased twenty times in potency by incubation with minced uterine tissue. This might account for the uterine factor so antagonistic to corpus luteum and explain the result of Oscar Hechter's uterine implants.

Where dysmenorrhœa is believed to be due to a lack of the corpus luteum hormone progesterone, it may be possible to diagnose the case better by detecting such a deficiency by employing the recently introduced technique of Venning for the assay of urinary pregnandiol, a degradation product of progestin.

The indiscriminate use of hormone therapy with little regard to threshold tolerance and the specific nature of the preparation, as well as the dosage, makes this work of Salmon very valuable. Having a dosage related to its objective effects is going to be very helpful.

A question to mind is the temporariness or permanency of these results. Past observation has been relatively short. It would be very surprising if the unwanted side effects (masculinization) of testosterone propionate were completely temporary and the beneficial effects permanent.

Therapy in the doses advocated by Salmon should be used with caution, especially in cases of young women anticipating pregnancy. Such a strong chemical attack on the ovary might be as basic as roentgen or x-ray therapy. The dose must be very high when it involves fundamental alterations in gonadal and uterine physiology. In the doses suggested a very vigorous attack is being made on the basic physiology of the primary and secondary reproductive organs. Menstruation is being delayed in some cases, producing an atrophic endometrium, inhibiting ovulation and in larger doses producing masculinization effects which in spite of their temporariness might possibly leave some bio-chemical scaring. The specific cause of dysmenorrhœa is not being eliminated by the substitution of an atrophic endometrium but are bringing about a partial if not complete cessation of functions of the reproduction tract and cycle. We only eliminate a medium by which the disfunction may manifest itself, not getting at the cause.

It is true there seems to be a fairly wide margin of safety between the theropeutic dosage and that which would produce œstrogen deficiency or androgenic effects.

Just why œstrogen therapy should alleviate dysmenorrhœa in certain cases is hard to say unless dysmenorrhœa may result from a lack as well as an excess of œstrogen. Endometrium and vaginal smear studies on these cases profiting by œstrogen administration may clarify this point, again the injected œstrin may have a different effect than

that produced naturally and may inhibit hypophysis in its production of follicle stimulating hormone even as does testosterone propionate.

Tstosterone is chemically related to corticosterone and progesterone. Under normal conditions a significant amount of androgenic hormone is excreted by the adult female. Therefore it is not too much to suggest that androgens probably play an important role in the metabolism of the androgens in the female. In giving testosterone propionate to patients with dysmenorrhœa they may be paralleling some phase of the normal physiological action of progesterone or some intermediate product of progesterone metabolism which is not as yet recognized.

Regarding insulin as a therapeutic agent, we must not forget C. A. Williams' statement that sex glands of girls and women are frequently stimulated by the use of insulin. Miller, moreover, states that probably all the glands of internal secretion play their part in the female menstrual cycle and bear a distinct relation also to their nervous and emotional constitution. The fact that carbohydrate feeding and intravenous glucose also helped patients with normal or high blood sugars discredits to some extent the hypoglycæmia theory of Altschul, *et al*. The physiological explanation for the success of high carohydrate feedings and intravenous glucose therapy in the treatment of dysmenorrhœa lies in the fact that such therapy may stimulate the pancreas to secrete more insulin and the favorable results therefore would be due primarily to insulin. This idea is supported by the fact that increasing blood sugar level of patients who had normal or high blood sugars also gave relief. Insulin therapy in functional dysmenorrhœa may be successful because of its effects on the ovaries.

Conclusions.

Dysmenorrhœa is a symptom and not an entity. A proper classification and an understanding of the ætiology back of each type will be necessary before consistent therapeutic success can be enjoyed. About 40 per cent of dysmenorrhœa cases can probably claim endocrinal origin. Intelligent specific endocrine therapy should be preceded by pelvic endometrium and vaginal smear examination and in many cases a graphing of the sex hormonal concentration and ratio, in blood and urine, throughout the menstrual cycle. The possibility of psychogenic and dietary factors should not be overlooked. The direct cause of functional dysmenorrhœa is probably a disorder in which normal uterine contractions during the phase of maximum amplitude reach consciousness. The nature of the disorder as an explanation for the reduction of the pain threshold is unknown.

Among the more rational theories as to the ætiology of functional dysmenorrhœa are the following:

(1) Deficiency of progesterone permitting of the unopposed action of œstrogenic hormone upon the uterine muscle;

(2) Excessive œstrogen production resulting in hypermotility of the uterine musculature (Salmon, *et al*);

(3) Excessive progesterone activity (D. J. Cannon);

(4) Disfunction of the hormone inactivating enzyme mechanism, or hormone activating enzyme mechanism in certain of the body tissues.

(5) An androgenic deficiency. (The androgens may balance or modify the physiological effect of the ovarian hormones.) (The deficiency may result in an unopposed or unmodified action of the ovarian hormones. The theory awaits verification.)

In summing up the ætiology, it seems probable a hormonal imbalance due to a disfuction in inactivation of œstrogens results in psychogenic or neurogenic changes that lower the pain threshold.

The rapid recovery of vaginal smear and prompt restitution of the normal proliferative and progestational endometrium, and return to normal menstrual cycle and normal pregnancy might indicate little danger of a lasting impairment of ovarian function by hormonal therapy. This would be true only if endometrium and vaginal patterns are carefully watched for threshold tolerance and dosage administered with relation to its objective effect. In spite of this the substitution of painful menses with anovulatory bleeding does not seem by the author to be advisable.

There seems to be a value in insulin therapy. Possibly its effect on the basal metabolic rate may lower the pain threshold. Again, it may have a direct effect on the ovaries.

Carcinogenic œstrogens as synthesized from coal tar ingredients should be used with reservations.

Therapeutic Measures.

An effective treatment of dysmenorrhœa necessitates the recognition of the type and if possible a comprehension of its ætiology by endometrium, vaginal smear, blood and urine, pelvic examination, together with an appreciation of possible psychogenic factors back of the case.

Following are therapeutic measures which may be employed as diagnosis indicates:

Calcium lactate either alone or in combination with caffein preparations is sometimes used. It seems effective in increasing the elimination of the hormone. Saline laxatives may also be used as female hormone is readily excreted through the bowel.

Greenhill and Freed find considerable success in relieving premenstrual tension by the use of ammonium chloride. It is their belief the trouble is due to tissue œdema due to sodium ion retention. The ammonium chloride encourages the sodium ion excretion. They were given 0.6 gm. of ammonium chloride three times daily for the few days preceding menses.

Palliative therapy is widely used in this malady. R. W. Johnstone strongly denounces the use of narcotics in view of the psychogenic possibilities of dysmenorrhœa and the inducing of addiction.

Surgical measures such a dilation of the cervix, a minor operation but frequently very effective, and presacral neurectomy are generally to be resorted to in the event of failure with the other therapeutic measures. The latter method is reciving considerable attention in the literature recently. It is evident that this operation, which is eminently successful, depends upon a proper choice of patients for operation. A patient with uterine dysmenorrhœa referred to the region of the anus and coccyx, and not into the lumbar or ovarian region, is likely to have relief. A patient with a questionable type of dysmenorrhœa, especially the type that may be confused with ovarian dysmenorrhœa, should obtain no relief. The operation causes change in menstrual habits, which are not serious. Pregnancy is not interfered with, although intercourse is. There are no serious changes of bladder or bowel habits.

Insulin therapy for functional dysmenorrhœa should be mentioned, as E. W. Schrick has found it very effective in some cases. He uses five units of insulin daily before lunch for three to five days prior to menses for two or three months. To counteract the effect of insulin on blood sugar, a supply of carbohydrate is also administered.

Proper sex hormone therapy should be preceded by careful study of endometrial patterns, vaginal epithelial smears, pelvic examination and blood and urine progestin and œstrin content. If such examination would indicate an androgen or œstrogen excess or deficiency, then antagonistic or supplementary hormone administration of a specific type may be suggested.

Most of the therapy to date using endocrine preparations or synthetics seems to have in most cases a temporary effect only.

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A DOCTOR LOOKS AT WAR

(We think the following, handed us by Dr. A. J. MacLachlan, will be of great interest to our readers—it must give us all a thrill of pride.—Ed.)

A letter interrupted by two air raids on London reached Dr. Earl D. McBride, 1607 Classen Boulevard, from his friend, Dr. R. Watson-Jones, Liverpool, England.

Dr. Watson-Jones, civilian consultant in orthopædic surgery to the Royal Air Force, has been appointed to organize its fracture service. Each week he spends "three, four or more days flying or motoring from one air force hospital to another—consulting, organizing, operating—treating youths and men who are desperately keen to get fit and back to their jobs."

As one of the 52 members of the Orthopædic Correspondence Club, it was Doctor Watson-Jones' week to write a letter and send a copy to each of the other members. Many of the club's letters deal with case histories. Not so with this letter. Doctor Watson-Jones wrote:

"Blood and sweat; toil and tears; that is our privilege for the moment. Never before have we been faced with a greater task; never before have we been more resolutely determined to accomplish it. On by one our friends and allies have been beaten down, some 'rotted within before they were smitten without,' each overwhelmed in turn.

"Week by week, one more language has disappeared from the air. The dialing boards of wireless sets enhance the illusion of isolation, for now there are but two transmissions—ours and theirs. Nevertheless we are not isolated. We may have our backs to the wall, but what a wall ! The Atlantic and our good friends beyond the Atlantic —our friends who believe with us in truth, in freedom and in tolerance.

"We will win. Whatever the cost, whatever the hardship, whatever the pain, by hard fighting, hard living, hard working, we will win. Why am I sure of that? '*Possunt quia posse credunt.*' They can, because they think they can.

Imperturbability Not Complacency.

"Imperturbability may have been our weakness in the past for it spells 'complacency,' but equally it is our strength now and in the future, for it also spells 'equanimity.' There is no panic—not a trace, not a sign—no fear, no emotion, no anxiety; just a cold disciplined determination.

"The many months of vigil, when the worst has been expected day by day and every day, the continued wearing which may be more difficult to bear than acute stress, the blackout precautions, air raid drills, and ambulance practices, the blast protections of windows, buttressing of walls, propping of ceilings and layering of sand on upper floors, the blockading, ditching, staking, mining of parks, fields, beaches and roads, the converting of garden lawns into vegetable patches, the minor annoyances of food, drink, fuel and petrol rationing, the digging of underground shelters, the fitting of gas masks, the wearing of indestructible identity discs, the testing of blood groups, the stocking of blood banks, the suffering of those whose sons, brothers and husbands will not return, all these insanities have strengthened and hardened the men and women of this country.

An Instance in Point.

"The wife of a doctor friend of mine, a girl who seems frail and very feminine, whose home is broken up, financial resources gone, child dead and husband now in an army hospital with head and chest injuries, wrote yesterday to my wife, 'Goodness me, I am knocked from pillar to post, and the more knocks I get the calmer I become, which astonishes even me.' "

Describing the setting in which the letter was composed, the doctor wrote:

"If this letter is too short, too long, or in any way below the usual standard of our club, blame the Nazis, for the drafting of it has now witnessed two air raids. At this moment as I write, although it is crisp, bright Sunday afternoon, apparently so peaceful and warm with the midsummer sun, the anti-aircraft guns are firing and the drone of bombers can be heard.

Children Take It Calmly.

"We carry on unconcernedly, but prepared at any moment to dive underground, if events 'hot up'. The children are playing on the lawn, a good part of which is lawn no more, for though the background of roses and clematis remains, the foreground consists of potatoes, onions and chickens. They are playing their favorite game—'air raid warnings.' One cries the blood-curdling wail of the sirens; the rest rush for their 'shelter,' where blankets, sticks and playboxes take the place of reinforced concrete and sandbags.

"My own two, aged 6 and 8, display their unconcern by often retiring to bed at night with ears already plugged with wool, dressing gowns and shoes already on, dolls already so comfortably arranged in the dugout, ready to save time in the night when warnings may sound."

In his letter he told how he had arranged for the transport of bone and joint injuries from the widely scattered R.A.F. hospitals to specially prepared fracture hospitals. Rehabilitation exercises are an important part of the healing.

Example Is Inspiring.

In one of the wards, the exercise leader is an air gunner with serious fractures and burns. "His enthusiasm as he waves his tannic blackened fingers in the air" is contagious, the doctor wrote, and asked, "and which of them can resist the stimulus of his example?"

Some of the letter was devoted to technical discussion: the use of sulphanilamide powdered into wounds, blood banks, dried plasma, making it "as easy to call for a pint of blood as for a quarter of morphine. Each is kept in the doctor's bag."

A note of professional optimism was written into his description of treatment of war injuries:

"Would all this work on sulphanilamide and its derivatives, on blood banks, and on dry plasma and dry serum have gone on as rapidly if there had been no war and no threat of war? Is it possible that advances in chemotherapy during the last few years may be of greater importance in the history of the world than European events during the same period? I wonder."

THE DIAGNOSIS OF SYPHILIS BY THE GENERAL PRACTITIONER

By Joseph Earle Moore, M.D.

From the Syphilis Division of the Medical Clinic, the Johns Hopkins Medical School and Hospital.
Reprinted from Supplement No. 5, United States Public Health Service.

(Continued from September Issue)

Case-finding in early syphilis does not differ in the least from case-finding in typhoid fever, tuberculosis, or any other communicable disease. Since infection in syphilis is from person to person, rather than indirectly, the problem is even simplified. The method of case-finding, reduced to its simplest elements, is shown in figure 13.

The wording of the questions in figure 13 is purposely to impress the physician and is not the form in which the patient should be addressed. From him one asks, in the vernacular if necessary: "With whom have you been exposed by sexual intercourse, or

Figure 13

TO FIND EARLY SYPHILIS

Ask each patient:

1. From whom did you get syphilis?
2. To whom may you have given syphilis?

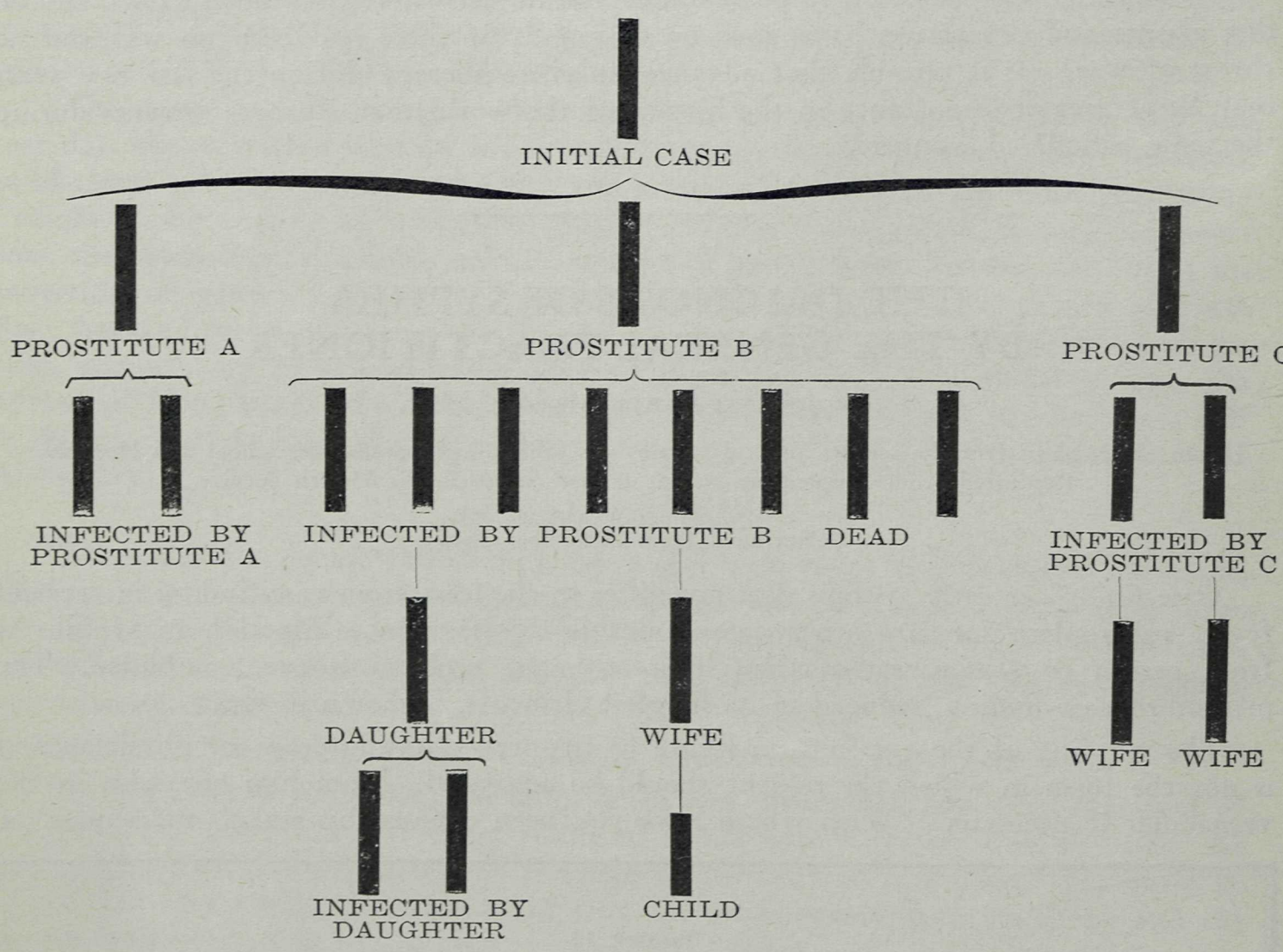
GET THE CONTACTS!

by kissing (e.g., sexual partner, friends, family), during the 3 months preceding the appearance of the chancre? With whom have you been exposed in similar fashion since the chancre appeared?" From any of the members of the first group the patient may have acquired syphilis. To those exposed to him in the latter part of the incubation period he may have given it, as well as to all of those in the second group exposed since the appearance of lesions. *All such individuals should be examined for syphilis clinically and by serologic test.* This is the unavoidable responsibility of every physician who makes the diagnosis of early syphilis.

It goes without saying that the physician is unlikely to obtain this information without first gaining the patient's confidence, explaining the reasons for the inquiry, and assuring the patient of secrecy and the safeguarding of his identity. The most desirable procedure is for the patient himself to persuade his contact or contacts to consult the physician. Failing this, he is often willing to supply the names and addresses of contacts who may be approached either through the agency of the trained workers provided by some health departments, or by the physician himself. The utmost gentleness and tact in dealing with such contacts is likewise essential.

The extent to which hidden syphilis may be uncovered and brought to treatment by this method of epidemiologic follow-up is illustrated by the admirable work of Smith and Brumfield, one of whose illustrative cases is reproduced herewith.

FIGURE 14



WITH EARLY SYPHILIS EVERY PHYSICIAN MUST BE HIS OWN PUBLIC HEALTH OFFICER

The nature of the disease, the special intimacy of the personal relationship between physician and patient, preclude the handing over to the health departments of such case-finding methods—unless the practicing physician demonstraets his unwillingness or inability to perform the task himself. Though in many instances there is involved a complete revolution of thought in regard to syphilis, the practitioner is certainly entitled to give the case-finding of early syphilis a thorough trial.

Vancouver General Hospital

NOMENCLATURE OF DISEASES

Keeping pace with other large and more advanced centres, the Medical Board of the Vancouver General Hospital has recommended that the Administration of the institution introduce the "Standard Classified Nomenclature of Diseases," thereby implicitly pledging the support of the hospital staffs to what is practically a Continent-wide attempt to standardize disease nomenclature.

Not without some hesitation on the part of the hospital authorities, the recommendation is receiving consideration.

In 1932, to encourage local uniformity in the use of diagnostic terminology, the Vancouver General Hospital relinquished the use of Dr. Ponton's Nomenclature of Diseases in favour of that of the Massachusetts General Hospital which, for some years, had been in use at St. Paul's Hospital. The results, over a period of years, have not been very marked either way, owing as much to the deficiencies of the nomenclature itself as to the lack of interest. Because of this, the question arises whether the preponderance of opinion will support such an advance as that implied in the recommended adoption of the Standard Nomenclature.

It is regrettable that such a question should exist, much less find room for expression—but that there is good reason for it seems beyond doubt, for, whereas the ordinary Disease Nomenclatures confined in their terms, as they are, ot broad topographical descriptions have not been very faithfully followed out, the Standard, based on particularized details of both topographical and ætiological factors, is likely to create still more problems, indifference and impatience.

We must admit that the Vancouver General Hospital could be an extremely fruitful field for research work. The records department there has proved itself a helpful and reliable source of information to all and sundry. Our interests have been followed and safeguarded to a marked degree so that we can afford to be the more disposed to receive the news that our support of the new Nomenclature is brought into question.

Undoubtedly, the increase in thought, labour and responsibility will devolve on that department no matter how much encouragement we give. The adherence to the system must be 100% or its value is greatly weakened.

We think the suggestion a good one and worthy of the fullest co-operation. If the records of the Vancouver General Hospital are valuable now, surely the adoption of a National Nomenclature will enhance that value and every means should be adopted to that end.

Speaking at a meeting of the National Conference on Medical Nomenclature in Chicago on March 1st, Dr. George Baehr, the Chairman of the Executive Committee, said "The resistance of clinicians to making the little extra effort required by the use of the Standard Nomenclature is soon replaced by appreciation of an orderly disease file in the hospital record room."

In that brief remark lies much of the truth of this matter of terminology. Our shortcomings might well be due for review.

The Standard system has been taken over by the American Medical Association and is the direct care of the National Conference on Medical Nomenclature which is permanently engaged in its improvement and dissemination.

A full report of the proceedings of a meeting of the Conference, held in Chicago, March 1st, 1940, appears in the *J.A.M.A.* of May 18 and May 25, to which your attention is earnestly directed.

The Canadian Hospital Council have appointed a National Committee on Nomenclature whose special study is the Standard Classified Nomenclature of Diseases, and the possibility of its adoption nationally. Of this Committee Mr. F. J. Fish is Chairman. Naturally his views are coloured—and rightly so—by his local experiences. If he is hesitant in acquiescing in the Board's recommendation we believe he must have good reason. If the fault lies with us his hands can be materially strengthened by the knowledge that the attending and visiting staffs of the Vancouver General Hospital are solidly in accordance with the recommendation.

Along with other journals, the BULLETIN has been asked to co-operate in this movement for better terminology and better clinical records.

It should be the policy of the editors of all such journals to see that, as frequently as possible, all reference to known diseases should be interms employed in the Standard Nomenclature. Eponyms, synonyms and loose phraseology should not be given room.

This journal is unhesitatingly behind the move and will take every opportunity to support it.

It will be several months before the necessary changes can be made in the Records Department equipment, but in the meantime copies of the Standard Nomenclature can be seen at the Hospital and before long a copy will be on hand in the Vancouver Medical Association Library. We recommend that every doctor secure a copy for his own office use.

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